DONALD SPECTER – 083925
RITA K. LOMIO – 254501
MARGOT MENDELSON – 268583
PRISON LAW OFFICE
1917 Fifth Street
Berkeley, California 94710-1916
Telephone: (510) 280-2621
Facsimile: (510) 280-2704

MICHAEL W. BIEN – 096891
GAY C. GRUNFELD – 121944
THOMAS NOLAN – 169692
PENNY GODBOLD – 226925
MICHAEL FREEDMAN – 262850
ROSEN BIEN
GALVAN & GRUNFELD LLP
101 Mission Street, Sixth Floor
San Francisco, California 94105-1738
Telephone: (415) 433-6830
Facsimile: (415) 433-7104

LINDA D. KILB – 136101
DISABILITY RIGHTS EDUCATION & DEFENSE FUND, INC.
3075 Adeline Street, Suite 201
Berkeley, California 94703
Telephone: (510) 644-2555
Facsimile: (510) 841-8645

Attorneys for Plaintiffs

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF CALIFORNIA
OAKLAND DIVISION

JOHN ARMSTRONG, et al.,

Plaintiffs,

v.

GAVIN NEWSOM, et al.,

Defendants.

Case No. C94 2307 CW

[REDACTED] DECLARATION OF THOMAS NOLAN IN SUPPORT OF MOTION TO STOP DEFENDANTS FROM ASSAULTING, ABUSING AND RETALIATING AGAINST PEOPLE WITH DISABILITIES AND EXHIBITS A-FF

Judge: Hon. Claudia Wilken
Date: July 21, 2020
Time: 2:30 p.m.
Crtrm.: TBD

REDACTED

I, Thomas Nolan, declare:

1. I am an attorney duly admitted to practice before this Court. I am *Of Counsel* at the law firm of Rosen Bien Galvan & Grunfeld LLP, counsel of record for Plaintiffs in this matter. I have personal knowledge of the facts set forth herein, and if called as a witness, I could and would competently so testify. I make this declaration in support of Plaintiffs' Motion to Stop Defendants From Assaulting, Abusing and Retaliating Against People With Disabilities ("Plaintiffs' Motion").

2. I have worked as a member of Plaintiffs' counsel's team in *Armstrong v. Newsom* for most of the past twenty years. I have been one of the attorneys assigned to monitor Defendants' compliance with the Americans with Disabilities Act, Rehabilitation Act, this Court's orders, and the *Armstrong* Remedial Plan.

3. I am also one of the attorneys who monitors California Department of Corrections and Rehabilitation ("CDCR") prisons in the *Coleman v. Newsom* lawsuit. Although there is a Court-Appointed Special Master whose team does the monitoring in *Coleman*, I have accompanied this team to many prisons, including California State Prison – Los Angeles County ("LAC") in Lancaster, California, a number of times to observe their monitoring tours. I have also frequently visited prisons in *Coleman,* including LAC, to interview *Coleman* class members. In the *Armstrong* case alone, I estimate that I have conducted more than one hundred monitoring tours of CDCR prisons.

4. In particular, I have been the main attorney for Plaintiffs' counsel assigned to monitor conditions at LAC since 2006. I conducted my first monitoring tour at LAC on November 13-14, 2006. Although a different attorney covered one tour at LAC in late 2007, I was the *Armstrong* monitor for LAC between 2006 and early 2016. During that time period, I toured the prison for *Armstrong* monitoring between two and four times each year. Between 2016 and early-2018, attorneys from co-counsel, the Prison Law Office, monitored LAC in *Armstrong*. In early 2018, our office once again took over responsibility for monitoring LAC. I have been the principle attorney monitoring LAC

since that time, although with an expanded team of monitors, given the serious problems we have observed.

5. Since 2006, I estimate that I have been on monitoring tours or class member interview visits to LAC, in either *Armstrong* or *Coleman* or both, approximately 60 times. During my various visits and tours of LAC, I estimate that I have interviewed close to 800 *Armstrong* and *Coleman* class members housed at the prison.

6. Starting in 2016 and 2017, our office and our co-counsel at the Prison Law Office began to receive significant reports of staff at LAC assaulting and otherwise abusing incarcerated people.

7. As is discussed more fully below, since 2017, in monitoring tour reports and letters, Plaintiffs' counsel has reported to Defendants in *Armstrong* and *Coleman* more than 140 instances of staff misconduct against people with disabilities at LAC. We have also repeatedly demanded that Defendants take action to stop the pervasive, ongoing staff misconduct at LAC. To date, Defendants have failed to provide any response to Plaintiffs' counsel regarding many of these reports. Moreover, as far as Plaintiffs' counsel is aware, Defendants have not (1) sustained a single allegation of misconduct raised by Plaintiffs' counsel or (2) disciplined a single employee for any of the misconduct that Plaintiffs' counsel reported to Defendants. Put somewhat differently, as far as Plaintiffs' counsel is aware, in every instance where Defendants have investigated Plaintiffs' counsel's reports of misconduct at LAC, Defendants have concluded either that the misconduct did not occur or that there was insufficient evidence to find that it did occur. In addition, Plaintiffs' counsel is not aware of any remedial measures taken by CDCR or LAC since 2017 to specifically address the chronic use of force problems at LAC reported by Plaintiffs' counsel.

8. More than half of the reports of staff misconduct against *Armstrong* class members at LAC set forth in tour reports since 2017 have not been added to Defendants' Division of Adult Institutions ("DAI") accountability logs. Indeed, in our two most recent monitoring reports, Plaintiffs' counsel raised a total of 34 incidents of staff misconduct

against *Armstrong* class members, but only 15 discrete incidents appear to have been added to the accountability logs. Inquiries into three of these incidents were not confirmed, meaning Defendants took no-further action in responding to these allegations. The other 12 allegations remain pending on the February 2020 accountability log—the most recent DAI log provided to Plaintiffs. *See* Declaration of Michael Freedman in Support of Motion ("Freedman Declaration") filed herewith as **Exhibit 76**.

9. On March 24, 2017, the Prison Law Office issued a report on allegations of staff misconduct that were reported during their monitoring tour on February 21-24, 2017. A true and correct copy of the report is attached hereto as **Exhibit A**.

10. Defendants responded to this report with 27 individual letters, each responding to a single incident set forth in the Prison Law Office report. True and correct copies of these letters are attached hereto as **Exhibit A1**. CDCR did not confirm a single one of the allegations. The overwhelming majority of the responses state that Investigative Services Unit ("ISU") staff at LAC investigated the report and found insufficient evidence to corroborate the allegation. In many cases, a few incarcerated individuals were interviewed in the unit where the misconduct occurred, but no information is provided as to how these individuals were selected to interview. In the letters, there is no effort to look for patterns of misconduct by location, officer, type of misconduct, or patterns in the disability or other personal characteristics of the individuals reporting misconduct. For example, there is an October 18, 2017 letter concerning an investigation into reports that custody staff in the D5 EOP ASU unit were not responding when individuals reported being suicidal. The response letter finds no evidence to support the allegation, even though this allegation is repeated in many different reports received and forwarded by Plaintiffs' Counsel about different LAC units, including D-5, over the years. No discipline against any officers is reported in any of these letters. Nor is there any report of policy changes to address the reported misconduct or prevent future similar incidents.

11. Because we were also hearing more reports about staff misconduct at LAC from our clients in the *Coleman* case, I traveled with the *Armstrong* team from the Prison

Law Office to LAC between August 28, 2017 and August 30, 2017 to interview *Armstrong* and *Coleman* class members. Based on our interviews, the Prison Law Office produced a separate monitoring report on staff misconduct issues at LAC that was sent to Defendants in *Armstrong* on October 24, 2017. A true and correct copy of that report is attached hereto as **Exhibit B**. The October 24, 2017 report listed 13 discrete allegations that LAC custody staff members used excessive force, six allegations that LAC custody staff members either ignored reports of suicidality or were verbally abusive towards individuals with disabilities, six instances of other misconduct, two reports of interference with or failure to log legal mail, and one instance of abusive conduct by non-custody staff.

12. Defendants responded to this report with 29 individual letters, each responding to a single incident set forth in the Prison Law Office report. True and correct copies of these letters are attached hereto as **Exhibit B1**. CDCR did not confirm a single one of the allegations. The vast majority of the responses state that Investigative Services Unit ("ISU") staff at LAC investigated the report, possibly interviewed the class member in question and or nearby individuals, and concluded that they were "unable to substantiate" the allegation of staff misconduct. In the letters, there is no effort to look for patterns of misconduct by location, officer, type of misconduct, or patterns in the disability or other personal characteristics of the individuals reporting misconduct. No discipline against any officers is reported in any of these letters. Nor is there any report of policy changes to address the reported misconduct or prevent future similar incidents.

13. Based on *Coleman* interviews conducted during the same August 28-30, 2017 visit to LAC, I wrote a letter to Nick Weber, the CDCR counsel in the Office of Legal Affairs in charge of *Coleman*, setting forth in detail our many concerns about staff misconduct at LAC against *Coleman* class members. A true and correct copy of that letter, dated September 7, 2017, is attached hereto as **Exhibit C**, with the exhibits omitted. Among other *Coleman* concerns related to suicide prevention and other issues, the letter reported five discrete incidents of misconduct against *Coleman* class members by LAC custody staff, or by other prisoners acting on behalf of custody staff.

14. Defendants responded to this report of misconduct against *Coleman* class members on October 6, 2017 in a letter from Nicholas Weber, a true and correct copy of which is attached hereto as **Exhibit D,** with the voluminous exhibits omitted. The response from Mr. Weber stated that each of the individual staff misconduct allegations reported in my September 7, 2017 letter was untrue and/or denied by LAC, but provided little detail about whether anything was done to investigate the claims in response to my letter.

15. Indeed, the specific responses to the individual inmate allegations in Mr. Weber's letter rely almost entirely on documentation from the CDCR disciplinary reports issued to *Coleman* class members in connection with these incidents where Plaintiffs had reported staff misconduct (including excessive force). CDCR calls their disciplinary charges and reports "Rules Violation Reports" ("RVRs"). However, it is important to note that class members at LAC in both *Coleman* and *Armstrong* who have reported staff misconduct to us overwhelmingly report that when they are assaulted by custody staff at LAC for trivial or for no reason at all, LAC custody staff then proceed to cover up the assault by issuing a false RVR charging the individual who has been assaulted by staff with made up infractions, including false claims that they assaulted staff, refused an order, or other fabricated charges. Many such instances of false RVRs at LAC are discussed in declarations submitted by *Armstrong* and *Coleman* class members that are attached to the Freedman Declaration. In some instances, CDCR has referred the false charges against incarcerated people to local district attorneys for prosecution.

16. We continued to report instances of staff misconduct against class members at LAC in 2018. On June 5, 2018, we sent a letter in *Coleman* reporting thirteen separate allegations of staff misconduct including at least five reports of excessive force. A true and correct copy of this letter, with the exhibits omitted, is attached hereto as **Exhibit E**.

17. Defendants responded to this letter on July 13, 2018. A true and correct copy of this response is attached hereto as **Exhibit F**. Defendants' letter asserted that, following investigations by LAC's Investigative Services Unit ("ISU"), the reports in our

letter were found to be unsubstantiated or were in the process of being investigated by ISU staff at LAC. Defendants did not provide a detailed account of the investigations into these reports, stating instead things like "the allegation was closed as unfounded" or "LAC investigated the allegation and determined there was no staff misconduct." In cases where the incarcerated person had filed a staff complaint using CDCR's grievance process, Defendants' response often relied upon the LAC response to the grievance. In cases where an RVR was issued, the response relies on the RVR paperwork. Moreover, Defendants never provided any information to Plaintiffs about several of the instances of alleged staff misconduct. In the letter, Defendants also refused our request for a corrective action plan to address staff misconduct at LAC, stating "A corrective action plan is unnecessary given that these allegations have largely been found to be [sic] unsubstantiated following the appropriate investigative process."

18. Next, on April 10, 2019, I wrote a letter to the *Coleman* Defendants listing more than 20 additional concerns about staff misconduct and additional discrete instances of staff misconduct. A true and correct copy of that letter is attached hereto as **Exhibit G,** with the exhibits to the letter omitted.

19. Defendants did not respond to the April 10, 2019 letter until eight months later on January 15, 2020. Attached hereto as **Exhibit H** is a true and correct copy of a letter dated January 15, 2020 from Katie Riley, a CDCR attorney, to me. The letter does not actually respond to the allegations in my April 10, 2019 Letter regarding staff misconduct. Rather, it reports that "Those portions of the letter involving allegations of staff misconduct were referred via the Associate Director to the Warden and to Office of Internal Affairs for further review. OLA attorney Alan Sobel has been working with former Associate Director Alfaro, current Acting Associate Director Lozano, the institution, and the Office of Internal Affairs on addressing the staff misconduct allegations." Defendants have not provided Plaintiffs' counsel with any other information about CDCR's response to the allegations in the April 10, 2019 letter. Plaintiffs' counsel does not know, for example, which (if any) of the allegations were referred to the Office of

Internal Affairs ("OIA") for investigation; which allegations (if any) the OIA accepted for investigation; which OIA investigations (if any) have been completed; whether CDCR sustained any of the allegations of misconduct; if yes, what (if any) discipline has been imposed on officers found to have violated policy; or whether any criminal investigations have been opened into any of the officers. We have also not been informed of any policy changes intended to reduce staff misconduct at LAC.

20. In April 2018, Plaintiffs' counsel conducted a trial joint monitoring tour of LAC with staff from Defendants' Office of Audits and Court Compliance ("OACC"). I was a member of the joint monitoring team during the joint tour. Although no report was produced in connection with this joint tour, during the tour, the monitors heard some reports about staff misconduct during our interviews with class members. I am not surprised that we did not hear more reports about staff misconduct during this tour, since our interviews took place in conjunction with CDCR staff members. In my experience, individuals reporting staff misconduct are most often wary of retaliation and further staff misconduct and will not share information about these issues until they have gotten to know and trust someone.

21. When our office took over *Armstrong* monitoring of LAC again fully in mid-2018, our office began notifying Defendants of staff misconduct allegations at LAC in routine *Armstrong* monitoring reports, and in individual advocacy letters in both *Armstrong* and *Coleman*.

22. Our first *Armstrong* monitoring tour once we started monitoring LAC in *Armstrong* again was on December 10-13, 2018. Our office issued a report to Defendants on the tour on March 19, 2019. A true and correct copy of the excerpts of the report discussing staff misconduct are attached hereto as **Exhibit I**. The report documented seven instances of staff misconduct based on interviews with class members during the tour.

23. Defendants responded to this *Armstrong* tour report on August 8, 2019. A true and correct copy of excerpts from the response are attached hereto as **Exhibit J**.

Defendants did not respond to three of the seven allegations. The responses to the four other allegations indicated that four of the staff misconduct incidents documented in Plaintiffs' Report were added to the accountability log and all four were "not confirmed." The response provided no meaningful details about what was done to investigate the allegations. There were no reported changes to policies or practices in response to the reports. There were no reports that staff members were disciplined in connection with any of the allegations of misconduct. None of the allegations were confirmed.

24. Plaintiffs' next *Armstrong* monitoring tour of LAC took place on May 21-24, 2019. A true and correct copy of excepts of our July 16, 2019 report for that tour is attached hereto as **Exhibit K**. In our report, we detailed 19 alleged instances of staff misconduct that had been reported to us during our *Armstrong* visit to LAC, including numerous instances of excessive and unreasonable force. In the July 16, 2019 tour report, we also specifically asked for information about what LAC management had done or was doing to address the ongoing staff misconduct at the institution, including asking the following questions:

- What has LAC management done thus far in response to the numerous staff misconduct complaints covering *Armstrong* and *Coleman* class members at LAC during the last few years?
- How many officers or other staff have been disciplined at LAC for the staff misconduct issues reported in plaintiffs' letter and reports?
- What other steps has LAC considered to combat staff misconduct?
- Has the institution considered expanding the use of video cameras to combat this problem?
- What about using the 30% of positions not covered by post and bid to hand select officers for the EOP buildings and the buildings with large numbers of individuals who use wheelchairs? Has LAC used this approach?
- Has LAC management moved any correctional officers to different yards or housing units due to reports of staff misconduct against them?

We never received responses to these questions.

25. On July 23, 2019, Defendants sent an acknowledgement letter, a true and correct copy of which is attached hereto as **Exhibit L**, regarding 13 of the 19 the staff misconduct allegations in our July 16, 2019 report. In the letter from Jennifer Neill, General Counsel for the CDCR Office of Legal Affairs, Defendants stated only that the allegations in our report "were routed to the appropriate personnel at CDCR" and that "[t]he Legal Liaison for the High Security Mission, Alan Sobel, will provide you with more information when it becomes available." The letter is notable because it does not treat these 13 instances of staff misconduct against *Armstrong* and *Coleman* class members as either an *Armstrong* or a *Coleman* issue. The letter does not indicate it is a response in either *Armstrong* or *Coleman,* and it is not from the attorneys who typically work on those cases. Out of these 13 incidents, we have only been given additional information regarding CDCR investigations into three incidents. The limited additional information Defendants provided about the three incidents is discussed in the next paragraph.

26. In a memo dated April 8, 2020, which Plaintiffs' counsel received on April 13, 2020, Defendants formally responded to our July 16, 2019 *Armstrong* monitoring tour report of LAC. A true and correct copy of excerpts from their response is attached hereto as **Exhibit M**. In their response to the tour report, Defendants do not address or respond to most of the 19 individual allegations of excessive force or improper conduct by LAC officers or staff in the July 16, 2019 report. For nine of the incidents, Defendants do provide partial responses regarding the allegations. Those nine responses generally focus on issues other than the alleged staff misconduct or abuse. In the only three instances where the use of force issues are addressed in the response, two responses merely rely on the disciplinary reports issued following the incident. The third response indicates that it will be addressed through CDCR's staff complaint process, but does not provide any additional information. For another of these incidents, Defendants response says they are not responding because the individual was not a class member at the time he was assaulted.

In a few of the responses, Defendants responded to an allegation of an improper removal of an assistive device using a review of the individual's medical record.

27. In one egregious response, in **Exhibit M** at page 39 (report pagination), Defendants responded to an allegation that a part-time wheelchair user was threatened with a disciplinary violation for taking his wheelchair into his cell. In their response, Defendants assert that the officer's alleged action was proper, since part-time wheelchair users do not require the use of their chairs in their cells. This is not an appropriate response. In my experience monitoring this case, I have learned that many part-time wheelchair users with codes of DPO do use their wheelchairs to get in and out of their cells, and other part-time wheelchair users generally want to fold up and keep their wheelchairs in their cells so that other prisoners do not use and damage them in the dayroom. At the very least, threatening a class member with a disciplinary write up for doing this is abusive and insensitive.

28. In none of the responses do Defendants provide information about investigations into the allegations, including which (if any) of the allegations were referred to the Office of Internal Affairs ("OIA") for investigation; which allegations (if any) the OIA accepted for investigation; which OIA investigations (if any) have been completed; whether CDCR sustained any of the allegations of misconduct; if yes, what (if any) discipline has been imposed on officers found to have violated policy; or whether any criminal investigations have been opened into any of the officers. Defendants also did not provide any information about any changes in policies or procedures made in response to the allegations.

29. At the end of the section of our July 16, 2019 report detailing staff misconduct incidents at LAC, we also asked for the following:

> Plaintiffs request an update regarding the investigations into the allegations of staff misconduct in our December 2018 Report. We also ask that all of the allegations detailed above be investigated by non-LAC ISU staff. We ask that this section of the report not be shared with line staff at LAC, and that any investigation into our class members' allegations be conducted by non-LAC staff.... [W]e are concerned that any investigation by LAC ISU staff will merely paper over our class members' complaints and obstruct any

> attempts to bring about badly needed changes to LAC. We furthermore request that headquarters and institutional leadership develop a corrective action plan to address our class members' repeated and consistent allegations of staff misconduct at LAC.

30. In the formal response to these requests that is set forth in **Exhibit M**, Defendants responded as follows:

> Defendants take staff complaints seriously and acknowledge the need for staff to foster an environment conducive to meeting the needs of inmates with disabilities. Defendants are in the process of developing regulations that will change CDCR's appeals and grievance process. Defendants have kept Plaintiffs' counsel advised of the status and progress of the new regulations and Defendants will continue to do so."

31. Our next *Armstrong* monitoring tour of LAC was on November 18-21, 2019. Attached hereto as **Exhibit N** is a true and correct copy of the staff misconduct sections of our monitoring report for this tour, which was sent to Defendants on February 7, 2020. The February 7, 2020 report detailed 16 additional reports of staff misconduct that came to the attention of the monitors or were confirmed based on interviews during the monitoring tour. We have not received a response to this tour report from Defendants.

32. For the last 15 months, from the time of our April 10, 2019 letter to Defendants to the present, my office has been keeping a detailed spreadsheet of all staff misconduct allegations we have received and investigated at LAC. We shared a version of this spreadsheet with Defendants on March 27, 2020 covering our reports to Defendants over the course of a little less than a full year, from April 10, 2019, through March 27, 2020. We provided the spreadsheet in order to assist Defendants in tracking and responding to the allegations that we have made. Attached hereto as **Exhibit O** is a true and correct copy of my March 27, 2020 cover letter providing Defendants with the spreadsheet detailing our concerns about staff misconduct at LAC, along with the spreadsheet itself. The spreadsheet was maintained by paralegals working under my direction and close supervision and I have worked with and frequently reviewed the spreadsheet and believe it to be accurate and complete for the period in question.

33. The spreadsheet in **Exhibit O** that we shared with Defendants includes 88 discrete instances of staff misconduct at LAC in 2018, 2019, and 2020. These 88 allegations include 49 allegations of unreasonable or excessive force at LAC. These figures include only the staff misconduct reported to Defendants in our LAC monitoring reports and letters between April 10, 2019 and the present. The figures do not include the many allegations of staff misconduct that were reported to Defendants by Plaintiffs prior to April 10, 2019.

34. Our March 27, 2020 cover letter attached as part of **Exhibit O** also contained our analysis showing that a number of officers at LAC had engaged in multiple instances of misconduct. We noted that a single officer on C-Yard was named as the main perpetrator in thirteen reported incidents of staff misconduct, including seven allegations of excessive force. We also noted that an Officer in D-Yard, Building 3 is cited as the main perpetrator in six incidents of staff misconduct, including four allegations of excessive and unreasonable force. We also noted that a second officer in D-Yard, Building 3 is cited as the main instigator in four allegations of excessive and unreasonable force. Finally, we noted that a fourth officer who works in the EOP Administrative Segregation Unit on D-Yard, in Building 5 has been named as the main perpetrator in four incidents, including two incidents alleging unreasonable and excessive force.

35. In addition, enclosed along with the letter attached hereto as **Exhibit O,** we provided Defendants with fourteen additional individual advocacy letters containing detailed allegations of staff misconduct and abusive staff behavior at LAC. We have been sending individual advocacy letters to defendants about staff misconduct at LAC since at least mid-2019 and those letters are included in the 88 incidents tracked on the spreadsheet shared with Defendants.

36. Since we sent the March 27, 2020 letter documenting 88 instances of staff misconduct in 2018, 2019 and 2020 (all of which we reported to Defendants in a period of one year between April 2019 and March 2020), we have been working on gathering

declarations from *Armstrong* and *Coleman* class members regarding misconduct they experienced or witnessed at LAC.

37. Since mid-April 2020, we have gathered 29 declarations from *Armstrong* and/or *Coleman* class members concerning staff misconduct at LAC. Copies of these declarations are attached to the Freedman Declaration filed herewith. Some of these declarations are about instances included in the list of 88 incidents discussed above. Some of the declarations discuss additional misconduct. These 29 declarations were all shared with Defendants using a file sharing site in May 2020.

38. At the time of our March 27, 2020 letter, Defendants had responded to only 27 of the 88 incidents raised, either in the form of individual letters or in formal responses to our monitoring tour reports. (The superficial and mostly non-responsive information Defendants provided in written responses to Plaintiffs' tour reports are discussed *supra* at ¶¶ 22 - 31.) True and correct copies of all of the 15 individuals response letters we have received from Defendants are attached hereto as **Exhibits P** through **DD**. There were a total of eight individual responsive letters at the time of our March 27, 2020 letter. Since we sent that letter to Defendants, they have responded to an additional seven allegations of staff misconduct, the most recent dated May 18, 2020. Copies of these seven additional letters are attached hereto as **Exhibits P** through **V**.

39. Thus, currently, CDCR has responded to 34 of the 88 allegations either (a) in Defendants' written responses to Plaintiffs' tour reports or (b) in the 15 individual allegation response letters attached hereto in **Exhibit P** through **Exhibit DD**.

40. The majority of the 15 responses attached in **Exhibits P-DD** are non-responsive, non-substantive, and based on unclear or incomplete sources of information. Four of these responsive letters are merely "status updates," wherein Defendants state that they have "committed additional resources (including assigning staff from other CDCR institutions) to expedite the completion of the outstanding inquiries." True and correct copies of these four letters are attached hereto as **Exhibits X** through **AA**. These letters promise further updates once the inquiries are completed. Defendants sent

these four "status updates" to Plaintiffs on February 13, 2020; we have yet to receive a complete response about investigations into these allegations. In these status updates, Defendants also admit that their response to each allegation "has been pending for some time." Defendants provide no timeline as to when they will complete these investigations.

41. Defendants labeled three of their responses to individual letters with allegations of staff misconduct against *Coleman* class members as acknowledgments of "Non-Class Action allegation(s)." True and correct copies of these responses are attached hereto as **Exhibits BB** through **DD**. In these letters, Defendants merely noted receipt of our allegations and stated that "they were routed to the appropriate personnel at CDCR." The letters indicated that Defendants would contact our office about these allegations when "more information becomes available." The earliest of these three non-class action acknowledgement letters dates back to August 26, 2019. Plaintiffs have not received any additional information about investigations into these three allegations of staff misconduct.

42. On November 22, 2019, I sent an email to Defendants objecting to the characterization of these allegations against *Coleman* class members as unrelated to the *Coleman* class action case. In the email I wrote that "Defendants cannot shirk their constitutional obligations to prevent the application of unreasonable force against *Coleman* class members simply by claiming that these issues are not part of the *Coleman* case." I also explained why the issues were part of that case. A true and correct copy of the email, as well as the letter from Defendants that prompted it being sent, is attached hereto as **Exhibit EE.** Defendants have not responded to this email.

43. The eight remaining responsive letters, attached hereto as **Exhibits P** through **W** include, on first look, more substantive responses to the allegations we have provided to Defendants. However, upon closer examination, the responses reflect the inadequacy of Defendants' investigative methods, failure to look for patterns as confirmation of allegations, and the enormous delays in investigating and responding to Plaintiffs' counsel. In all eight, letters, Defendants found that the allegations could not be confirmed or substantiated.

44. The most recent response we received on May 18, 2020, attached as **Exhibit P**, reflects the inadequacies in Defendants' investigations into and decision-making regarding staff misconduct allegations. The letter concerns one of the allegations of staff misconduct sent to Defendants more than a year earlier in my April 10, 2019 letter. The allegation in Plaintiffs' April 10, 2019 letter is set forth in the response: "[The incarcerated individual] reported that on October 12, 2018, he told staff on first watch in his unit (C5) that he was suicidal, but they refused to help him or contact mental health staff. He was EOP at the time. Later that night, [the incarcerated individual] told multiple officers on first watch, including [an Officer], that he was suicidal and showed them his arm, which was bleeding profusely from a cut he made. [The incarcerated individual] was kept in his cell until second watch, when he was taken to see mental health staff." The May 18, 2020 response letter explains that two inmates who were "housed in close proximity" to the prisoner who made the allegation were interviewed about what took place that night. It does not say where the men were housed that night or how far away they were from the cell of the suicidal individual who made the allegations. It also does not say how the two men were selected to interview, or by whom, or why only two individuals were interviewed. One of the two prisoners interviewed recalled the suicidal individual telling staff he was going "man down" on the evening in question, which is prison slang for telling staff you need urgent, immediate medical care. However, this witness said he was unsure whether the suicidal individual also said he was suicidal. The second "witness" said he did not see the suicidal inmate asking for help. The letter also states that custody and medical records confirm the suicidal individual was taken out of his cell with his arms bleeding and given sutures at 6:00 a.m. the next morning, when second watch staff arrived. Despite the confirming evidence found through the superficial investigation reported in the letter – that staff ignored the individual when he called for urgent medical care by saying "man down" and that he was only taken out the next morning when second watch staff arrived, this letter concludes by saying "[t]he evidence obtained during the inquiry does not indicate that staff failed to follow policy and

procedure. The information revealed during the inquiry was insufficient to warrant a referral to the Office of Internal Affairs, and we now consider this matter closed."

45. A second, similar responsive letter, dated May 11, 2020 and attached as **Exhibit Q**, described a similar investigation into another incident in the C5 housing unit where two class members reported that a suicidal patient's pleas for help were ignored by custody staff. Despite the identical allegation in two claims from class members in C5, they are not used to corroborate each other in these investigations. In the May 11, 2020 letter, LAC reports that staff interviewed three inmates who were "housed in cells in close proximity" to the suicidal individual. The letter indicates that these individuals did not observe the individual in question telling staff he was suicidal. Once again, the letter does not say how these three individuals were selected to be interviewed or how far they were from the individual in question, or even whether they were in the housing unit on the day in question. The letter also includes a vague reference to information from the inquiry that "indicates inmates may have presented false information when making the allegation." The letter does not explain this charge.

46. These two most recent responsive letters are also notable in that they do not mention the fact that two very similar claims have been made from the same housing unit. In these letter responses in general, it is clear that no meaningful effort was made to identify patterns of misconduct by individual officers, in individual locations, or against particular groups of vulnerable individuals. Moreover, none of the allegations are confirmed and no remedial action or policy changes are reported.

47. Another letter, attached hereto as **Exhibit R**, similarly show the weakness of the CDCR and LAC investigation approach. The May 8, 2020 letter responded to an April 29, 2019 allegation that staff in the EOP ASU used racist epithets. The investigation into the allegation resulted in an interview with two inmates in that unit at the time. In the May 8, 2020 letter, LAC reports that the two incarcerated persons reported they did not hear the officers use such epithets. There is no indication the individual who made the complaint was interviewed or asked for witnesses, or if he was asked if other staff were

witnesses. There is also no indication that the investigators searched for other similar allegations or that such allegations are tracked in a way that would allow them to identify other similar allegations**.**

48. The next responsive letter, dated May 7, 2020 and attached hereto as **Exhibit S**, concerns similar allegations of racist abuse of individuals in the same EOP ASU. Again there is no link between these two similar allegations. Again the investigation relied heavily on random interviews with individuals housed in the EOP ASU at that time. The letter then says all of the interviewed inmates said Officers in the unit treated people fairly and equally. However, two sentences later it acknowledges that one of the six individuals interviewed said he heard a racial slur one time. This individual's report is disregarded. The letter says grievances were also reviewed for similar allegations, but CDCR does not have a good system for doing such a review, and many prisoners are reluctant to file staff misconduct appeals. Out of the 88 incidents in the spreadsheet we sent to Defendants on March 27, 2020, listing all of the staff misconduct we have reported to Defendants in the last year, see **Exhibit O** hereto, there were 8 discrete incidents of racially-charged staff misconduct, including incidents with either the use of racist language or the targeting of people of a particular racial or ethnic group, or both.

49. A handful of the more detailed responsive letters in **Exhibit P** through **W** concern allegations against the individual Officer accused of staff misconduct in 13 of the 88 incidents Plaintiffs' counsel reported in the spreadsheet we sent Defendants on March 27, 2020. Those letters, and in particular a March 26, 2020 letter, attached hereto as **Exhibit U**, suggest without any supporting evidence provided that there was an improper attempt by prisoners to get the officer moved to another housing unit. However, the letters do not acknowledge that the misconduct by this officer has taken place in many different housing units.

50. The only other responsive letter that is more detailed is dated January 17, 2020. A true and correct copy of the letter is attached hereto as **Exhibit W**. That letter

demonstrates the need for cameras at LAC. The individual in question reported two incidents where staff assaulted him. The investigation letter recites that several prisoners, including the individual who was assaulted, were interviewed. It does not say how many individuals were interviewed or how they were selected, but it says that based on the interviews, it was concluded that the allegation "is unfounded." The best evidence would be video of the housing unit at the time of those two incidents.

51. Plaintiffs' counsel has also received frequent reports from class members at LAC of retaliation for working with Plaintiffs' counsel and for complaining about staff misconduct more generally. Most recently, on Friday May 29, 2020, we spoke on the phone with a class member currently housed at Kern Valley State Prison ("KVSP") who has complained about staff misconduct at LAC in the past, and who submitted a Declaration that is part of this filing. Attached hereto as **Exhibit FF** is a true and correct copy of an e-mail that I wrote to Defendants on May 29, 2020 after speaking with this individual. The email expresses my concerns about ongoing staff misconduct that appears to have followed this individual from LAC to KVSP when LAC staff called him at KVSP to investigate his allegations of staff misconduct. The retaliation this individual has experienced is also detailed in this individual's Declaration which is attached to the Freedman Declaration filed herewith as **Exhibit 62**.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct, and that this declaration is executed at San Francisco, California this 3rd day of June, 2020.

Thomas Nolan

Exhibit A

California State Prison – Los Angeles County (LAC)
***Armstrong* Monitoring Tour, February 2017**
Report of Staff Misconduct

Representatives from the Prison Law Office visited California State Prison – Los Angeles County (LAC) on February 21-24, 2017, to evaluate compliance with the requirements of the *Armstrong* Remedial Plan, Americans with Disabilities Act, and *Armstrong* court orders. During our visit, we received reports that custody staff used excessive force against prisoners, verbally abused and harassed prisoners, and ignored or encouraged expressions of suicidal ideation. The reported staff misconduct appears to be concentrated in units that house people with the most serious mental illnesses and, in particular, D5, which houses EOP prisoners in administrative segregation. Those prisoners do not always have the capacity to respond appropriately to stressful situations. We note that, during the most recent Continuous Quality Improvement tour at LAC in October 2016, "interviews in the D-5 EOP ASU unit revealed pervasive and serious concerns about staff misconduct against patients in the unit. These complaints were later corroborated during the group interview with clinical staff members." Letter from Krista Stone-Manista, Plaintiffs' Counsel, to Matthew Lopes, Special Master, and Nick Weber, CDCR Health Care Legal Team, *Coleman v. Brown: Plaintiffs' Comments re CQI Process* at 5 (Mar. 2, 2017).

In the interest of allowing CDCR to promptly address these serious allegations, and as requested by Warden Asuncion, we are submitting this report before the complete *Armstrong* tour report. This report includes only allegations for which the class member either was willing to let us share his name with CDCR, or was willing to let us share the facts of the allegation but not his name. We heard of other incidents of staff misconduct but did not have permission from those class members to share the details of their experiences. This report also includes several allegations of misconduct reported in 1824 requests for disability accommodations.

We ask that all allegations of staff misconduct identified in this report be fully investigated, regardless of any informal fact-finding determinations that already may have been made by the institution. We request that the investigations include review of any disciplinary actions, including the issuance of RVRs, taken against prisoners alleging staff misconduct, especially those who received RVRs following physical confrontations with staff. We ask that we be apprised of the result of CDCR's inquiries. We hope that we can work together to identify, address, and prevent staff misconduct at LAC.

I. HOUSING UNIT D5

A. Excessive Use of Force

Prisoners living in D5, administrative segregation for EOP prisoners, reported that custody staff often immediately use force instead of employing mental health interventions to deescalate conflicts occurring between staff and prisoners with serious mental illness, or among prisoners with serious mental illness.

Prisoner 1 reported that in late January or early February, Officer A got into a verbal argument with a black prisoner (name unknown) and provoked the prisoner by, among other things, calling the prisoner a "nigger." Another prisoner, Prisoner 2, who is EOP, reportedly tried to verbally intervene and calm down the situation. About twenty minutes later, the prisoners were released to group. Prisoner 1 reported that after the group ended, he witnessed Officer A shove Prisoner 2, who was at that time fully cuffed, against the wall. Officer A reportedly took Prisoner 2 to the ground and attempted to strangle him. According to the medical record, on January 30, 2017, Prisoner 2 suffered an abrasion on the upper right side of his top and bottom lips, bleeding on the back of his head, an abrasion on his left elbow, and dried blood on his right ear. Prisoner 2 was placed on suicide watch the same day. The following day, according to the medical record, he reported to mental health staff: "*I fear for my life. I was attacked by an officer in D5. I was feuding with this officer for a while and he was upset with another inmate then took it out on me . . . . I'd rather kill myself than to be killed by an officer*."

Prisoner 3 reported that, on February 14, 2017, he was being escorted by three officers in D5. He reported that one officer was holding his left elbow, and another was holding his right elbow. The officers were walking quickly, and Prisoner 3 reported that he repeatedly said, "Can you please slow down? You're going too fast. I don't have my cane. I'm going to fall."[1] The officers reportedly did not slow down. Prisoner 3 reported that his back gave out, and he tried to hold himself up—possibly by holding onto or leaning into the escorting officers. Officer B, who still is working in the building, reportedly then slammed Prisoner 3 to the ground. Prisoner 3 reported and medical records confirm that he suffered fractured ribs that day. Prisoner 3 reported that the officers now are alleging that he elbowed them, and that he has received a DA referral. The officer, however, reportedly told Prisoner 3 that he would drop the 115 if Prisoner 3 dropped the 602 against him. Prisoner 3 reported that he at first refused an interview about the incident, because he was not told what he was charged with, and they would not tell him if he needed an attorney.

Prisoner 4 reported that he was placed in D5 in November 2016 for his safety. He reported that he had a classification committee meeting on February 2, 2017, at which time he told staff that he did not want to go to Facility C because he was concerned for his safety there. After the meeting, he reported that he was carried, with his arms and legs shackled. He reported

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[1] Prisoner 3 reported that he fell the week before this incident, while walking to medical without his cane. According to the medical record, he reported falling in a 7362 dated February 8, 2017, when a doctor ordered a cane. Prisoner 3, however, was not issued a cane until February 16, after he reportedly almost fell a second time and was injured by officers.

that staff did not tell him where he was being taken. When he realized he was being taken to C yard, he reported that he again voiced his safety concerns. He reported that Officer C then slammed his head onto the ground. According to the medical record, Prisoner 4 reported that he was assaulted by custody staff. Prisoner 4 sustained facial injuries, "including abrasions near the mouth and slight swelling under the left eye." The medical provider completed an urgent referral to ophthalmology because of the injuries. During the *Armstrong* tour on February 22, 2017, we observed wounds on his legs where he said the shackles had cut into him. Prisoner 4 reported that the day after the altercation, he was placed in a corner cell with a suicide watch blanket and mattress, even though he was not on suicide watch. He also reported that he received a 115 the week before the *Armstrong* tour, charging him with battery of an officer, stealing a handcuff key, and trying to unlock himself.

Prisoner 5 reported that officers treat the younger prisoners badly. They push the prisoners against the wall unnecessarily when cuffing them. Another class member reported that an officer beat Prisoner 6; that Officer D beat Prisoner 7, and that an RN tried unsuccessfully to intervene; and that Officer A and Officer E took down a prisoner and continued to beat him the week of February 20.

B. Failure to Respond to Medical and Mental Health Emergencies

Class members in D5 also reported that custody staff do not timely respond to medical emergencies and either ignore prisoners who express thoughts of suicide or encourage them to hurt themselves. For example:

1. Prisoner 8 reported he told Officer F that he was feeling suicidal in mid-February, following the death of his grandmother. Officer F reportedly did not do anything other than say, "Go ahead—cut yourself." Prisoner 8 did; we observed thin cuts along his arms during the *Armstrong* tour. According to the medical record, Prisoner 8 reported to medical and mental health staff in mid-February that he was feeling suicidal and that he had asked custody staff to contact the mental health clinicians, but the officer did not do so.

2. One prisoner, who asked not to be named for fear of retaliation, reported that officers in D5 often do not respond to calls of "man down." Officers also reportedly ignore when people say they are suicidal. In early February, Prisoner 9 reportedly set fire to himself or his cell after officers refused to respond to his statement that he was feeling suicidal. (Prisoner 8 separately reported that officers did not immediately respond to Prisoner 9's situation.) According to the medical record, Prisoner 9 was found unresponsive in his cell on February 7, 2017, and suffered from smoke inhalation. Prisoner 9 reported that after being hospitalized, he was returned to his cell, which had not been cleaned of smoke and water damage.

3. Prisoner 3 reported that many prisoners in D5 say that they are suicidal, but the officers simply ignore them.

4. Prisoner 10 reported that, on July 30, 2016, two custody officers in D5, including Officer H, ignored his yells for help as he was having a seizure. *See* HC [redacted]. The RAP response dated August 10, 2016, fails to address his allegation of staff misconduct. The RAP response further states: "Dr. [redacted] has reviewed your medical file indicating you have no record of any seizure disorder." That, however, is incorrect. A 7371 dated August 1, 2016, lists one of Prisoner 10's "significant medical problems" as "seizures."

C. Harassment, Verbal Abuse, and Other Misconduct

Class members asked us whether the officers assigned to the unit had training in interacting with EOP prisoners, and believed that such training would be beneficial because officers were rude and attempted to provoke prisoners with serious mental illness. For example:

1. Prisoner 11 reported that Officer I and Officer C call prisoners "bitches" and cuss people out. He said that Officer A is "looking for a fight."

2. Prisoner 12 reported that Officer D told other officers that Prisoner 12 had been convicted of a sex offense.

3. Prisoner 3 reported that in late December when he was removed from suicide watch, he was left naked in his cell for nineteen hours despite staff knowing that he had been released from suicide watch.

4. Prisoner 1 reported that the officers on D5 need training on how to deal with EOP prisoners. He believes that officers try to provoke prisoners and play with their emotions.

D. Denial of Access to Grievance Process

We received a number of reports that prisoners in D5 often are denied forms and pen fillers, so they cannot confidentially raise or exhaust concerns regarding staff misconduct or their disabilities.

1. Prisoner 5 reported that officers do not give envelopes to prisoners that they do not like. He also reported that 1824s are hard to come by in the unit. Officers say they will give him an 1824 "when I feel like giving it to you." 602s and 22s reportedly are easier to get from officers. He also reported that officers will not give them pen fillers to use to fill out the forms. They have to find someone friendly on the mental health staff to give them one.

2. Prisoner 4 reported that officers on D5 do not keep forms in stock. For example, Form 22s were not available for the last month. They reportedly came back in stock the first day of the *Armstrong* tour. Prisoner 4 also reported that when prisoners ask for forms, including 602s, the officers say, "No, we don't have them." He reported that officers also will say that they do not have any pen

fillers. Officers reportedly will only hand out pencils (if anything), but prisoners reported that forms filled out with a pencil are rejected on that basis. He reported that officers tell prisoners to wait for weekly supply runs to request forms and pen fillers. Then during supply runs, the officers say they do not have any forms or pen fillers. He also reported that prisoners were not given indigent envelopes for the last month. They received them on the first day of the *Armstrong* tour.

3. One prisoner, who asked not to be named for fear of retaliation, reported that officers in D5 will not give prisoners 1824s, 602s, 22s, or pen fillers. Officers reportedly say that they will give the prisoners the forms with weekly supplies, but then during the weekly supply run, the officers say that they do not have any forms or pen fillers.

4. Prisoner 8 reported that he has to sign up for the law library if he wants access to forms, including 1824s and 602s. Officer will not bring the forms to prisoners; they will either say they "forgot," "there is none," or will simply refuse to provide them.

5. Prisoner 3 reported that officers rarely have pen fillers or forms for prisoners. Nurse A, however, sometimes will help and try to find an 1824 for prisoners. He thinks very highly of Nurse A.

6. Prisoner 1 reported that officers in D5 make excuses like "We don't have none," and "They're not down there," to avoid giving forms, including 1824s and 602s, to prisoners they do not like. He reported that officers will give other prisoners an Inmate Request for Interview form instead of a Form 22 (saying they are out of Form 22s). But without a Form 22, a prisoner cannot start an appeal, and he has seen 602s rejected because a Form 22 had not yet been filed. He also reported that officers ran out of pen fillers for about two months (November-January). There also were no envelopes for about a month; they were passed out the first day of the *Armstrong* tour.

II. OTHER HOUSING UNITS

A. Excessive Use of Force

We also received reports from EOP and CCCMS class members that officers used excessive force against them in other housing units in Facility D. For example:

1. Prisoner 13 reported that second watch staff in D3 are the most problematic. He reported that in mid-February 2017, a prisoner was having an episode of paranoia. Custody staff asked the prisoner to go to the shower for a search. Instead of talking to the prisoner, staff slammed him to the ground. Prisoner 13 said that he often avoids going to mental health groups because people get into fights and custody immediately use pepper spray, making it difficult for everybody to breathe.

2. Prisoner 12 reported that the morning of November 20, 2016, when he was housed in D1, he was standing by the counselor's office. He did not notice anything out of the ordinary. Tower Officer A, who was new to the unit, pushed the alarm. Sgt. [redacted] and Officer J came running and told him to sit on the benches by the television. (Prisoner 12 was wearing his mobility impaired vest at the time.) Prisoner 12 complied. The Tower Officer reportedly said that Prisoner 12 had been standing over a person who had been beaten. Officer J then came at Prisoner 12 from behind and started to handcuff him behind his back. Prisoner 12 reportedly turned his head and asked to be handcuffed in the front because it was painful for him to be handcuffed from behind. Officer J then reportedly pushed him to the ground (forward off the bench), and hit Prisoner 12's finger, which was clinging to the bench, with his baton. Another officer kicked his face and pepper sprayed him. Officer D reportedly hit him on the head with a baton. Medical records confirm an open laceration on left middle finger, raised reddened area above right eyebrow, swelling around left eye, scratch on the left side of his forehead, and pepper spray exposure to face and upper torso.

We also received reports of improper force used against CCCMS class members in the ASU. Prisoner 14 reported that in late December 2016, he was walking in waist chains. Officer K pulled his hands together to the side, so he could not use his cane to walk. Prisoner 14 reported that he told the officer that he could not use his cane in that position. The officer reportedly then took him to the ground and slammed his head to the ground, injuring his wrist in the fall. According to the medical record, Prisoner 14 reported that an officer knocked him down. He received sutures to his face, and X-Rays were ordered. Prisoner 14 said he received a 115 saying that he tried to swing his right hand (which he reported would be impossible in waist chains) and a DA referral as a result. He reported that he had not yet had his 115 hearing as of the date of the *Armstrong* interview. In addition, Prisoner 15 reported that in January 2017, he put his arm though the food tray slot. The second watch officer closed the door on his arm and he had a bruise. He said that he did not report the injury to medical staff.

Finally, Prisoner 16 reported that around November 2016, he was entering his cell when Tower Officer B, who electronically closes cell doors, closed the door before Prisoner 16, who uses a cane, could fully enter. As a result, he was caught in the door. Prisoner 16 reported that Tower Officer B has done this to other prisoners.

B. Harassment, Verbal Abuse, and Other Misconduct

We also received reports of harassment, verbal abuse, and other misconduct by officers against class members housed outside of D5. For example:

Facility B: At least two 1824s raise staff misconduct allegations relating to B1. First, Prisoner 17 in B1 reported that custody staff harass him because of his DPV status: "I would like to be remove [sic] from the DPV program because it to [sic] much stress and i [sic] keep being harass [sic] by officials. . . . I would like to continue to do my braille learning without being harass [sic] by officials." *See* B-[redacted]. The RAP response, dated December 21, 2016, does not address this allegation. Second, Prisoner 18 reported that custody staff in B1 do not call

the plumber when the toilet or sink is clogged and that they will not turn on the electricity, which stays off for weeks at a time as a form of punishment. *See* B-[redacted]. The RAP response, dated September 28, 2016, fails to investigate any possible staff misconduct. The allegation does not appear in the employee non-compliance logs.

Facility C: Prisoner 16 reported that the canteen manager uses foul language. In the last month, Prisoner 16 attempted to talk with the canteen manager who told him to "get the fuck away from my window." The canteen manager and other staff make fun of Prisoner 16's name, calling him "nigger." He reported that many prisoners do not report the canteen manager's misconduct because people fear the manager might tamper with their canteen draw. Prisoner 19, a right-leg amputee, reported on November 13, 2016, that custody officers call him a "gimp." *See* C-[redacted]. The RAP response, dated November 22, 2016, states that Lt. [redacted] conducted an interview with Prisoner 19, and that Prisoner 19 stated that he banters "back and forth with custody staff" and that he "could not provide any name of staff that were calling him names." The RAP response states that there was "no way to determine if staff were in fact being unprofessional and calling [him] names."

Facility D: Prisoner 9 reported that custody staff on D1 daily verbally abuse prisoners. Officer L and another officer on third watch call people "bitches" and "retards," and say things like, "this is my fucking building." He reported that on the morning of February 22, 2017, one prisoner (name unknown) attempted to give another prisoner a biscuit from his breakfast. Tower Officer C said to the prisoner, "You're going to do that the fuck I say," then called everybody "retards." As the prisoner was leaving, another officer said to him, "I should be spraying you." One prisoner in D1 who asked to remain anonymous out of fear of retaliation reported that in December or January in his mental health group two prisoners started fighting. No mental health or custody staff were present. He reports there often are not any staff around for about 5-10 minutes before the group begins, and he is scared another fight might happen. Prisoner 20 reported that custody staff on D4 third watch daily verbally disrespect prisoners. On February 21, 2017, Officer G approached a cell and said, "Move that fucking curtain! Open the goddamned door!" Officer G called the prisoner a "bitch" and a "coward." Officer G entered the cell even though the prisoner was still inside. Prisoner 20 said that prisoners often do not report staff misconduct because they fear retaliation.

Exhibit A1

OFFICE OF LEGAL AFFAIRS
Patrick R. McKinney II
General Counsel
P.O. Box 942883
Sacramento, CA 94283-0001

October 3, 2017

Rita Lomio
Prison Law Office
General Delivery
San Quentin, CA 94964

Dear Ms. Lomio:

This letter is in response to the allegations raised in your February 2017, *Armstrong* Monitoring Tour report concerning California State Prison Los Angeles County (LAC). The California Department of Corrections and Rehabilitation (CDCR) takes every allegation seriously, and as such has conducted an inquiry into your allegation as stated below:

Prisoner 12 [redacted] reported that Officer [redacted] told other officers that [redacted] had been convicted of a sex offense.

Please be advised that the Investigative Services Unit (ISU) initiated an inquiry into *Armstrong* class member Inmate [redacted] allegation on April 19, 2017. ISU ultimately determined there was insufficient evidence to corroborate it. Upon ISU's subsequent interview on September 11, 2017, Inmate [redacted] could not recall the other officer that Officer [redacted] allegedly spoke with, the time frame which it occurred, nor could he identify any inmate witnesses who may have overheard Officer [redacted] comment. Inmate [redacted] statements during his PLO interview and his September 11, 2017 interview were also deemed to be inconsistent.

Based upon the above information, CDCR will be closing the inquiry into the above allegation.

Should you have any questions, or concerns, please contact Attorney IV Mike Davis, Legal Liaison for the High Security Mission, at [redacted].

Sincerely,

JAMES MICHAEL DAVIS
Attorney IV Legal Liaison, High Security Mission
Office of Legal Affairs

cc: Warden D. Asuncion
Corene Kendrick

LAC-0217-010

OFFICE OF LEGAL AFFAIRS
Patrick R. McKinney II
General Counsel
P.O. Box 942883
Sacramento, CA 94283-0001

October 4, 2017

Rita Lomio
Prison Law Office
General Delivery
San Quentin, CA 94964

Dear Ms. Lomio:

This letter is in response to the allegations raised in your February 2017, *Armstrong* Monitoring Tour report concerning California State Prison Los Angeles County (LAC). The California Department of Corrections and Rehabilitation (CDCR) takes every allegation seriously, and as such has conducted an inquiry into your allegation as stated below:

> *Inmate [redacted] reported that in January 2017, a second watch officer closed the door on his arm when he put his arm through the food tray slot. As a result [redacted] claims he sustained a bruise. [redacted] stated he did not report the injury to medical staff.*

Please be advised that the Investigative Services Unit (ISU) initiated an inquiry into this matter on April 19, 2017. Inmate [redacted] an *Armstrong* class member, who has since transferred to Mule Creek State Prison, was interviewed by ISU staff on September 15, 2017. Inmate [redacted] in sum, stated that since the officer apologized and based on his belief that the incident was an accident, he did not pursue a 602 appeal. He further clarified that it was his hand that was closed in the food tray slot, not his arm.

Based upon the above information, CDCR will be closing the inquiry into the above allegation.

Should you have any questions, or concerns, please contact Attorney IV Mike Davis, Legal Liaison for the High Security Mission, at [redacted].

Sincerely,

JAMES MICHAEL DAVIS
Attorney IV Legal Liaison, High Security Mission
Office of Legal Affairs

cc: Warden D. Asuncion
Corene Kendrick

LAC-0217-022

OFFICE OF LEGAL AFFAIRS
Patrick R. McKinney II
General Counsel
P.O. Box 942883
Sacramento, CA 94283-0001

October 4, 2017

Rita Lomio
Prison Law Office
General Delivery
San Quentin, CA 94964

Dear Ms. Lomio:

This letter is in response to the allegations raised in your February 2017, *Armstrong* Monitoring Tour report concerning California State Prison Los Angeles County (LAC). The California Department of Corrections and Rehabilitation (CDCR) takes every allegation seriously, and as such has conducted an inquiry into your allegation as stated below:

> ***Inmate [redacted] ([redacted]) reported that custody staff harasses him because of his DPV status: "I would like to be removed from the DPV program because it's too much stress and I keep being harassed by officials .I would like to continue to do my braille learning without being harassed by officials."***

Please be advised that the Investigative Services Unit (ISU) initiated an inquiry into this matter on April 19, 2017. ISU interviewed Inmate [redacted] an *Armstrong* class member, on September 22, 2017. During the interview, on more than one occasion, Inmate [redacted] denied being harassed by custody staff. ISU staff believes that his allegation was misinterpreted and that his concern at the time was that he believed receipt of his ADA equipment was taking inordinately long. He is currently in receipt of all requested ADA equipment and he reiterated that staff has treated him professionally.

Based upon the above information, CDCR will be closing the inquiry into the above allegation.

Should you have any questions, or concerns, please contact Attorney IV Mike Davis, Legal Liaison for the High Security Mission, at [redacted].

Sincerely,

JAMES MICHAEL DAVIS
Attorney IV Legal Liaison, High Security Mission
Office of Legal Affairs

cc: Warden D. Asuncion
Corene Kendrick

LAC-0217-023

OFFICE OF LEGAL AFFAIRS
Patrick R. McKinney II
General Counsel
P.O. Box 942883
Sacramento, CA 94283-0001

October 9, 2017

Rita Lomio
Prison Law Office
General Delivery
San Quentin, CA 94964

Dear Ms. Lomio:

This letter is in response to the allegations raised in your February 2017, *Armstrong* Monitoring Tour report concerning California State Prison Los Angeles County (LAC). The California Department of Corrections and Rehabilitation (CDCR) takes every allegation seriously, and as such has conducted an inquiry into your allegation as stated below:

> *Inmate [redacted] reported that custody staff in B1 do not call the plumber when the toilet or sink is clogged and they will not turn on the electricity, which stays off for weeks at a time as a form of punishment. The RAP response, dated September 28, 2016, fails to investigate any possible staff misconduct.*

Please be advised that the Investigative Services Unit (ISU) initiated an inquiry into this matter on April 19, 2017. Inmate [redacted] was interviewed by ISU on September 12, 2017. He re-asserted the allegations above. However, a review of Plumbing Work Orders for B1 showed that plumbers were inside the building at least three times per week to resolve plumbing issues. According to discussions with inmates and staff, electricians were in the building approximately twice per week. But unlike a plumbing issue, with the exception of lighting, loss of electrical power to a cell is not considered an emergency and is responded to as time permits. There appears to be no evidence supporting an allegation of staff misconduct.

Based upon the above information, CDCR will be closing the inquiry into the above allegation.

Should you have any questions, or concerns, please contact Attorney IV Mike Davis, Legal Liaison for the High Security Mission, at [redacted].

Sincerely,

JAMES MICHAEL DAVIS
Attorney IV Legal Liaison, High Security Mission
Office of Legal Affairs

cc: Warden D. Asuncion
Corene Kendrick

LAC-0217-024

OFFICE OF LEGAL AFFAIRS
Patrick R. McKinney II
General Counsel
P.O. Box 942883
Sacramento, CA 94283-0001

October 11, 2017

Rita Lomio
Prison Law Office
General Delivery
San Quentin, CA 94964

Dear Ms. Lomio:

This letter is in response to the allegations raised in your February 2017, *Armstrong* Monitoring Tour report concerning California State Prison Los Angeles County (LAC). The California Department of Corrections and Rehabilitation (CDCR) takes every allegation seriously, and as such has conducted an inquiry into your allegation as stated below:

> ***Prisoner 9 [redacted] reported that custody staff on D1 daily verbally abuse prisoners. Officer L (Officer [redacted]) and another officer on third watch call people "bitches" and "retards," and say things like, "this is my fucking building." He reported that on the morning of February 22, 2017, one prisoner (name unknown) attempted to give another prisoner a biscuit from his breakfast. Tower Officer C (Unknown) said to the prisoner, "You're going to do that the fuck I say," then called everybody "retards." As the prisoner was leaving, another officer said to him, "I should be spraying you."***

Please be advised that the Investigative Services Unit (ISU) initiated an inquiry into this matter on April 19, 2017. ISU interviewed Inmate [redacted] on July 10, 2017. Inmate [redacted] named another inmate, who is not an *Armstrong* class member, who he confirmed would corroborate his story. ISU interviewed that inmate but he did not corroborate Inmate [redacted] biscuit story. Moreover, he stated that he has been on the D1 facility for a while and all the staff gets along well with the inmates.

Based upon the above information, CDCR will be closing the inquiry into the above allegation.

Should you have any questions, or concerns, please contact Attorney IV Mike Davis, Legal Liaison for the High Security Mission, at [redacted].

Sincerely,

JAMES MICHAEL DAVIS
Attorney IV Legal Liaison, High Security Mission
Office of Legal Affairs

cc: Warden D. Asuncion
Corene Kendrick

LAC-0217-027

OFFICE OF LEGAL AFFAIRS
Patrick R. McKinney II
General Counsel
P.O. Box 942883
Sacramento, CA 94283-0001

October 11, 2017

Rita Lomio
Prison Law Office
General Delivery
San Quentin, CA 94964

Dear Ms. Lomio:

This letter is in response to the allegations raised in your February 2017, *Armstrong* Monitoring Tour report concerning California State Prison Los Angeles County (LAC). The California Department of Corrections and Rehabilitation (CDCR) takes every allegation seriously, and as such has conducted an inquiry into your allegation as stated below:

> *Prisoner 19, (Inmate [redacted] a right-leg amputee, reported on November 13, 2016, that custody officers call him a "gimp." See C-[redacted] The RAP response, dated November 22, 2016, states that Lt. [redacted] conducted an interview with Prisoner 19, and that Prisoner 19 stated that he banters "back and forth with custody staff" and that he "could not provide any name of staff that were calling him names." The RAP response states that there was "no way to determine if staff were in fact being unprofessional and calling [him] names."*

Please be advised that the Investigative Services Unit (ISU) initiated an inquiry into this matter on April 19, 2017. ISU interviewed Inmate [redacted] an *Armstrong* class member, who was unable to name any inmates or staff to corroborate his allegations. Moreover, a review of inmate appeals records confirmed that Inmate [redacted] did not file a Form 602 regarding the above allegations.

Based upon the above information, CDCR will be closing the inquiry into the above allegation.

Should you have any questions, or concerns, please contact Attorney IV Mike Davis, Legal Liaison for the High Security Mission, at [redacted]-[redacted]-[redacted]

Sincerely,

JAMES MICHAEL DAVIS
Attorney IV Legal Liaison, High Security Mission
Office of Legal Affairs

cc: Warden D. Asuncion
Corene Kendrick

OFFICE OF LEGAL AFFAIRS
Patrick R. McKinney II
General Counsel
P.O. Box 942883
Sacramento, CA 94283-0001

October 14, 2017

Rita Lomio
Prison Law Office
General Delivery
San Quentin, CA 94964

Dear Ms. Lomio:

This letter is in response to the allegations raised in your February 2017, *Armstrong* Monitoring Tour report concerning California State Prison Los Angeles County (LAC). The California Department of Corrections and Rehabilitation (CDCR) takes every allegation seriously, and as such has conducted an inquiry into your allegation as stated below:

- Prisoner 16 ([redacted] [redacted] reported that around November 2016, he was entering his cell when Tower Officer B, (Officer [redacted] who electronically closes cell doors, closed the door before Prisoner 16, ([redacted] [redacted] who uses a cane, could fully enter. As a result, he was caught in the door. Prisoner 16 ([redacted] [redacted] reported that Tower Officer B (Officer [redacted] has done this to other prisoners.

Please be advised that the Investigative Services Unit (ISU) initiated an inquiry into this matter on April 19, 2017. Inmate [redacted] an *Armstrong* class member, was interviewed on April 19, 2017. During the interview, Inmate [redacted] was unable to provide any staff or inmate witnesses. Moreover, because of the location of Inmate [redacted] cell, it did not appear that any witnesses could be found randomly. Accordingly, no further interviews were conducted. However, investigative staff also referenced various documents, databases, and records in an attempt to gather as much useful information as possible. Ultimately, ISU staff determined that there is insufficient cause for further investigation.

Based upon the above information, CDCR will be closing the inquiry into the above allegation.

Should you have any questions, or concerns, please contact Attorney IV Mike Davis, Legal Liaison for the High Security Mission, at [redacted].

Sincerely,

JAMES MICHAEL DAVIS
Attorney IV Legal Liaison, High Security Mission
Office of Legal Affairs

cc: Warden D. Asuncion
Corene Kendrick

LAC-0217-021

OFFICE OF LEGAL AFFAIRS
Patrick R. McKinney II
General Counsel
P.O. Box 942883
Sacramento, CA 94283-0001

October 18, 2017

Rita Lomio
Prison Law Office
General Delivery
San Quentin, CA 94964

Dear Ms. Lomio:

This letter is in response to the allegations raised in your February 2017, *Armstrong* Monitoring Tour report concerning California State Prison-Los Angeles County (LAC). The California Department of Corrections and Rehabilitation (CDCR) takes every allegation seriously, and as such has conducted an inquiry into your allegation as stated below:

- An unidentified inmate claimed that Officer [redacted] and Officer [redacted] took down a prisoner and continued to beat him the week of February 20.

Please be advised that the Investigative Services Unit (ISU) initiated an inquiry into this matter on April 19, 2017. Departmental paperwork from February 13 through 24 was reviewed. Five D5 inmates and four correctional officer staff were interviewed, including Officers [redacted] and Officer [redacted] In short, no documentation or interview responses support the assertion that Officers [redacted] or Officer [redacted] was involved in a Use of Force event the week of February 20 2017. Moreover, Officer [redacted] interview and paperwork corroborated that he was not assigned to unit D5 that week.

Based upon the above information, CDCR will be closing the inquiry into the above allegation.

Should you have any questions, or concerns, please contact Attorney IV Mike Davis, Legal Liaison for the High Security Mission, at [redacted].

Sincerely,

JAMES MICHAEL DAVIS
Attorney IV Legal Liaison, High Security Mission
Office of Legal Affairs

cc: Warden D. Asuncion
Corene Kendrick
LAC-0217-004(D)

OFFICE OF LEGAL AFFAIRS
Patrick R. McKinney II
General Counsel
P.O. Box 942883
Sacramento, CA 94283-0001

October 18, 2017

Rita Lomio
Prison Law Office
General Delivery
San Quentin, CA 94964

Dear Ms. Lomio:

This letter is in response to the allegations raised in your February 2017, *Armstrong* Monitoring Tour report concerning California State Prison Los Angeles County (LAC). The California Department of Corrections and Rehabilitation (CDCR) takes every allegation seriously, and as such has conducted an inquiry into your allegation as stated below:

- Class members in D5 reported that custody staff does not timely respond to medical emergencies and either ignores prisoners who express thoughts of suicide or encourage them to hurt themselves, For example:
- Officers in D5 often do not respond to calls of "man down." Officers also reportedly ignore when people say they are suicidal."
- Prisoner 3 ([redacted] [redacted] reported that many prisoners in D5 say that they are suicidal, but the officers simply ignore them.

Please be advised that the Investigative Services Unit (ISU) initiated an inquiry into this matter on or about July 10, 2017. The investigator spot-checked staff and interviewed D5 inmates on staff response to inmates manifesting suicidal ideation or calling "man down". The investigator further questioned *Armstrong* class member, Inmate [redacted] who was unable to provide any specific information to support his allegation that officers ignore inmates that claim to be suicidal. Moreover, his position was undercut by the opinions expressed by the other inmates interviewed.

Based upon the above information, CDCR will be closing the inquiry into the above allegation.

Should you have any questions, or concerns, please contact Attorney IV Mike Davis, Legal Liaison for the High Security Mission, at [redacted].

Sincerely,

JAMES MICHAEL DAVIS
Attorney IV Legal Liaison, High Security Mission
Office of Legal Affairs

cc: Warden D. Asuncion
Corene Kendrick

LAC-0217-006(A)(B)7

OFFICE OF LEGAL AFFAIRS
Patrick R. McKinney II
General Counsel
P.O. Box 942883
Sacramento, CA 94283-0001

October 18, 2017

Rita Lomio
Prison Law Office
General Delivery
San Quentin, CA 94964

Dear Ms. Lomio:

This letter is in response to the allegations raised in your February 2017, *Armstrong* Monitoring Tour report concerning California State Prison Los Angeles County (LAC). The California Department of Corrections and Rehabilitation (CDCR) takes every allegation seriously, and as such has conducted an inquiry into your allegation as stated below:

- In early February, Prisoner 9 ([redacted] [redacted] reportedly set fire to himself or his cell after officers refused to respond to his statement that he was feeling suicidal. According to the medical record, Prisoner 9 was found unresponsive in his cell on February 7, 2017, and suffered from smoke inhalation. Prisoner 9 ([redacted] reported that after being hospitalized, he was returned to his cell, which had not been cleaned of smoke and water damage. Prisoner 8 ([redacted] [redacted] separately reported that officers did not immediately respond to Prisoner 9's situation.

Please be advised that the Investigative Services Unit (ISU) initiated an inquiry into this matter on April 19, 2017. Inmate [redacted] who is an *Armstrong* class member, was interviewed by ISU staff on July 10, 2017. Inmate [redacted] too, an *Armstrong* class member was interviewed by ISU staff on August 14, 2017. Nine correctional officers and a doctor involved in this allegation were also interviewed. Further, investigative staff also referenced various documents, databases, and records in an attempt to gather as much useful information as possible. The inquiry revealed that due to a lack of corroboration between Inmate [redacted] and [redacted] accounts, both during their subsequent interviews relative to their statements to the PLO and in view of the interviews of the other parties, there is insufficient cause for further investigation.

Should you have any questions, or concerns, please contact Attorney IV Mike Davis, Legal Liaison for the High Security Mission, at [redacted].

Sincerely,

JAMES MICHAEL DAVIS
Attorney IV Legal Liaison, High Security Mission
Office of Legal Affairs

cc: Warden D. Asuncion
Corene Kendrick

LAC-0217-06(C)(D)(E)

OFFICE OF LEGAL AFFAIRS
Patrick R. McKinney II
General Counsel
P.O. Box 942883
Sacramento, CA 94283-0001

October 18, 2017

Rita Lomio
Prison Law Office
General Delivery
San Quentin, CA 94964

Dear Ms. Lomio:

This letter is in response to the allegations raised in your February 2017, *Armstrong* Monitoring Tour report concerning California State Prison Los Angeles County (LAC). The California Department of Corrections and Rehabilitation (CDCR) takes every allegation seriously, and as such has conducted an inquiry into your allegation as stated below:

- Inmate [redacted] reported Officer [redacted] and Officer [redacted] call inmates "Bitches". [redacted] also alleges that Officer [redacted] is "Looking for a Fight."

Please be advised that the Investigative Services Unit (ISU) initiated an inquiry into this matter on April 19, 2017. Inmate [redacted] an *Armstrong* class member, was interviewed on July 25, 2017. Inmate [redacted] was unable to provide the names of any inmate witnesses. Accordingly, ISU staff randomly selected three D5-housed inmates to be interviewed. None of the randomly-selected inmates corroborated Inmate [redacted] allegation. Further, investigative staff also referenced various documents, databases, and records in an attempt to gather as much useful information as possible. ISU staff determined that there is insufficient cause for further investigation.

Should you have any questions, or concerns, please contact Attorney IV Mike Davis, Legal Liaison for the High Security Mission, at [redacted].

Sincerely,

JAMES MICHAEL DAVIS
Attorney IV Legal Liaison, High Security Mission
Office of Legal Affairs

cc: Warden D. Asuncion
Corene Kendrick

OFFICE OF LEGAL AFFAIRS
Patrick R. McKinney II
General Counsel
P.O. Box 942883
Sacramento, CA 94283-0001

October 18, 2017

Rita Lomio
Prison Law Office
General Delivery
San Quentin, CA 94964

Dear Ms. Lomio:

This letter is in response to the allegations raised in your February 2017, *Armstrong* Monitoring Tour report concerning California State Prison Los Angeles County (LAC). The California Department of Corrections and Rehabilitation (CDCR) takes every allegation seriously, and as such has conducted an inquiry into your allegation as stated below:

- It is alleged by multiple inmates that CDCR forms such as 602 Appeals, GA Form 22's and CDCR 1824, Reasonable Accommodation Request forms are not readily available to inmates housed at LAC's, housing unit D5. Specifically, Prisoner 5 ([redacted] alleges no access to CDCR 1824's, Prisoner 4 ([redacted] alleges no access to CDCR Form 22's, CDCR 602's and CDCR 1824's, Prisoner 8 ([redacted] alleges no access to CDCR 1824's and CDCR 602's, Prisoner 3 ([redacted] alleges no access to CDCR 1824's, Prisoner 1 ([redacted] alleges no access to CDCR Form 22's, CDCR 602's and CDCR 1824's
- Additionally, Prisoner 1 ([redacted] reported that officers in D5 ·need training on how to deal with EOP prisoners. [redacted] believes that Officers try to provoke prisoners and play with their emotions.

Please be advised that the Investigative Services Unit (ISU) initiated an inquiry into this matter on April 19, 2017. Pursuant to this inquiry, ISU staff interviewed multiple inmates and staff. Further, investigative staff also referenced various documents, databases, and records in an attempt to gather as much useful information as possible. ISU determined that D5 staff understand the importance of making CDCR forms available to inmates, particularly those in a segregated housing status. Interviewed inmates also confirmed D5 staff is taking extra steps to attain forms when those forms become scarce. In short, ISU staff determined that there is insufficient cause for further investigation.

Based upon the above information, CDCR will be closing the inquiry into the above allegation.

Should you have any questions, or concerns, please contact Attorney IV Mike Davis, Legal Liaison for the High Security Mission, at [redacted].

Sincerely,

JAMES MICHAEL DAVIS
Attorney IV Legal Liaison, High Security Mission
Office of Legal Affairs

cc: Warden D. Asuncion
Corene Kendrick
LAC-0217-012 - 17

OFFICE OF LEGAL AFFAIRS
Patrick R. McKinney II
General Counsel
P.O. Box 942883
Sacramento, CA 94283-0001

October 18, 2017

Rita Lomio
Prison Law Office
General Delivery
San Quentin, CA 94964

Dear Ms. Lomio:

This letter is in response to the allegations raised in your February 2017, *Armstrong* Monitoring Tour report concerning California State Prison Los Angeles County (LAC). The California Department of Corrections and Rehabilitation (CDCR) takes every allegation seriously, and as such has conducted an inquiry into your allegation as stated below:

> ***Inmate [redacted] [redacted] reported that second watch staff in D3 is the most problematic. He reported that in mind February, 2017, a prisoner was having an episode of paranoia. According to [redacted] custody staff asked the prisoner to go to the shower for a search. According to [redacted] instead of talking to the prisoner, staff slammed him to the ground.***
>
> ***[redacted] said that he often avoids going to mental health groups because people get into fights and custody immediately use pepper spray, making it difficult for everybody to breathe.***

Please be advised that the Investigative Services Unit (ISU) initiated an inquiry into this matter and ISU staff interviewed Inmate [redacted] an *Armstrong* class member, on September 1, 2017. During the interview Inmate [redacted] was unable to provide any greater specificity to his allegation. ISU staff also interviewed several staff clinicians. Lastly, investigative staff referenced various documents, databases, and records in an attempt to gather as much useful information as possible. Inmate [redacted] was largely uncooperative during the inquiry. When he did participate, his allegation was undercut by his own vague or contradictory, testimony and the information provided by the other interviewees.

Based upon the above information, CDCR will be closing the inquiry into the above allegation.

Should you have any questions, or concerns, please contact Attorney IV Mike Davis, Legal Liaison for the High Security Mission, at [redacted].

Sincerely,

JAMES MICHAEL DAVIS
Attorney IV Legal Liaison, High Security Mission
Office of Legal Affairs

cc: Warden D. Asuncion
Corene Kendrick

LAC-0217-018(A)(B)

OFFICE OF LEGAL AFFAIRS
Patrick R. McKinney II
General Counsel
P.O. Box 942883
Sacramento, CA 94283-0001

October 18, 2017

Rita Lomio
Prison Law Office
General Delivery
San Quentin, CA 94964

Dear Ms. Lomio:

This letter is in response to the allegations raised in your February 2017, *Armstrong* Monitoring Tour report concerning California State Prison Los Angeles County (LAC). The California Department of Corrections and Rehabilitation (CDCR) takes every allegation seriously, and as such has conducted an inquiry into your allegation as stated below:

- [redacted] [redacted] reported that, on February 14, 2017, he was being escorted by three officers in D5. He reported that one officer was holding his left elbow, and another was holding his right elbow. The officers were walking quickly, and [redacted] reported that he repeatedly said, "Can you please slow down? You're going too fast. I don't have my cane. I'm going to fall."[1] The officers reportedly did not slow down. [redacted] reported that his back gave out, and he tried to hold himself up—possibly by holding onto or leaning into the escorting officers. Officer D. [redacted] who still is working in the building, reportedly then slammed [redacted] to the ground. [redacted] reported and medical records confirm that he suffered fractured ribs that day. [redacted] reported that the officers now are alleging that he elbowed them, and that he has received a DA referral. The officer, however, reportedly told [redacted] that he would drop the 115 if [redacted] dropped the 602 against him. [redacted] reported that he at first refused an interview about the incident, because he was not told what he was charged with, and they would not tell him if he needed an attorney.

Please be advised that the Investigative Services Unit (ISU) initiated an inquiry into this matter on April 19, 2017. ISU staff interviewed Inmate [redacted] an *Armstrong* class member on July 5, 2017. ISU staff also interviewed four D5 inmates and a D5-assigned correctional officer. Investigative staff also referenced various documents, databases, and records in an attempt to gather as much useful information as possible. ISU concluded there was insufficient evidence to corroborate Inmate [redacted]'s version of events. Moreover, Inmate [redacted] own testimony was materially inconsistent over multiple interviews regarding this allegation.

Based upon the above information, CDCR will be closing the inquiry into the above allegation.

Should you have any questions, or concerns, please contact Attorney IV Mike Davis, Legal Liaison for the High Security Mission, at [redacted].

Sincerely,

JAMES MICHAEL DAVIS
Attorney IV Legal Liaison, High Security Mission
Office of Legal Affairs

cc: Warden D. Asuncion
Corene Kendrick

LAC-0217-002

OFFICE OF LEGAL AFFAIRS
Patrick R. McKinney II
General Counsel
P.O. Box 942883
Sacramento, CA 94283-0001

October 18, 2017

Rita Lomio
Prison Law Office
General Delivery
San Quentin, CA 94964

Dear Ms. Lomio:

This letter is in response to the allegations raised in your February 2017, *Armstrong* Monitoring Tour report concerning California State Prison Los Angeles County (LAC). The California Department of Corrections and Rehabilitation (CDCR) takes every allegation seriously, and as such has conducted an inquiry into your allegation as stated below:

> *Inmate [redacted] reported that in mid-February he told Officer [redacted] that he was feeling suicidal, following the death of his grandmother. [redacted] alleges that [redacted] failed to act and said to him, "Go ahead, cut yourself." As a result [redacted] claims that he cut his arms.*

Please be advised that the Investigative Services Unit (ISU) initiated an inquiry into this matter on April 19, 2017. ISU noted that during the month of February he had eight visits with mental health professionals but there was no annotation in the patient notes of him cutting himself. Moreover, his Universal Health Records during the month of February do not show any request for treatment nor treatment for any cuts to his arms. Lastly, a mental health clinician that met with him on numerous occasions between February and March denied he expressed any suicidal ideation nor did he manifest any indication that he had cut himself.

Based upon the above information, CDCR will be closing the inquiry into the above allegation.

Should you have any questions, or concerns, please contact Attorney IV Mike Davis, Legal Liaison for the High Security Mission, at [redacted].

Sincerely,

JAMES MICHAEL DAVIS
Attorney IV Legal Liaison, High Security Mission
Office of Legal Affairs

cc: Warden D. Asuncion
Corene Kendrick

LAC-0217-005

OFFICE OF LEGAL AFFAIRS
Patrick R. McKinney II
General Counsel
P.O. Box 942883
Sacramento, CA 94283-0001

October 18, 2017

Rita Lomio
Prison Law Office
General Delivery
San Quentin, CA 94964

Dear Ms. Lomio:

This letter is in response to the allegations raised in your February 2017, *Armstrong* Monitoring Tour report concerning California State Prison Los Angeles County (LAC). The California Department of Corrections and Rehabilitation (CDCR) takes every allegation seriously, and as such has conducted an inquiry into your allegation as stated below:

> *Inmate [redacted] reported that in late December when he was removed from suicide watch, he was left naked in his cell for nineteen hours despite staff knowing that he had been released from suicide watch.*

Please be advised that the Investigative Services Unit (ISU) initiated an inquiry into this matter on or about July 5, 2017. ISU ascertained that this complaint was nearly verbatim to a 602 Appeal Inmate [redacted] an *Armstrong* class member, initiated on January 4, 2017. The appeal was partially granted by conducting interviews but Inmate [redacted] failed to sustain the allegations of staff misconduct he alleged. ISU subsequently re-interviewed [redacted] several other D5 inmate witnesses and a correctional officer who, although not alleged to have committed staff misconduct, interacted with Inmate [redacted] during the time he was allegedly denied clothes and linen. In short, ISU found insufficient evidence to corroborate Inmate [redacted] allegations.

Based upon the above information, CDCR will be closing the inquiry into the above allegation.

Should you have any questions, or concerns, please contact Attorney IV Mike Davis, Legal Liaison for the High Security Mission, at [redacted].

Sincerely,

JAMES MICHAEL DAVIS
Attorney IV Legal Liaison, High Security Mission
Office of Legal Affairs

cc: Warden D. Asuncion
Corene Kendrick

LAC-0217-011

OFFICE OF LEGAL AFFAIRS
Patrick R. McKinney II
General Counsel
P.O. Box 942883
Sacramento, CA 94283-0001

October 18, 2017

Rita Lomio
Prison Law Office
General Delivery
San Quentin, CA 94964

Dear Ms. Lomio:

This letter is in response to the allegations raised in your February 2017, *Armstrong* Monitoring Tour report concerning California State Prison Los Angeles County (LAC). The California Department of Corrections and Rehabilitation (CDCR) takes every allegation seriously, and as such has conducted an inquiry into your allegation as stated below:

> *Prisoner 16 [redacted] reported that the canteen manager (Canteen Supervisor [redacted]) uses foul language. In the last month, Prisoner 16 attempted to talk with the canteen manager who told him to "get the fuck away from my window." The canteen manager and other staff make fun of Prisoner 16's name, calling him "nigger." He reported that many prisoners do not report the canteen manager's misconduct because people fear the manager might tamper with their canteen draw.*

Please be advised that the Investigative Services Unit (ISU) initiated an inquiry into this matter on April 19, 2017. ISU interviewed Inmate [redacted] an *Armstrong* class member, on April 19, 2017. Significantly, he denied that the canteen manager and other staff ever called him "nigger". He said that the pronunciation of his name resulted in some teasing but was adamant he was not called that name by any staff. Although Inmate [redacted] corroborated his PLO allegation regarding Mr. [redacted] profanity, no other witnesses were able to corroborate it. Moreover, two inmates disputed Inmate [redacted] contention that Mr. [redacted] was profane or lacking in professionalism. Lastly, a review of inmate grievances confirmed that Inmate [redacted] filed no grievances regarding the alleged inappropriate behavior of Mr. [redacted] prior to his allegation during the Armstrong tour in February of 2017.

Based upon the above information, CDCR will be closing the inquiry into the above allegation.

Should you have any questions, or concerns, please contact Attorney IV Mike Davis, Legal Liaison for the High Security Mission, at [redacted].

Sincerely,

JAMES MICHAEL DAVIS
Attorney IV Legal Liaison, High Security Mission
Office of Legal Affairs

cc: Warden D. Asuncion
Corene Kendrick

LAC-0217-025

OFFICE OF LEGAL AFFAIRS
Patrick R. McKinney II
General Counsel
P.O. Box 942883
Sacramento, CA 94283-0001

October 18, 2017

Rita Lomio
Prison Law Office
General Delivery
San Quentin, CA 94964

Dear Ms. Lomio:

This letter is in response to the allegations raised in your February 2017, *Armstrong* Monitoring Tour report concerning California State Prison Los Angeles County (LAC). The California Department of Corrections and Rehabilitation (CDCR) takes every allegation seriously, and as such has conducted an inquiry into your allegation as stated below:

> *A prisoner in D1 who asked to remain anonymous out of fear of retaliation reported that in December of 2016 or January of 2017 in his mental health group two prisoners started fighting. No mental health or custody staff was present. He reports that often times staff are not present for about 5- 10 minutes before the group begins, and he is scared another fight might happen.*

Please be advised that the Investigative Services Unit (ISU) initiated an inquiry into this matter on April 19, 2017. ISU initially reviewed all relevant documents and logs for D Facility during the December 2016/January 2017 timeframe. The documents had no record of a fight occurring on the D Facility Education or D Facility Mental Health Building during that time frame. Having insufficient information to interview the complaining inmate, staff interviewed two correctional staff who noted that fights there are very rare and are documented. Moreover, one of the correctional officers interviewed explained that inmates are not left without custody presence. They are received at the Education or Mental Health building by custody staff standing at the door. The custody staff has a list of approved attendees and verifies the identity of each inmate before allowing them in the class. The class facilitators are to arrive at least five minutes prior to the class and all facilitators are given a personal alarm to signal in the event of an emergency.

Based upon the above information, CDCR will be closing the inquiry into the above allegation.

Should you have any questions, or concerns, please contact Attorney IV Mike Davis, Legal Liaison for the High Security Mission, at [redacted].

Sincerely,

JAMES MICHAEL DAVIS
Attorney IV Legal Liaison, High Security Mission
Office of Legal Affairs

cc: Warden D. Asuncion
Corene Kendrick

LAC-0217-028

OFFICE OF LEGAL AFFAIRS
Patrick R. McKinney II
General Counsel
P.O. Box 942883
Sacramento, CA 94283-0001

October 18, 2017

Rita Lomio
Prison Law Office
General Delivery
San Quentin, CA 94964

Dear Ms. Lomio:

This letter is in response to the allegations raised in your February 2017, *Armstrong* Monitoring Tour report concerning California State Prison Los Angeles County (LAC). The California Department of Corrections and Rehabilitation (CDCR) takes every allegation seriously, and as such has conducted an inquiry into your allegation as stated below:

> *Prisoner 20 ([redacted] reported that custody staff on D4 third watch daily verbally disrespect prisoners. On February 21, 2017, Officer [redacted] approached a cell and said, "Move that fucking curtain! Open the goddamned door!" Officer [redacted] called the prisoner a "bitch" and a "coward." Officer [redacted] entered the cell even though the prisoner was still inside. [redacted] said that prisoners often do not report staff misconduct because they fear retaliation.*

Please be advised that the Investigative Services Unit (ISU) staff interviewed Inmate [redacted], an *Armstrong* class member, on September 18, 2017. During the interview, Inmate [redacted] was unable to provide the names of any inmates who could potentially support his allegation. ISU staff is currently seeking additional inmates to interview regarding this allegation. More information will be provided as it becomes available.

Should you have any questions, or concerns, please contact Attorney IV Mike Davis, Legal Liaison for the High Security Mission, at [redacted].

Sincerely,

JAMES MICHAEL DAVIS
Attorney IV Legal Liaison, High Security Mission
Office of Legal Affairs

cc: Warden D. Asuncion
Corene Kendrick

LAC-0217-029

OFFICE OF LEGAL AFFAIRS
Patrick R. McKinney II
General Counsel
P.O. Box 942883
Sacramento, CA 94283-0001

October 18, 2017

Rita Lomio
Prison Law Office
General Delivery
San Quentin, CA 94964

Dear Ms. Lomio:

This letter is in response to the allegations raised in your February 2017, *Armstrong* Monitoring Tour report concerning California State Prison Los Angeles County (LAC). The California Department of Corrections and Rehabilitation (CDCR) takes every allegation seriously, and as such has conducted an inquiry into your allegation as stated below:

> [redacted] *reported that on July 30, 2016, Officer* [redacted] *ignored his yells for help as he was having a seizure. See HC-*[redacted] *The RAP response dated August 10, 2016, fails to address his allegation of staff misconduct.*

Please be advised that the Investigative Services Unit (ISU) initiated an inquiry into this matter on or about July 3, 2017. Four inmates from D5 were interviewed including Inmate [redacted] who is an *Armstrong* class member. Significantly, [redacted] denied speaking to the PLO about staff misconduct and denied suffering a seizure and hitting his head while housed at LAC. His Bed Movement History supports his statement that he did not speak with the PLO because it shows him housed at Salinas Valley State Prison in February of 2017.

Based upon the above information, CDCR will be closing the inquiry into the above allegation.

Should you have any questions, or concerns, please contact Attorney IV Mike Davis, Legal Liaison for the High Security Mission, at [redacted]-[redacted]-[redacted]

Sincerely,

JAMES MICHAEL DAVIS
Attorney IV Legal Liaison, High Security Mission
Office of Legal Affairs

cc: Warden D. Asuncion
Corene Kendrick
LAC-0217-008

OFFICE OF LEGAL AFFAIRS
Patrick R. McKinney II
General Counsel
P.O. Box 942883
Sacramento, CA 94283-0001

October 23, 2017

Rita Lomio
Prison Law Office
General Delivery
San Quentin, CA 94964

Dear Ms. Lomio:

This letter is in response to the allegations raised in your February 2017, *Armstrong* Monitoring Tour report concerning California State Prison Los Angeles County (LAC). The California Department of Corrections and Rehabilitation (CDCR) takes every allegation seriously, and as such has conducted an inquiry into your allegation as stated below:

> *Unidentified Inmate reported that Officer [redacted] beat Inmate [redacted], and that an RN tried unsuccessfully to intervene.*

Please be advised that the Investigative Services Unit (ISU) initiated an inquiry into this matter on April 19, 2017. Shortly thereafter, ISU staff determined that the above allegation is identical to an incident that was referred to CDCR's Office of Internal Affairs (OIA) in January 2017. OIA investigation concluded the allegations regarding Officer [redacted] were not sustained.

Based upon the above information, CDCR will be closing the inquiry into the above allegation.

Should you have any questions, or concerns, please contact Attorney IV Mike Davis, Legal Liaison for the High Security Mission, at [redacted].

Sincerely,

JAMES MICHAEL DAVIS
Attorney IV Legal Liaison, High Security Mission
Office of Legal Affairs

cc: Warden D. Asuncion
Corene Kendrick

LAC-0217-004(C)

OFFICE OF LEGAL AFFAIRS
Patrick R. McKinney II
General Counsel
P.O. Box 942883
Sacramento, CA 94283-0001

October 23, 2017

Rita Lomio
Prison Law Office
General Delivery
San Quentin, CA 94964

Dear Ms. Lomio:

This letter is in response to the allegations raised in your February 2017, *Armstrong* Monitoring Tour report concerning California State Prison Los Angeles County (LAC). The California Department of Corrections and Rehabilitation (CDCR) takes every allegation seriously, and as such has conducted an inquiry into your allegation as stated below:

- Inmate [redacted] [redacted] reported that in late January or early February, Officer [redacted] got into a verbal argument with a black prisoner (Possibly Inmate [redacted] D5-[redacted]) and provoked the prisoner by, among other things, calling the prisoner a "nigger." Another prisoner, [redacted] [redacted] who is EOP, reportedly tried to verbally intervene and calm down the situation. About twenty minutes later, the prisoners were released to group. Inmate [redacted] reported that after the group ended, he witnessed Officer [redacted] shove Inmate [redacted] who was at the time fully cuffed, against the wall. Officer [redacted] reportedly took Inmate [redacted] to the ground and attempted to strangle him. According to the medical record, on January 30, 2017, Inmate [redacted] suffered an abrasion on the upper right side of his top and bottom lips, bleeding on the back of his head, an abrasion on his left elbow, and dried blood on his right ear. Inmate [redacted] was placed on suicide watch the same day. The following day, according to the medical record, he reported to mental health staff: "I fear for my life. I was attacked by an officer in D5. I was feuding with this officer for a while and he was upset with another inmate then took it out on me…I'd rather kill myself than to be killed by an officer."

Please be advised that the Investigative Services Unit (ISU) initiated an inquiry into this *Armstrong* class member's matter on April 19, 2017. Inmate [redacted] an *Armstrong* class member, was interviewed by ISU staff on April 24, 2017. His testimony was deemed not credible because his cell location would not afford him the line of sight to see what he alleged. Moreover, a review of the documentation that was prepared immediately following the incident and interviews with other inmates and custody staff further undercut Inmate [redacted] allegation.

Based upon the above information, CDCR will be closing the inquiry into the above allegation.

Should you have any questions, or concerns, please contact Attorney IV Mike Davis, Legal Liaison for the High Security Mission, at [redacted].

Sincerely,

JAMES MICHAEL DAVIS
Attorney IV Legal Liaison, High Security Mission
Office of Legal Affairs

cc: Warden D. Asuncion
Corene Kendrick

LAC-0217-001

OFFICE OF LEGAL AFFAIRS
Patrick R. McKinney II
General Counsel
P.O. Box 942883
Sacramento, CA 94283-0001

October 23, 2017

Rita Lomio
Prison Law Office
General Delivery
San Quentin, CA 94964

Dear Ms. Lomio:

This letter is in response to the allegations raised in your February 2017, *Armstrong* Monitoring Tour report concerning California State Prison Los Angeles County (LAC). The California Department of Corrections and Rehabilitation (CDCR) takes every allegation seriously, and as such has conducted an inquiry into your allegation as stated below:

> *Prisoner 5 ([redacted] reported that officers treat the younger prisoners badly. They push the prisoners against the wall unnecessarily when cuffing them.*

Please be advised that the Investigative Services Unit (ISU) initiated an inquiry into this matter on or about June 28, 2017. Pursuant to that inquiry, Inmate [redacted] an *Armstrong* class member, and several other inmates were interviewed. A review of relevant departmental paperwork was also reviewed. During ISU's interview with Inmate [redacted] he stated that the allegation above had not been personally witnessed by him but instead relayed to him from other inmates. However, he was unable to provide the names of the inmates that provided him the information. Moreover, both Inmate [redacted] and the other inmates interviewed stated that the D5 officers comported themselves in a professional manner on a day-to-day basis.

Based upon the above information, CDCR will be closing the inquiry into the above allegation.

Should you have any questions, or concerns, please contact Attorney IV Mike Davis, Legal Liaison for the High Security Mission, at [redacted]

Sincerely,

JAMES MICHAEL DAVIS
Attorney IV Legal Liaison, High Security Mission
Office of Legal Affairs

cc: Warden D. Asuncion
LAC-0217-004(A)

OFFICE OF LEGAL AFFAIRS
Patrick R. McKinney II
General Counsel
P.O. Box 942883
Sacramento, CA 94283-0001

October 23, 2017

Rita Lomio
Prison Law Office
General Delivery
San Quentin, CA 94964

Dear Ms. Lomio:

This letter is in response to the allegations raised in your February 2017, *Armstrong* Monitoring Tour report concerning California State Prison Los Angeles County (LAC). The California Department of Corrections and Rehabilitation (CDCR) takes every allegation seriously, and as such has conducted an inquiry into your allegation as stated below:

> *A class member reported that an officer beat Inmate [redacted] (No specific date provided).*

Please be advised that the Investigative Services Unit (ISU) initiated an inquiry into this matter on April 19, 2017. ISU staff attempted to interview Inmate [redacted] an *Armstrong* class member on June 28, 2017. He refused to participate in the interview, remaining in his cell. ISU staff's research uncovered that the above allegation seemingly involved an altercation between Inmate [redacted] and custody staff on June 17, 2014. The incident resulted in Inmate [redacted] receiving a Rules Violation Report. ISU reviewed the relevant paperwork regarding this matter and found it to be adequately investigated.

Based upon the above information, CDCR will be closing the inquiry into the above allegation.

Should you have any questions, or concerns, please contact Attorney IV Mike Davis, Legal Liaison for the High Security Mission, at [redacted]

Sincerely,

JAMES MICHAEL DAVIS
Attorney IV Legal Liaison, High Security Mission
Office of Legal Affairs

cc: Warden D. Asuncion
Corene Kendrick
LAC-0217-004(B)

OFFICE OF LEGAL AFFAIRS
Patrick R. McKinney II
General Counsel
P.O. Box 942883
Sacramento, CA 94283-0001

October 25, 2017

Rita Lomio
Prison Law Office
General Delivery
San Quentin, CA 94964

Dear Ms. Lomio:

This letter is in response to the allegations raised in your February 2017, *Armstrong* Monitoring Tour report concerning California State Prison Los Angeles County (LAC). The California Department of Corrections and Rehabilitation (CDCR) takes every allegation seriously, and as such has conducted an inquiry into your allegation as stated below:

- Inmate [redacted] alleged that in late December 2016, (12/22/2016) while being escorted in waist chains, Officer [redacted] pulled his hands together to the side so he couldn't use his cane. [redacted] informed [redacted] that he was unable to use the cane in that position. [redacted] alleged [redacted] then took him to the ground and slammed his head.

Please be advised that the Investigative Services Unit (ISU) initiated an inquiry into this matter on April 19, 2017. ISU staff attempted a telephonic interview with Inmate [redacted] an *Armstrong* class member, on August 8, 2017. Currently housed at Kern Valley State Prison, he refused to participate in the interview. Investigative staff referenced various documents, databases, and records in an attempt to gather as much useful information as possible. ISU staff reviewed the CDCR 837 Crime/Incident Report prepared following this event, which chronicled Inmate [redacted] acting extremely angry and agitated following his classification committee and that Inmate [redacted] then attempted to assault Officer [redacted] as he was escorted. This version of events was corroborated by a custody staff witness who was interviewed on August 30, 2017. Lastly, a review of Inmate [redacted] records shows that Inmate [redacted] has received more than ten Rule Violation Reports for threats or battery to staff.

Based upon the above information, CDCR will be closing the inquiry into the above allegation.

Should you have any questions, or concerns, please contact Attorney IV Mike Davis, Legal Liaison for the High Security Mission, at [redacted].

Sincerely,

JAMES MICHAEL DAVIS
Attorney IV Legal Liaison, High Security Mission
Office of Legal Affairs

cc: Warden D. Asuncion
Corene Kendrick

LAC-0217-020

OFFICE OF LEGAL AFFAIRS
Patrick R. McKinney II
General Counsel
P.O. Box 942883
Sacramento, CA 94283-0001

October 25, 2017

Rita Lomio
Prison Law Office
General Delivery
San Quentin, CA 94964

Dear Ms. Lomio:

This letter is in response to the allegations raised in your February 2017, *Armstrong* Monitoring Tour report concerning California State Prison Los Angeles County (LAC). The California Department of Corrections and Rehabilitation (CDCR) takes every allegation seriously, and as such has conducted an inquiry into your allegation as stated below:

- Prisoner 12 ([redacted] [redacted] reported that the morning of November 20, 2016, when he was housed in D1, he was standing by the counselor's office. He did not notice anything out of the ordinary. Tower Officer [redacted] who was new to the unit, pushed the alarm. Sgt. [redacted] and Officer [redacted] came running and told him to sit on the benches by the television. (Prisoner 12 was wearing his mobility impaired vest at the time.) [redacted] complied. The Tower Officer reportedly said that [redacted] had been standing over a person who had been beaten. Officer [redacted] then came at [redacted] from behind and started to handcuff him behind his back. [redacted] reportedly turned his head and asked to be handcuffed in the front because it was painful for him to be handcuffed from behind. Officer [redacted] then reportedly pushed him to the ground (forward off the bench), and hit [redacted] finger, which was clinging to the bench, with his baton. Another officer kicked his face and pepper sprayed him. Officer [redacted] reportedly hit him on the head with a baton. Medical records confirm an open laceration on left middle finger, raised reddened area above right eyebrow, swelling around left eye, scratch on the left side of his forehead, and pepper spray exposure to face and upper torso.

Please be advised that the Investigative Services Unit (ISU) initiated an inquiry into this matter and, accordingly, interviewed Inmate [redacted] an *Armstrong* class member, on September 11, 2017. ISU also confirmed that this event was the subject of an inmate appeal as well as several inmate and outside reports provided to the Office of Internal Affairs (OIA) and the hiring authority. In short, the initial ISU/OIA inquiry, the PLO allegation and this ISU allegation inquiry provided inconsistent information. For instance, Inmate [redacted] 602 appeal only sought to have his Rules Violation Report rescinded and made no mention of the alleged injuries. Several inmates were interviewed on September 11, 2017, but their interview responses were either guarded in an apparent attempt not to contradict statements they made earlier, or

contradicted Inmate [redacted] above allegation. Thus, ISU staff found insufficient evidence to corroborate Inmate [redacted] allegation of staff misconduct.

Based upon the above information, CDCR will be closing the inquiry into the above allegation.

Should you have any questions, or concerns, please contact Attorney IV Mike Davis, Legal Liaison for the High Security Mission, at [redacted]

Sincerely,

JAMES MICHAEL DAVIS
Attorney IV Legal Liaison, High Security Mission
Office of Legal Affairs

cc: Warden D. Asuncion
Corene Kendrick

LAC-0217-019

OFFICE OF LEGAL AFFAIRS
Patrick R. McKinney II
General Counsel
P.O. Box 942883
Sacramento, CA 94283-0001

January 23, 2018

Rita Lomio
Prison Law Office
General Delivery
San Quentin, CA. 94964

Dear Ms. Lomio:

This letter is in response to the allegations raised in your February 2017, *Armstrong* Monitoring Tour report concerning California State Prison Los Angeles County (LAC) regarding Inmate [redacted]

The California Department of Corrections and Rehabilitation (CDCR) takes every allegation seriously, and as such has conducted an inquiry into the allegation as stated below:

- "On February 21, 2017, Officer G ([redacted] approached a cell and said, "Move that fucking curtain! Open the goddamned door!" Officer G called the prisoner a "bitch" and a "coward." Officer G entered the cell even though the prisoner was still inside. Prisoner 20 ([redacted] said that prisoners often do not report staff misconduct because they fear retaliation."

LAC conducted an inquiry into this allegation by referencing various documents, databases, and records to procure all useful information regarding the allegations. LAC also interviewed Inmate [redacted] and several other inmate(s). Based upon the review of the documentary materials, and the information derived from the interviews of the inmate(s), LAC is unable to substantiate the above referenced allegation(s) of staff misconduct. As such, the inquiry into this matter has been closed.

Should you have any questions, please contact the undersigned at [redacted]

Sincerely,

/s/ Alan L. Sobel

ALAN L. SOBEL
Attorney IV
Legal Liaison, High Security Mission
Office of Legal Affairs

cc: D. Asuncion, Warden

Exhibit B

California State Prison – Los Angeles County (LAC)
***Armstrong* Monitoring Tour, August 2017**
Report of Staff Misconduct

Representatives from the Prison Law Office visited California State Prison – Los Angeles County (LAC) on August 28-30, 2017, to evaluate compliance with the requirements of the *Armstrong* Remedial Plan, Americans with Disabilities Act, and *Armstrong* court orders. A representative from Rosen Bien Galvan & Grunfeld LLP conducted *Coleman* and *Armstrong* interviews during the tour.[1] During our visit, we again received reports that staff—primarily custody staff—use excessive force against class members, verbally abuse and harass class members, and ignore or encourage expressions of suicidal ideation.[2]

This report includes allegations for which the class member either was willing to let us share his name with CDCR, or was willing to let us share the facts of the allegation but not his name. We heard of other incidents of staff misconduct but did not have permission from those class members to share the details of their experiences. This report also includes several allegations of misconduct reported through 1824 requests for disability accommodations.

We ask that all allegations of staff misconduct identified with an asterisk (*) in this report be fully investigated, regardless of any informal fact-finding determinations that already may have been made by the institution. We request that the investigations include review of any disciplinary actions, including the issuance of RVRs, taken against people alleging staff misconduct, especially those who received RVRs following physical confrontations with staff. We ask that we be apprised of the result of CDCR's inquiries.[3] We hope that we can work together to identify, address, and prevent staff misconduct at LAC.

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[1] The representative from Rosen Bien Galvan & Grunfeld LLP sent a letter under *Coleman* regarding some of our findings. *See* Letter from Thomas Nolan, Plaintiffs' Counsel, to Nick Weber, CDCR Legal Team, *Coleman v. Brown: Concerns about Non-Designated Yard Status, Staff Misconduct, and the Three Recent Suicides in D-Yard EOP Programs* (Sept. 7, 2017).

[2] We issued a report about similar allegations after our February 2017 *Armstrong* tour.

[3] We have not received much information from CDCR about the status of any investigations that have been initiated as a result of our previous staff misconduct report. We note that Person 1 was referenced in our previous staff misconduct report and, during this monitoring tour, reported that no one has spoken with him about his allegations of staff misconduct in that report, except for initial interviews about staff misconduct in response to the 602 submitted before the Plaintiffs' staff misconduct report.

I. EXCESSIVE USE OF FORCE

We received a number of reports of excessive force by staff. The allegations primarily were concentrated on Facilities C and D. For example:

1. (*) Person 2 reported that on 7/31/17, he was exiting the Facility B dining hall around 7 am. An ADA worker, Person 3, was pushing Person 2's wheelchair. Person 3 reportedly was on a liquid diet at the time, and Person 2 was carrying Person 3's juice boxes and a cup of coffee. The custody staff standing outside the dining hall, including Person 4, told Person 2 and Person 3 to throw away the juice boxes and coffee. Person 2 and Person 3 returned to the dining hall where Person 2 discarded the coffee and place the juice boxes on a table. Person 3 took the juice boxes and returned to speak with the officer, at which time Person 2 grabbed the juices and told Person 3 to drop the issue.

   Person 4 then roughly grabbed Person 2's hand that was holding the juice boxes and squeezed so hard that a juice box broke and spilled. Person 4 told Person 2 that Person 2 was gassing him. Person 4 and Person 5 pulled Person 2 out of his wheelchair and threw him to the ground onto his stomach. The officers told Person 2 to cuff up behind his back, which Person 2 could not do because of his disability. (Person 2 had major spinal surgery in March. He wears a large plastic neck brace.)

   A gurney was brought, and an officer lifted Person 2 onto a gurney by his pants and shirt without supporting his head. Person 2 was taken to the medical clinic and then to the CTC, where he received X-rays of his spine. Person 2 reported that approximately 20 minutes after the X-rays were taken, staff video recorded Person 2 about the incident, during which time a lieutenant stated that the X-rays were normal and that Person 2 would be charged with battery on an officer. Person 2 reported that he did not assault the officers, and that he is so weak that he cannot "whip butter with an egg beater." Person 2's medical records confirm that he reported that custody staff threw him from his wheelchair. He was wearing a neck collar at the time and he arrived to TTA in a gurney when X-rays ordered.

2. (*) Person 6 reported that on 7/26/17, while he was living in C1, he was called to the program office to speak with the Sergeant. He reported that while waiting, Person 7 aggressively ordered him to go into a holding cage. Person 6 refused, and walked out of the program office. Person 7 reportedly chased after Person 6, screaming that he cuff up. When Person 6 turned around, Person 7 reportedly raised his clenched fists to eye level and was about to punch Person 6. Person 6 admits that he struck Person 7, at which time Person 8 tackled Person 6. While Person 6 was one the ground, staff punched him repeatedly in the head, kneed him in the head, jumped on his back, and hit him with a weapon on the upper leg, leaving the back of his leg severely bruised.

Person 6 reported that he was unable to get up, so staff tied him to a wheelchair while he was cuffed behind his back. When he was being escorted to ASU in the wheelchair, a door opened and Person 9 began punching him repeatedly in the stomach saying, "Never put your hands on an officer."

Person 6 was taken to the TTA by ASU staff. He reported that 911 was called and that he was taken to an outside hospital. Medical records indicate that on 7/26/17, Person 6 presented with a "right forehead hematoma, lower back pain, redness on right arm and on right face following altercation with custody" and that he was discharged to an outside hospital in an ambulance. The outside hospital noted multiple abrasions on his face.

Person 6 was issued an RVR for assault with a deadly weapon; staff alleged that Person 6 hit staff with his cane. Person 6 said that he did not use his cane to hit staff. Person 6 reported that he filed two 602s: one about ISU staff breaking his TV and another stating that his injuries were not photographed following the confrontation with staff.

3. (*) Person 10 reported that on 5/20/17, while housed in C2, custody staff extracted him from his cell after he claimed he would kill himself and custody reportedly saw him take a handful of pills. He was CCCMS at the time. He said that the extraction was not recorded on camera because custody claimed it was a "medical extraction." Person 10 reported that during the extraction, he was on his bunk lying face up and a large officer, Person 11, was on top of him, pressing his shield into him. Another officer instructed Person 10 to cuff up, so Person 10 grabbed the shield and pushed it so that he could turn over to be cuffed. Person 10 was sent off-site for ingestion of an unknown substance, because staff allegedly witnessed him taking a handful of medication. At the prison, while at the hospital, and upon return from the hospital, Person 10 maintained that he was not suicidal and took only his regular medication. On 5/26/17, Person 10 submitted a 7362 reporting that he was in severe pain as a result of the cell extraction.

   Person 10 was subsequently found guilty of staff assault because he was told that the shield is "part of the officer." He was given an 18 month SHU sentence.

4. (*) Person 12 reported that on 3/7/17, he returned to the prison from an outside hospital. When Person 13 picked him up from the hospital, the wheelchair the officer brought did not have a leg rest. Because there was no leg rest and he was restrained by cuffs with a black box and unable to hold himself up by the arm rests, Person 12 could not hold himself up in the wheelchair and was slipping out of the wheelchair as the officer was escorting him back to his housing unit. Person 12 reported that the multiple times he slipped out of the wheelchair, Person 13 very roughly threw him back into the wheelchair and laughed at him.

In the process, Person 12's shoes kept falling off, so Person 13 threw the shoes in the trash.

5. Person 60 reported that in early July 2017, he saw custody staff pat down Person 14 around noon medication pass. When Person 14 flinched, custody staff struck him with batons. Several other people told us that Person 14 is frequently harassed by officers. Person 14 is particularly vulnerable because of his cognitive and mental health disabilities. By email dated September 1, 2017, we referred these allegations to CDCR under the *Clark* case.

6. Person 15 reported through an 1824 that on 4/29/17, Person 16 refused to allow him an ADA shower and phone time. He alleged that on the same night, the officer closed him in the cell door trapping him, which the officer found "hilarious." The response, which does not have an issue date stamp, states that the allegation would be handled through the Inmate Appeals Office.

7. Person 17 reported that officers in D3 slam people on the ground in the units when they are in handcuffs. Officers also will lift people off of their feet when handcuffed. The officers take people's property, such as fans, televisions, and hotpots, and give it to other people. Person 17 reported that the yard officers "look for excuses to hit you."

8. Person 18 reported that in early August, in D3, Person 19 was returning to his cell from breakfast. He stopped by another person's cell. Person 20 yelled at him to put his hands behind his back. He asked why. In response, the officer picked Person 19 up and slammed him on the floor. There was blood on the floor; Person 19 was removed from the unit in a wheelchair.

9. Person 21 reported that on 8/21/17, Person 25 was assaulted by staff. Person 21 reported that he watched Person 22, Person 23, and Person 24 handcuff Person 25 after finding a cellphone in his cell. Person 22 then kneed Person 25 in the back and began kicking him while he was handcuffed on the floor.

10. Person 26 reported that Person 27 sprayed Person 28 for no good reason in early August. Person 26 recently was interviewed about it, apparently for the 115 hearing. We note that Person 28 reported to a mental health clinician that he had been pepper sprayed toward the end of July. It appears that Person 28's participation in mental health groups declined after that date. Person 29 reported seeing Person 28 get pepper sprayed on approximately July 28 by Person 30.

11. (*) Person 34 reported that in April, in front of C5, he saw custody staff make Person 35 get down on the ground. Person 35 was not struggling but six or seven officers started hitting him. Someone yelled, "He's not resisting!" to which an officer responded, "Shut the fuck up!"

12. Person 31 reported that on 7/27/17, Person 32 pushed Person 33 without justification.

13. (*) Person 34 reported that in March, Person 36 was exiting the C Yard dining hall and talking with an officer about not receiving his kosher meal. Multiple officers slammed the man to the ground, where six or seven staff repeatedly hit him. According to Person 34, Person 36 was not resisting.

II. FAILURE TO APPROPRIATELY RESPOND TO MEDICAL AND MENTAL HEALTH EMERGENCIES

Class members again reported that custody staff do not timely respond to medical emergencies and either ignore people who express thoughts of suicide or encourage them to hurt themselves. One class member on D yard reported that people have to act out—and sometimes claim to be suicidal—just to get officers to acknowledge them and give them what they are entitled to (for example, property). If officers treated people appropriately, he believed, fewer people would claim to be suicidal if they in fact were not. Class members largely reported that the default was for officers to ignore most people who expressed thoughts of suicide.

1. (*) Person 37 reported that two to three nights before the *Armstrong* tour, Person 38 had a plastic bag over his head. The floor officer, who was conducting count, shouted to control, "This guy has a plastic bag on his head." The control officer responded, "Deal with that shit later. Continue your count." Person 38 later was placed on suicide watch. Person 38 later reported to Person 37 that he tried to hang himself while on suicide watch, and the officer just watched him but did not try to stop him.

2. Person 37 reported that officers taunt or ignore people who say they are suicidal. He reported that Person 39 is taunted by officers and has to say he is suicidal 10-15 times before they respond.

3. Person 40 reported that officers do not deal with people with mental health issues well; officers "pick at" or "aggravate" such people to "get a rise out of them." Officers reportedly ignore people when they say they have mental health problems. Officers reportedly put people in the shower for 3-4 hours when they say they are suicidal. The doctor visits the person in the shower and evaluates the person there.

4. The medical record of Person 41 includes a 7362 dated 5/4/17 (when he was in D1), on which he reported: "I was told by a CO if I'd suck his dick he would give me a cell phone, so now I'm thing [sic] about killing myself." The response states that staff called the "psych hotline and left a messages at 0754. I/p is placed in the shower awaiting psych evaluation. Called psych hotline again at 0845 and left a message….Dr. [redacted] called back at 0859, stated pt will be seen by Dr. [redacted]." According to the record, Dr. [redacted] spoke with Person 41 at

0930 during which time Person 41 said about the officer, "he might have been joking, I don't know."

5. (*) Person 42 reported that in mid-June, he tried to hang himself on the door of his cell. He was in his wheelchair at the time, and slumped over by the door. The officer came by to do the pipe check. The officer put his hand through the food slot, cut the rope, and moved on. The officer did not refer Person 42 to medical or mental health, and did not check to see if he was OK. Person 42 does not know who the officer was, as he (Person 42) was facing into the cell.

6. Person 43 reported that he has to miss showers weekly because the ADA shower in C5 is being used inappropriately to house people who are expressing suicidal ideations. Another person reported that when people with disabilities ask staff to use the ADA shower they respond by saying "screw you guys."

III. OTHER MISCONDUCT

Class members again reported that custody officers harass and mistreat them. There is a widespread belief among class members that if you get on the officers' bad side, they will plant contraband in your cell. Person 34 reported that Person 44 commented: "I could easily plant a knife on you guys." We also received widespread reports of officers "picking on" people—particularly those who were the most mentally ill.

1. In May 2017, Person 45 reported through two separate 1824s that staff had locked him in a single shower with his cellmate.[4] On 7/3/17, we raised this concern in a letter to CDCR. During the tour, ADA staff informed us that Warden Asuncion has said that this practice would "never happen again."

   (*) Unfortunately, we continue to receive reports that this practice currently is in effect in the segregation units.

2. (*) Person 46 reported through another 1824 that on 6/14/17, an unnamed lieutenant attempted to pressure him into withdrawing a staff complaint on 5/30/17 and said to Person 46, "I'll beat you fuckin' ass, you fucking baby raper! Bitch! Get out!" and started walking toward Person 46. Another officer reportedly appeared, stepped in between the two men, and led Person 46 out. Person 46 attached a signed declaration from Person 47, who states that Person 48

[4] In the first 1824, Person 45 reported that on 5/15/17 staff locked him in a single shower with his cellmate. The response, issued on 6/1/17, states, "In the PSR it was determined due to circumstances that created the modified program that Cell Partners will shower together on their own tier." In the second 1824, Person 45 reported that on 5/19/17 custody staff forced people to shower with their cellmates. The response, issued on 6/1/17, states that the allegation was referred to ISU for investigation, and that ISU determined that it did not meet the criteria for a PREA case number.

attempted to dissuade him from filing a staff complaint on 6/1/17 by making him wait an hour in the 100-degree weather and then being "very, extremely aggressive." The response, issued on 6/21/17, states that the allegation would be reviewed as a staff complaint.

3. (*) Person 49 reported through an 1824 signed on 5/31/17 that Person 50 harassed him in the dining hall "for getting water prior to walking to the ADA feeding section," and that custody is attempting to inflate his security level. The response, issued on 6/7/17, states that he received an RVR on 3/24/17 for "behavior which would lead to violence," of which he was found guilty. The response states he also received an RVR on 3/25/17 and was found guilty of disobeying orders. The response instructs him to pursue the matter via a 602. It does not appear that RAP referred the allegations for investigation.

4. Person 51 reported that officers "tear cells up" and are disrespectful of private space. Officers tear up photos and spill coffee on the floor. Officers reportedly direct their harassment and abuse toward people with mental disabilities. Second watch officers are problematic; third watch officers reportedly treat people respectfully.

5. Person 34 reported that on 5/8/17, after he was reportedly falsely accused of manufacturing a weapon and of drug possession with the intent to distribute, Person 52 told him and the others who had been accused, "All three of you mother fuckers are done."

6. Person 53 reported that Person 54 and Person 55 constantly harass him. Person 54 and Person 55 tell him that they are going to get him kicked out of their building, saying things like "don't get too comfortable" or "pack your stuff."

IV. INTERFERENCE WITH MAIL, INCLUDING LEGAL MAIL

Class members reported that custody staff interfere with legal mail processing. For example:

1. Person 56 reported that his legal mail to OIA reporting staff misconduct has not been logged. He reportedly has written to the OIA about staff inciting violence and paying certain people to physically assault other people.

2. Person 57 reported that his legal mail is being held. He reported that he attempted to mail a writ about six months ago. When he turned it in, the officer said, "Why are you trying to go home? They feed you ice cream here." Regular mail has taken two months to reach his family.

V. MISCONDUCT BY MEDICAL STAFF

Several class members reported misconduct by medical staff. For example, Person 58 reported that Person 59 is disrespectful and says things like: "If it was up to me, I'd give none of you meds," and "Get the fuck out of my office."

Exhibit B1

OFFICE OF LEGAL AFFAIRS
Patrick R. McKinney II
General Counsel
P.O. Box 942883
Sacramento, CA 94283-0001

October 25, 2017

Sara Norman
Prison Law Office
General Delivery
San Quentin, CA 94964

Dear Ms. Norman:

This letter is in response to the allegations raised in your September 1, 2017 email regarding concerns raised during your August 2017 *Armstrong* Monitoring Tour at California State Prison Los Angeles County (LAC). I understand your request for a copy of [redacted] adaptive support logs is being addressed under separate cover. The California Department of Corrections and Rehabilitation (CDCR) takes every allegation seriously, and as such has conducted an inquiry into your allegation synopsized below:

> ***I write regarding [redacted], who is DD3 in Facility D at Lancaster. On our Armstrong tour this week, several other prisoners told us that he is being harassed by officers. They said that officers will pat him down roughly and when he flinches, hit him with their sticks. They reported that staff do this in the unit and when he is leaving chow. He reportedly tries to take bread out of chow to feed the birds.***
>
> ***I am very concerned about the reports of staff misconduct, particularly given Mr. [redacted] apparent inability to report such problems. The other prisoners we spoke with were uniformly afraid to give their names out of fear of retaliation. My report from my September 2016 visit (as well as subsequent Armstrong reports on Lancaster) supports these ongoing staff concerns.***

Please be advised that the Investigative Services Unit (ISU) initiated an inquiry into this matter on September 7, 2017. ISU staff attempted to interview Inmate [redacted] ([redacted] on October 5, 2017. The interviewer, a state-sponsored English-Spanish interpreter, had to conclude the interview after several minutes as Inmate [redacted] was unable to stay focused. However, with the assistance of a DPP Officer, the ISU staff member was able to ask him if he had any problems at LAC. His response was "No they are OK".

Notwithstanding the allegation mentioning inmates reluctant to provide their names, ISU staff found and interviewed inmates that, on a daily basis, interact and assist Inmate [redacted] Besides a non-*Armstrong* class member, *Armstrong* class members [redacted] ([redacted] [redacted] ([redacted]

and [redacted] ([redacted] have all taken it upon themselves to look after Inmate [redacted] and willingly provide him assistance. All four were emphatic that they have never witnessed or heard of allegations that Inmate [redacted] is mistreated by staff. Moreover, his clinician, a Clinical Social Worker, and four Facility D custody staff were interviewed and none of them were aware of any staff mistreatment nor were they aware of any inmates alleging the same. In short, ISU staff found the above allegation lacks cause for further investigation.

Based upon the above information, CDCR will be closing the inquiry into the above allegation.

Should you have any questions, or concerns, please contact Attorney IV Mike Davis, Legal Liaison for the High Security Mission, at [redacted]

Sincerely,

JAMES MICHAEL DAVIS
Attorney IV Legal Liaison, High Security Mission
Office of Legal Affairs

cc: Warden D. Asuncion
Corene Kendrick
Rana Anabtawi
Sia Henry
Meg O'Neill
Tania Amarillas
Rita Lomio

OFFICE OF LEGAL AFFAIRS
Patrick R. McKinney II
General Counsel
P.O. Box 942883
Sacramento, CA 94283-0001

February 27, 2018

VIA EMAIL ONLY

Ms. Tania Amarillas
Ms. Rita Lomio
Attorneys
Prison Law Office
tania@prisonlaw.com
rlomio@prisonlaw.com

Re: *Armstrong | August 2017 LAC Staff Misconduct Report*

Dear Ms. Amarillas and Ms. Lomio:

This letter is in response to the allegations raised in your October 2017 Staff Misconduct Report associated with the *Armstrong* Monitoring Tour concerning California State Prison Los Angeles County (LAC), regarding Inmate [redacted] ([redacted]).

The California Department of Corrections and Rehabilitation (CDCR) takes every allegation seriously, and as such has conducted an inquiry into the allegation as stated below:

- Person 6 ([redacted] [redacted] reported that on 7/26/17, while he was living in C1, he was called to the program office to speak with the Sergeant. He reported that while waiting, Person 7 (Officer [redacted] aggressively ordered him to go into a holding cage. Person 6 refused, and walked out of the program office. Person 7 reportedly chased after Person 6, screaming that he cuff up. When Person 6 turned around, Person 7 reportedly raised his clenched fists to eye level and was about to punch Person 6. Person 6 admits that he struck Person 7, at which time Person 8 (Officer [redacted] tackled Person 6. While Person 6 was one the ground, staff punched him repeatedly in the head, kneed him in the head, jumped on his back, and hit him with a weapon on the upper leg, leaving the back of his leg severely bruised.
    - Person 6 reported that he was unable to get up, so staff tied him to a wheelchair while he was cuffed behind his back. When he was being escorted to ASU in the wheelchair, a door opened and Person 9 (Unknown Officer) began punching him repeatedly in the stomach saying, “Never put your hands on an officer.”
    - On 7/26/17, Person 6 presented with a “right forehead hematoma, lower back pain, redness on right arm and on right face following altercation with custody” and that he was discharged to an outside hospital in an ambulance. The outside hospital noted multiple abrasions on his face.

- Person 6 was issued an RVR for assault with a deadly weapon; staff alleged that Person 6 hit staff with his cane."

LAC conducted an inquiry into this allegation by referencing various documents, databases, and records to procure all useful information regarding the allegations. LAC reviewed Incident Log LAC-CYRD-[redacted] which included eight Correctional Staff 837s regarding the July 26, 2017 incident, including Management review. LAC also further reviewed other various materials including, but not limited to, the Rules Violation Report involved, photographs of Inmate [redacted] and Correctional Staff after the incident. Lastly, LAC also conducted an interview of Inmate [redacted] regarding the incident.

Based upon the review of the documentary materials, and the information derived from the interviews of the inmate, LAC is unable to substantiate the above referenced allegation(s) of staff misconduct. As such, the inquiry into this matter has been closed.

Should you have any questions, please contact the undersigned at [redacted].

Sincerely,

/s/ Alan L. Sobel

ALAN L. SOBEL
Attorney IV
Legal Liaison, High Security Mission
Office of Legal Affairs

cc: Debbie Asuncion, Warden

OFFICE OF LEGAL AFFAIRS
Patrick R. McKinney II
General Counsel
P.O. Box 942883
Sacramento, CA 94283-0001

March 6, 2018

VIA EMAIL ONLY

Ms. Tania Amarillas
Ms. Rita Lomio
Attorneys
Prison Law Office
tania@prisonlaw.com
rlomio@prisonlaw.com

Re: *Armstrong | August 2017 LAC Staff Misconduct Report*

Dear Ms. Amarillas and Ms. Lomio:

This letter is in response to the allegations raised in your October 2017, *Armstrong* Monitoring Tour report concerning California State Prison Los Angeles County (LAC) regarding an Anonymous class member.

The California Department of Corrections and Rehabilitation (CDCR) takes every allegation seriously, and as such has conducted an inquiry into the allegation as stated below:

> "Person 43 (Anonymous class member) reported that he has to miss showers weekly because the ADA shower in C5 is being used inappropriately to house people who are expressing suicidal ideations. Another person reported that when people with disabilities ask staff to use the ADA shower they respond by saying "screw you guys."

Despite the lack of specificity and identification of the inmate who is alleged to have made the allegation, LAC interviewed a number of Correctional Staff and inmate witnesses concerning the allegation regarding the use of ADA showers in C5 being used in some manner to house people, who are expressing suicidal ideations.

With the lack of specificity provided, LAC was unable to substantiate the allegation(s) of staff misconduct based upon the information gained from the interviews. As such, the inquiry into this matter has been closed.

Should you have any questions, please contact the undersigned at [redacted].

Sincerely,

/s/ Alan L. Sobel

ALAN L. SOBEL
Attorney IV
Legal Liaison, High Security Mission
Office of Legal Affairs

cc: D. Asuncion, Warden

OFFICE OF LEGAL AFFAIRS
Patrick R. McKinney II
General Counsel
P.O. Box 942883
Sacramento, CA 94283-0001

March 6, 2018

VIA EMAIL ONLY

Ms. Tania Amarillas
Ms. Rita Lomio
Attorneys
Prison Law Office
tania@prisonlaw.com
rlomio@prisonlaw.com

Re: *Armstrong | August 2017 LAC Staff Misconduct Report*

Dear Ms. Amarillas and Ms. Lomio:

This letter is in response to the allegations raised in your August 2017, *Armstrong* Monitoring Tour report concerning California State Prison Los Angeles County (LAC) regarding Inmate [redacted] ([redacted]).

The California Department of Corrections and Rehabilitation (CDCR) takes every allegation seriously, and as such has conducted an inquiry into the allegation as stated below:

> "Person 12 ([redacted] [redacted] reported that on 3/7/17, he returned to the prison from an outside hospital. When Person 13 (Officer [redacted] picked him up from the hospital, the wheelchair the officer brought did not have a leg rest. Because there was no leg rest and he was restrained by cuffs with a black box and unable to hold himself up by the arm rests, Person 12 could not hold himself up in the wheelchair and was slipping out of the wheelchair as the officer was escorting him back to his housing unit. Person 12 reported that the multiple times he slipped out of the wheelchair, Person 13 very roughly threw him back into the wheelchair and laughed at him.
>
> --In the process, Person 12's shoes kept falling off, so Person 13 threw the shoes in the trash."

LAC conducted an inquiry into this allegation by referencing various documents, databases, and records to procure all useful information regarding the allegations. LAC reviewed Inmate [redacted] appeals history and determined that no appeal had been filed as to the allegation. LAC also interviewed Correctional Staff and Inmate [redacted] identified inmate witness to the allegations. Further, Inmate [redacted] was also interviewed regarding the allegation presented.

Based upon the review of the documentary materials, and the information derived from the interviews conducted, LAC was unable to substantiate the above referenced allegation(s) of staff misconduct. As such, the inquiry into this matter has been closed.

Should you have any questions, please contact the undersigned at [redacted].

Sincerely,

/s/ Alan L. Sobel

ALAN L. SOBEL
Attorney IV
Legal Liaison, High Security Mission
Office of Legal Affairs

cc: D. Asuncion, Warden

OFFICE OF LEGAL AFFAIRS
Patrick R. McKinney II
General Counsel
P.O. Box 942883
Sacramento, CA 94283-0001

March 6, 2018

VIA EMAIL ONLY

Ms. Tania Amarillas
Ms. Rita Lomio
Attorneys
Prison Law Office
tania@prisonlaw.com
rlomio@prisonlaw.com

Re: *Armstrong | August 2017 LAC Staff Misconduct Report*

Dear Ms. Amarillas and Ms. Lomio:

This letter is in response to the allegations raised in your August 2017, *Armstrong* Monitoring Tour report concerning California State Prison Los Angeles County (LAC) regarding Inmate [redacted] ([redacted]).

The California Department of Corrections and Rehabilitation (CDCR) takes every allegation seriously, and as such has conducted an inquiry into the allegation as stated below:

> "Person 2 ([redacted] [redacted] reported that on 7/31/17, he was exiting the Facility B dining hall around 7 am. An ADA worker, Person 3 (I/M [redacted] Spelling Unknown), was pushing Person 2's wheelchair. Person 3 reportedly was on a liquid diet at the time, and Person 2 was carrying Person 3's juice boxes and a cup of coffee. The custody staff standing outside the dining hall, including Person 4 (Officer [redacted]), told Person 2 and Person 3 to throw away the juice boxes and coffee. Person 2 and Person 3 returned to the dining hall where Person 2 discarded the coffee and place the juice boxes on a table. Person 3 took the juice boxes and returned to speak with the officer. Person 4 then roughly grabbed Person 2's hand that was holding the juice boxes and squeezed so hard that a juice box broke and spilled. Person 4 told Person 2 that Person 2 was gassing him. Person 4 and Person 5 (Unknown Officer) pulled Person 2 out of his wheelchair and threw him to the ground onto his stomach.
>
> --A gurney was brought, and an officer lifted Person 2 onto a gurney by his pants and shirt without supporting his head. Person 2 was taken to the medical clinic and then to the CTC, where he received X-rays of his spine. Person 2 reported that approximately 20 minutes after the X-rays were taken, staff video recorded Person 2 about the incident, during which time a lieutenant stated that the X-rays were normal and that Person 2 would be charged with battery on an officer"

LAC conducted an inquiry into this allegation by referencing various documents, databases, and records to procure all useful information regarding the allegations. LAC reviewed Incident Log LAC-BYRD-[redacted] which included nine Correctional Staff 837s regarding the July 31, 2017 incident, including Management review. LAC also further reviewed various other materials including but not limited to, Rules Violation Reports, Appeals history of Inmate [redacted] and a photograph of Inmate [redacted] after the incident. In addition, LAC also interviewed both Inmate [redacted] and [redacted] regarding the incident.

Based upon the review of the documentary materials, and the information derived from the interviews of the inmate, LAC was unable to substantiate the above referenced allegation(s) of staff misconduct. As such, the inquiry into this matter has been closed.

Should you have any questions, please contact the undersigned at [redacted].

Sincerely,

/s/ Alan L. Sobel

ALAN L. SOBEL
Attorney IV
Legal Liaison, High Security Mission
Office of Legal Affairs

cc: D. Asuncion, Warden

OFFICE OF LEGAL AFFAIRS
Patrick R. McKinney II
General Counsel
P.O. Box 942883
Sacramento, CA 94283-0001

March 6, 2018

VIA EMAIL ONLY

Ms. Tania Amarillas
Ms. Rita Lomio
Attorneys
Prison Law Office
tania@prisonlaw.com
rlomio@prisonlaw.com

Re: *Armstrong | August 2017 LAC Staff Misconduct Report*

Dear Ms. Amarillas and Ms. Lomio:

This letter is in response to the allegations raised in your August 2017, *Armstrong* Monitoring Tour report concerning California State Prison Los Angeles County (LAC) regarding Inmate [redacted] ([redacted]).

The California Department of Corrections and Rehabilitation (CDCR) takes every allegation seriously, and as such has conducted an inquiry into the allegation as stated below:

> "Person 10 ([redacted] [redacted] reported that on 5/20/17, while housed in C2, custody staff extracted him from his cell after he claimed he would kill himself and custody reportedly saw him take a handful of pills. He was CCCMS at the time. He said that the extraction was not recorded on camera because custody claimed it was a "medical extraction." Person 10 reported that during the extraction, he was on his bunk lying face up and a large officer, Person 11 (Officer [redacted] was on top of him, pressing his shield into him. Another officer instructed Person 10 to cuff up, so Person 10 grabbed the shield and pushed it so that he could turn over to be cuffed.
>
> --Person 10 was sent off-site for ingestion of an unknown substance, because staff allegedly witnessed him taking a handful of medication. At the prison, while at the hospital, and upon return from the hospital, Person 10 maintained that he was not suicidal and took only his regular medication. On 5/26/17, Person 10 submitted a 7362 reporting that he was in severe pain as a result of the cell extraction.
>
> --Person 10 was subsequently found guilty of staff assault because he was told that the shield is "part of the officer." He was given an 18 month SHU sentence"

LAC conducted an inquiry into this allegation by referencing various documents, databases, and records to procure all useful information regarding the allegations. LAC reviewed Incident Log

LAC-C[redacted] which included thirteen Correctional Staff 837s regarding the May 20, 2017 incident, including Management review. LAC also further reviewed various other materials including but not limited to Rules Violation Reports, Appeals history of Inmate [redacted] and a photograph of Inmate [redacted] after the incident. In addition, LAC also interviewed Inmate [redacted] regarding the incident.

Based upon the review of the documentary materials, and the information derived from the interviews of the inmate, LAC was unable to substantiate the above referenced allegation(s) of staff misconduct. As such, the inquiry into this matter has been closed.

Should you have any questions, please contact the undersigned at [redacted].

Sincerely,

/s/ Alan L. Sobel

ALAN L. SOBEL
Attorney IV
Legal Liaison, High Security Mission
Office of Legal Affairs

cc: D. Asuncion, Warden

OFFICE OF LEGAL AFFAIRS
Patrick R. McKinney II
General Counsel
P.O. Box 942883
Sacramento, CA 94283-0001

March 12, 2018

VIA EMAIL ONLY

Ms. Tania Amarillas
Ms. Rita Lomio
Attorneys
Prison Law Office
tania@prisonlaw.com
rlomio@prisonlaw.com

Re: *Armstrong | August 2017 LAC Staff Misconduct Report*

Dear Ms. Amarillas and Ms. Lomio:

This letter is in response to the allegations raised in your August 2017, *Armstrong* Monitoring Tour report concerning California State Prison Los Angeles County (LAC) regarding the allegation from Person(s) No. 18 & 19 (Anonymous class member(s)).

It should be noted that it appears that the allegations presented in the Prison Law Office (PLO) report from Person 7, along with the allegation from Person 51 which emanate from allegations concerning conduct in D3, and may involve purported observation(s) of the similar incident.

In any event, the California Department of Corrections and Rehabilitation (CDCR) takes every allegation seriously, and as such has conducted an inquiry into the allegation as stated below:

> "Person 18 (Anonymous Class member) reported that in early August, in D3, Person 19 (Unidentified black person)was returning to his cell from breakfast. He stopped by another person's cell. Person 20 (Unidentified Latino Officer) yelled at him to put his hands behind his back. He asked why. In response, the officer picked Person 19 up and slammed him on the floor. There was blood on the floor; Person 19 was removed from the unit in a wheelchair"

LAC conducted an inquiry into this allegation(s) by referencing various documents, databases, and records to procure all useful information regarding the allegations. Based upon that review, LAC determined that the incident alleged by Person 18 & 19, although not factually as presented in the allegation, most closely resembles the incident that was previously addressed by LAC through Incident Log (LAC-D[redacted]) and Appeal D-[redacted].

LAC reviewed the incident log and appeal, including the Use of Force video of the inmate involved in the incident (LAC-D[redacted]). LAC also interviewed Correctional Staff in D3, along with a number of inmate(s) housed in D3 regarding the allegations. Based upon the

review of the documentation, and the information derived from the interviews conducted, LAC could not substantiate the allegations of staff misconduct. As such, the inquiry into this matter has been closed.

Should you have any questions, please contact the undersigned at [redacted].

Sincerely,

/s/ Alan L. Sobel

ALAN L. SOBEL
Attorney IV
Legal Liaison, High Security Mission
Office of Legal Affairs

cc: D. Asuncion, Warden

OFFICE OF LEGAL AFFAIRS
Patrick R. McKinney II
General Counsel
P.O. Box 942883
Sacramento, CA 94283-0001

March 12, 2018

VIA EMAIL ONLY

Ms. Tania Amarillas
Ms. Rita Lomio
Attorneys
Prison Law Office
tania@prisonlaw.com
rlomio@prisonlaw.com

Re: *Armstrong | August 2017 LAC Staff Misconduct Report*

Dear Ms. Amarillas and Ms. Lomio:

This letter is in response to the allegations raised in your August 2017, *Armstrong* Monitoring Tour report concerning California State Prison Los Angeles County (LAC) regarding the allegation from Person No. 51 (Anonymous class member).

The California Department of Corrections and Rehabilitation (CDCR) takes every allegation seriously, and as such has conducted an inquiry into the allegation as stated below:

> "Person 51 (D3 Anonymous Class member) reported that officers "tear cells up" and are disrespectful of private space. Officers tear up photos and spill coffee on the floor. Officers reportedly direct their harassment and abuse toward people with mental disabilities. Second watch officers are problematic; third watch officers reportedly treat people respectfully."

LAC conducted an inquiry into this allegation(s) by referencing various documents, databases, and records to procure all useful information regarding the allegations. LAC reviewed the Inmate Appeals Tracking System (IATS) and determined that there were no appeals presented by Inmate(s) regarding the allegations presented on behalf of Person 51.

Based upon the lack of specificity and detail in the allegation, LAC was unable to interview the involved inmate that presented the allegation. As such, LAC interviewed a number of inmate(s) from LAC D3 regarding the allegation(s) presented, and was unable to procure any information that correlated to the allegations presented. Based upon the review of the documentation, and the information derived from the interviews conducted, LAC could not substantiate the allegations of staff misconduct. As such, the inquiry into this matter has been closed.

Should you have any questions, please contact the undersigned at [redacted].

Sincerely,

/s/ Alan L. Sobel

ALAN L. SOBEL
Attorney IV
Legal Liaison, High Security Mission
Office of Legal Affairs

cc: D. Asuncion, Warden

OFFICE OF LEGAL AFFAIRS
Patrick R. McKinney II
General Counsel
P.O. Box 942883
Sacramento, CA 94283-0001

March 12, 2018

VIA EMAIL ONLY

Ms. Tania Amarillas
Ms. Rita Lomio
Attorneys
Prison Law Office
tania@prisonlaw.com
rlomio@prisonlaw.com

Re: *Armstrong | August 2017 LAC Staff Misconduct Report*

Dear Ms. Amarillas and Ms. Lomio:

This letter is in response to the allegations raised in your August 2017, *Armstrong* Monitoring Tour report concerning California State Prison Los Angeles County (LAC) regarding the allegation from Person No. 17 (Anonymous class member).

It should be noted that it appears that the allegations presented in the Prison Law Office (PLO) report from Person(s) 18 & 19, along with the allegation from Person 51 emanate from allegations concerning conduct in D3, and may involve purported observation(s) of the similar incident.

In any event, the California Department of Corrections and Rehabilitation (CDCR) takes every allegation seriously, and as such has conducted an inquiry into the allegation as stated below:

> "Person 17 (Anonymous class member) reported that officers in D3 slam people on the ground in the units when they are in handcuffs. Officers also will lift people off of their feet when handcuffed. The officers take people's property, such as fans, televisions, and hotpots, and give it to other people. Person 17 reported that the yard officers "look for excuses to hit you"

LAC conducted an inquiry into this allegation(s) by referencing various documents, databases, and records to procure all useful information regarding the allegations. Based upon that review, LAC determined that the incident alleged by Person 17, although not factually as presented in the allegation, most closely resemble the incident that was previously addressed by LAC through an Incident Log (LAC-D[redacted]) and Appeal D-[redacted].

LAC reviewed the incident log and appeal, including the Use of Force video of the inmate involved in the incident (LAC-D[redacted]). LAC also interviewed Correctional Staff in D3, along with a number of inmate(s) housed in D3 regarding the overall allegations.

Based upon the review of the documentation, and the information derived from the interviews conducted, LAC could not substantiate the allegations of staff misconduct. As such, the inquiry into this matter has been closed.

Should you have any questions, please contact the undersigned at [redacted].

Sincerely,

/s/ Alan L. Sobel

ALAN L. SOBEL
Attorney IV
Legal Liaison, High Security Mission
Office of Legal Affairs

cc: D. Asuncion, Warden

OFFICE OF LEGAL AFFAIRS
Patrick R. McKinney II
General Counsel
P.O. Box 942883
Sacramento, CA 94283-0001

March 12, 2018

VIA EMAIL ONLY

Ms. Tania Amarillas
Ms. Rita Lomio
Attorneys
Prison Law Office
tania@prisonlaw.com
rlomio@prisonlaw.com

Re: *Armstrong | August 2017 LAC Staff Misconduct Report*

Dear Ms. Amarillas and Ms. Lomio:

This letter is in response to the allegations raised in your August 2017, *Armstrong* Monitoring Tour report concerning California State Prison Los Angeles County (LAC) regarding Inmate [redacted] ([redacted]) alleged observation of staff misconduct.

The California Department of Corrections and Rehabilitation (CDCR) takes every allegation seriously, and as such has conducted an inquiry into the allegation as stated below:

> "Person 21 ([redacted] [redacted] reported that on 8/21/17, Person 25 (Person Housed in C1) was assaulted by staff. Person 21 reported that he watched Person 22 (Officer [redacted] Person 23 (Officer [redacted] and Person 24 (Officer [redacted] handcuff Person 25 after finding a cellphone in his cell. Person 22 then kneed Person 25 in the back and began kicking him while he was handcuffed on the floor."

LAC conducted an inquiry into this allegation by referencing various documents, databases, and records to procure all useful information regarding the allegations. Based upon the review, LAC was able to identify an incident (involving a non-Armstrong class member), although not as described in the presented allegation, was reflected in LAC Incident Log No.: LAC-[redacted] occurring on August 16, 2017 in Housing Unit C01 .

LAC reviewed Incident Log No.: LAC-C[redacted], the corresponding documentation, along with photographs of the involved inmate(s) and Correctional Staff. LAC also interviewed Inmate [redacted] and the inmate involved in the incident regarding the allegations as presented. Inmate [redacted] ([redacted]) denied communicating the allegation(s) as presented in the Prison Law Office (PLO) report.

Based upon the review of the materials secured by LAC, and the information derived from the interviews of the inmate(s), LAC was unable to substantiate the above referenced allegation(s) of staff misconduct. In addition, as such, the inquiry into this matter has been closed.

Should you have any questions, please contact the undersigned at [redacted]

Sincerely,

/s/ Alan L. Sobel

ALAN L. SOBEL
Attorney IV
Legal Liaison, High Security Mission
Office of Legal Affairs

cc: D. Asuncion, Warden

OFFICE OF LEGAL AFFAIRS
Patrick R. McKinney II
General Counsel
P.O. Box 942883
Sacramento, CA 94283-0001

March 12, 2018

VIA EMAIL ONLY

Ms. Tania Amarillas
Ms. Rita Lomio
Attorneys
Prison Law Office
tania@prisonlaw.com
rlomio@prisonlaw.com

Re: *Armstrong | August 2017 LAC Staff Misconduct Report*

Dear Ms. Amarillas and Ms. Lomio:

This letter is in response to the allegations raised in your August 2017, *Armstrong* Monitoring Tour report concerning California State Prison Los Angeles County (LAC) regarding Inmate [redacted] ([redacted]) allegation of staff misconduct.

The California Department of Corrections and Rehabilitation (CDCR) takes every allegation seriously, and as such has conducted an inquiry into the allegation as stated below:

> "Person 26 ([redacted] [redacted] reported that Person 27 (Possibly, Officer [redacted] sprayed Person 28 (Likely, I/M [redacted] [redacted] for no good reason in early August. Person 26 recently was interviewed about it, apparently for the 115 hearing. We note that Person 28 reported to a mental health clinician that he had been pepper sprayed toward the end of July. It appears that Person 28's participation in mental health groups declined after that date.
>
> Person 29 (Anonymous class member) reported seeing Person 28 get pepper sprayed on approximately July 28 by Person 30 (Officer [redacted]

LAC conducted an inquiry into this allegation by referencing various documents, databases, and records to procure all useful information regarding the allegations. Although not factually as presented in the allegation, LAC determined that the issue involved was originally addressed in Incident Log No.: LAC-D[redacted]. It was also determined that the incident purportedly observed by Inmate [redacted] occurred on July 27th (not in early August), and involved Correctional Officer (CO) [redacted] as a CO [redacted] does not work at LAC.

LAC reviewed the materials in Incident Log No.: LAC-D[redacted], and the corresponding materials, including the Institutional Executive Review Committee. The matter was reviewed at the time of the incident, and the force employed was determined to be within policy.

However, in order to complete the inquiry into the allegations presented, LAC also interviewed Inmate [redacted] and Inmate [redacted] regarding the alleged incident.

Based upon the review of the materials secured by LAC, combined with the inconsistent information derived from the interviews of the inmate(s), LAC was unable to substantiate the above allegation(s) of staff misconduct. As such, LAC's inquiry into this matter has been closed.

Should you have any questions, please contact the undersigned at [redacted].

Sincerely,

/s/ Alan L. Sobel

ALAN L. SOBEL
Attorney IV
Legal Liaison, High Security Mission
Office of Legal Affairs

cc: D. Asuncion, Warden

OFFICE OF LEGAL AFFAIRS
Patrick R. McKinney II
General Counsel
P.O. Box 942883
Sacramento, CA 94283-0001

March 12, 2018

VIA EMAIL ONLY

Ms. Tania Amarillas
Ms. Rita Lomio
Attorneys
Prison Law Office
tania@prisonlaw.com
rlomio@prisonlaw.com

Re: *Armstrong | August 2017 LAC Staff Misconduct Report*

Dear Ms. Amarillas and Ms. Lomio:

This letter is in response to the allegations raised in your August 2017, *Armstrong* Monitoring Tour report concerning California State Prison Los Angeles County (LAC) regarding Inmate [redacted] ([redacted]).

The California Department of Corrections and Rehabilitation (CDCR) takes every allegation seriously, and as such has conducted an inquiry into the allegation as stated below:

> "Person 15 ([redacted] [redacted] reported through an 1824 that on 4/29/17, Person 16 (Officer [redacted] refused to allow him an ADA shower and phone time. He alleged that on the same night, the officer closed him in the cell door trapping him, which the officer found "hilarious." The response, which does not have an issue date stamp, states that the allegation would be handled through the Inmate Appeals Office (Log # [redacted])"

LAC conducted an inquiry into this allegation by referencing various documents, databases, and records to procure all useful information regarding the allegations. Based upon that review, LAC was aware of Inmate [redacted]'s filing of a Reasonable Accommodation Request (1824). In reviewing the allegations contained within the PLO report, LAC conducted a review of Inmate [redacted] 1824, and also conducted a variety of interviews of Correctional Staff and inmate(s), including Inmate [redacted]

LAC interviewed an inmate in the next cell to Inmate [redacted] who never witnessed any event consistent with the allegation(s) presented by Inmate [redacted] In addition, Inmate [redacted] former cellmate, who has since paroled, did not respond to LAC's contact attempts regarding Inmate [redacted] allegations. Based upon the review of the documentation, and the information derived from the interviews conducted, LAC could not substantiate the allegations of staff misconduct. As such, the inquiry into this matter has been closed.

Should you have any questions, please contact the undersigned at [redacted].

Sincerely,

/s/ Alan L. Sobel

ALAN L. SOBEL
Attorney IV
Legal Liaison, High Security Mission
Office of Legal Affairs

cc: D. Asuncion, Warden

OFFICE OF LEGAL AFFAIRS
Patrick R. McKinney II
General Counsel
P.O. Box 942883
Sacramento, CA 94283-0001

March 19, 2018

VIA EMAIL ONLY

Ms. Tania Amarillas
Ms. Rita Lomio
Attorneys
Prison Law Office
tania@prisonlaw.com
rlomio@prisonlaw.com

Re: *Armstrong | August 2017 LAC Staff Misconduct Report*

Dear Ms. Amarillas and Ms. Lomio:

This letter is in response to the allegations raised in your August 2017, *Armstrong* Monitoring Tour report concerning California State Prison- Los Angeles County (LAC) regarding the allegation from Inmate [redacted] ([redacted]

The California Department of Corrections and Rehabilitation (CDCR) takes every allegation seriously, and as such has conducted an inquiry into the allegation as stated below:

> "Person 49 ([redacted] reported through an 1824 signed on 5/31/17 that Person 50 (Officer [redacted] harassed him in the dining hall "for getting water prior to walking to the ADA feeding section," and that custody is attempting to inflate his security level. The response, issued on 6/7/17, states that he received an RVR on 3/24/17 for "behavior which would lead to violence," of which he was found guilty. The response states he also received an RVR on 3/25/17 and was found guilty of disobeying orders. The response instructs him to pursue the matter via a 602. It does not appear that RAP referred the allegations for investigation."

LAC conducted an inquiry into this allegation(s) by referencing various documents, databases, and records to procure all useful information regarding the allegations. LAC determined, although not factually accurate, the incident described in the allegation was addressed by LAC in LAC-B-[redacted], dated March 29, 2017. LAC attempted to interview Inmate [redacted] regarding the above-referenced allegations, but Inmate [redacted] disagreed that he raised the issue of getting water in the 1824, and then subsequently claimed that he had been issued an illegal Rules Violation Reports. Inmate [redacted] then refused to discuss the substance of the allegation(s) further indicating that he was separately pursuing such claims in Court.

LAC then reviewed LAC-B-[redacted] determining that Inmate [redacted] refused to sit at a designated table in the dining hall, responding to Correctional Officer (CO) [redacted] directive as follows: "Shut the f-ck up b-tch! F-ck the police!" In review of the disciplinary hearing, it appears that Inmate [redacted] became irate and stated he was going to "sit wherever the f-ck he wanted to sit." LAC also reviewed Inmate [redacted] 602 (LAC-B-[redacted]) where he alleged procedural irregularities and the fact that the Senior Hearing Officer was biased against him. In his appeal, inmate [redacted] did not reference that he was being harassed by CO [redacted]

LAC also reviewed Inmate [redacted] classification history for his current period of incarceration, including the Rules Violation Reports issued to Inmate [redacted] Through such review, LAC determined that there was no effort to inflate Inmate [redacted] and that any changes in Inmate [redacted] placement score occurred as a result of Inmate [redacted]'s own actions.

Based upon the review of documentation, and the information derived from the interview of Inmate [redacted] LAC determined that the allegations of staff misconduct were unfounded. As such, the inquiry into this matter has been closed.

Should you have any questions, please contact the undersigned at [redacted]-[redacted]-[redacted]

Sincerely,

/s/ Alan L. Sobel

ALAN L. SOBEL
Attorney IV
Legal Liaison, High Security Mission
Office of Legal Affairs

cc: D. Asuncion, Warden

OFFICE OF LEGAL AFFAIRS
Patrick R. McKinney II
General Counsel
P.O. Box 942883
Sacramento, CA 94283-0001

March 19, 2018

VIA EMAIL ONLY

Ms. Tania Amarillas
Ms. Rita Lomio
Attorneys
Prison Law Office
tania@prisonlaw.com
rlomio@prisonlaw.com

Re: *Armstrong | August 2017 LAC Staff Misconduct Report*

Dear Ms. Amarillas and Ms. Lomio:

This letter is in response to the allegations raised in your August 2017, *Armstrong* Monitoring Tour report concerning California State Prison- Los Angeles County (LAC) from Inmate [redacted] ([redacted] regarding a number of instances of alleged staff misconduct. In order to avoid confusion, each of the allegations as to Inmate [redacted] observations will be responded to separately.

The California Department of Corrections and Rehabilitation (CDCR) takes every allegation seriously, and as such has conducted an inquiries into the following allegation from Inmate [redacted], as stated below:

- "Person 34 ([redacted] [redacted] reported that in April, in front of C5, he saw custody staff make Person 35 (Unidentified black male) get down on the ground. Person 35 was not struggling but six or seven officers started hitting him. Someone yelled, "He's not resisting!" to which an officer responded, "Shut the f-ck up!"

LAC conducted an inquiry into this allegation by referencing various documents, databases, and records to procure all useful information regarding the allegations. LAC also interviewed Inmate [redacted] seeking clarification of the above-referenced allegation, and regarding the substance of the allegation. Through the allegation presented, and the information derived from Inmate [redacted] LAC was able to determine that the event, although the date of occurrence and factual depiction is not entirely accurate, occurred on March 24, 2017, and was addressed in Incident Log No. LAC-C[redacted].

LAC reviewed the Incident Log No. LAC-C[redacted] which included Correctional Staff 837 reports, the 7219 Medical Report of Injury, the Supervisory and Management Level Review documentation. Further, LAC's review of ERMS determined that the involved inmate did not

file a 602 appeal regarding the interaction with Correctional Staff. In addition, Inmate [redacted] was not able to provide the identity of any staff or inmate witnesses to the allegations as presented. Lastly, the inconsistencies in Inmate [redacted] interview regarding the incident which reflect that Inmate [redacted] may not have witnessed the incident, and in the event that he did, would not have been able to hear what was said.

Based upon the review of the documentary materials, and the information derived from the interviews of Inmate [redacted] LAC is unable to substantiate the above referenced allegation(s) of staff misconduct. As such, the inquiry into this matter has been closed.

Should you have any questions, please contact the undersigned at [redacted].

Sincerely,

/s/ Alan L. Sobel

ALAN L. SOBEL
Attorney IV
Legal Liaison, High Security Mission
Office of Legal Affairs

cc: D. Asuncion, Warden

OFFICE OF LEGAL AFFAIRS
Patrick R. McKinney II
General Counsel
P.O. Box 942883
Sacramento, CA 94283-0001

March 19, 2018

VIA EMAIL ONLY

Ms. Tania Amarillas
Ms. Rita Lomio
Attorneys
Prison Law Office
tania@prisonlaw.com
rlomio@prisonlaw.com

Re: *Armstrong | August 2017 LAC Staff Misconduct Report*

Dear Ms. Amarillas and Ms. Lomio:

This letter is in response to the allegations raised in your August 2017, *Armstrong* Monitoring Tour report concerning California State Prison- Los Angeles County (LAC) from Inmate [redacted] ([redacted] regarding a number of instances of alleged staff misconduct. In order to avoid confusion, each of the allegations as to Inmate [redacted] observations will be responded to separately.

The California Department of Corrections and Rehabilitation (CDCR) takes every allegation seriously, and as such has conducted an inquiries into the following allegation from Inmate [redacted], as stated below:

- "Person 34 ([redacted] [redacted] reported that in March, Person 36 (Unidentified Hispanic Male) was exiting the C Yard dining hall and talking with an officer about not receiving his kosher meal. Multiple officers slammed the man to the ground, where six or seven staff repeatedly hit him. According to Person 34, Person 36 was not resisting"

LAC conducted an inquiry into this allegation by referencing various documents, databases, and records to procure all useful information regarding the allegations. LAC also interviewed Inmate [redacted] seeking clarification of the above-referenced allegation, and regarding the substance of the allegation. Through the allegation presented, and the information derived from Inmate [redacted] LAC was able to determine that the event, although the date of occurrence and factual depiction is not entirely accurate, occurred on April 18, 2017, and was addressed in Incident Log No. LAC-C[redacted].

LAC reviewed the Incident Log No. LAC-C[redacted] which included Correctional Staff 837 reports, the 7219 Medical Report of Injury, the Supervisory and Management Level Review

documentation, and the Use of Force video of the subject inmate. LAC also reviewed the Rules Violation Report for the involved inmate, along with the 602 appeal filed by the involved inmate.

In addition, in the interview with Inmate [redacted] regarding his observations of the incident, he was not able to provide the identity of any staff or inmate witnesses to the allegations as presented. Furthermore, Inmate [redacted] was inconsistent as to whether the involved inmate was observed resisting correctional staff. Lastly, LAC determined from Inmate [redacted] interview that he was approximately fifty (50) yards away from the incident, and would have difficulty in witnessing the event as described.

Based upon the review of the documentary materials, and the inconsistent information derived from the interviews of the inmate, LAC is unable to substantiate the above referenced allegation(s) of staff misconduct. As such, the inquiry into this matter has been closed.

Should you have any questions, please contact the undersigned at [redacted].

Sincerely,

/s/ Alan L. Sobel

ALAN L. SOBEL
Attorney IV
Legal Liaison, High Security Mission
Office of Legal Affairs

cc: D. Asuncion, Warden

OFFICE OF LEGAL AFFAIRS
Patrick R. McKinney II
General Counsel
P.O. Box 942883
Sacramento, CA 94283-0001

March 19, 2018

VIA EMAIL ONLY

Ms. Tania Amarillas
Ms. Rita Lomio
Attorneys
Prison Law Office
tania@prisonlaw.com
rlomio@prisonlaw.com

Re: *Armstrong | August 2017 LAC Staff Misconduct Report*

Dear Ms. Amarillas and Ms. Lomio:

This letter is in response to the allegations raised in your August 2017, *Armstrong* Monitoring Tour report concerning California State Prison- Los Angeles County (LAC) from Inmate [redacted] ([redacted] regarding a number of instances of alleged staff misconduct. In order to avoid confusion, each of the allegations as to Inmate [redacted] observations will be responded to separately.

The California Department of Corrections and Rehabilitation (CDCR) takes every allegation seriously, and as such has conducted an inquiries into the following allegation from Inmate [redacted], as stated below:

- "Person 34 ([redacted] [redacted] reported that Person 44 (Officer [redacted] commented: "I could easily plant a knife on you guys."

LAC conducted an inquiry into this allegation by referencing various documents, databases, and records to procure all useful information regarding the allegations. LAC also interviewed Inmate [redacted] who stated that although he confirmed hearing the comment, indicated that he did not believe that the Correctional Officer [redacted] would plant a weapon on him. Inmate [redacted] was unable to identify any staff witnesses, but stated that his cellmate at the time was a witness to the purported statement. LAC interviewed the Inmate [redacted] cellmate who did not confirm that CO [redacted] ever made that comment to Inmate [redacted]

Based upon the review of the documentary materials, and the inconsistent information derived from the interview of the inmate(s), LAC is unable to substantiate the above referenced allegation(s) of staff misconduct. As such, the inquiry into this matter has been closed.

Should you have any questions, please contact the undersigned at [redacted]

Sincerely,

/s/ Alan L. Sobel

ALAN L. SOBEL
Attorney IV
Legal Liaison, High Security Mission
Office of Legal Affairs

cc: D. Asuncion, Warden

OFFICE OF LEGAL AFFAIRS
Patrick R. McKinney II
General Counsel
P.O. Box 942883
Sacramento, CA 94283-0001

March 19, 2018

VIA EMAIL ONLY

Ms. Tania Amarillas
Ms. Rita Lomio
Attorneys
Prison Law Office
tania@prisonlaw.com
rlomio@prisonlaw.com

Re: *Armstrong | August 2017 LAC Staff Misconduct Report*

Dear Ms. Amarillas and Ms. Lomio:

This letter is in response to the allegations raised in your August 2017, *Armstrong* Monitoring Tour report concerning California State Prison- Los Angeles County (LAC) from Inmate [redacted] ([redacted]) regarding a number of instances of alleged staff misconduct. In order to avoid confusion, each of the allegations as to Inmate [redacted] observations will be responded to separately.

The California Department of Corrections and Rehabilitation (CDCR) takes every allegation seriously, and as such has conducted an inquiries into the following allegation from Inmate [redacted], as stated below:

- "Person 34 ([redacted] [redacted] reported that on 5/8/17, after he was reportedly falsely accused of manufacturing a weapon and of drug possession with the intent to distribute, Person 52 (Lt. [redacted] told him and the others who had been accused, "All three of you mother f-ckers are done."

LAC conducted an inquiry into this allegation by referencing various documents, databases, and records to procure all useful information regarding the allegations. LAC interviewed Inmate [redacted] seeking clarification and discussing the substance of the allegation presented. Inmate [redacted] communicated to LAC that the central issue of the allegation presented to the Prison Law Office (PLO) was not the alleged comment by Lt. [redacted] but that he should not have been sent to Ad-Seg, as he was incorrectly charged by CDCR.

Based upon the above-referenced review, LAC was able to determine that Inmate [redacted] had filed an Appeal No.: LAC-[redacted] regarding the incident alleged above. In fact, this is the only appeal that Inmate [redacted] filed regarding the allegation(s) attributed to him in the PLO August 2017 report. In the appeal, Inmate [redacted] did not allege (1) that LAC Correctional

Staff made inappropriate comments to him about going to the hole; or (2) that Inmate [redacted] was falsely accused of manufacturing an inmate weapon. Rather, the only issue alleged in the appeal was the incorrect imposition of a ninety (90) day exercise yard restriction.

Through the interview of Inmate [redacted] LAC was able to determine that Inmate [redacted] believed that he should not have been sent to Ad-Seg because CDCR did not locate an inmate manufactured weapon in his cell. However, Inmate [redacted] admitted in his interview that he had illegally purchased the wheelchair for fifty ($50) dollars. In addition, Inmate [redacted] admitted that he was in possession of a wheelchair that was used to make Inmate Manufactured Weapons. In the review of Inmate [redacted] Rules Violation Report (RVR) No. [redacted], it appears that the information was documented correctly, and the charge against Inmate [redacted] was reduced to possession of dangerous contraband.

Based upon the review of the documentary materials, Inmate [redacted] 602 appeal filed at the time, the RVR issued to Inmate [redacted] and the information derived from the interview of Inmate [redacted] LAC was unable to substantiate the above referenced allegation(s) of staff misconduct. As such, the inquiry into this matter has been closed.

Should you have any questions, please contact the undersigned at [redacted].

Sincerely,

/s/ Alan L. Sobel

ALAN L. SOBEL
Attorney IV
Legal Liaison, High Security Mission
Office of Legal Affairs

cc: D. Asuncion, Warden

OFFICE OF LEGAL AFFAIRS
Patrick R. McKinney II
General Counsel
P.O. Box 942883
Sacramento, CA 94283-0001

March 19, 2018

VIA EMAIL ONLY

Ms. Tania Amarillas
Ms. Rita Lomio
Attorneys
Prison Law Office
tania@prisonlaw.com
rlomio@prisonlaw.com

Re: *Armstrong | August 2017 LAC Staff Misconduct Report*

Dear Ms. Amarillas and Ms. Lomio:

This letter is in response to the allegations raised in your August 2017, *Armstrong* Monitoring Tour report concerning California State Prison- Los Angeles County (LAC) regarding the allegation from Inmate [redacted] ([redacted]

The California Department of Corrections and Rehabilitation (CDCR) takes every allegation seriously, and as such has conducted an inquiry into the allegation as stated below:

> "Person 42 ([redacted] [redacted] reported that in mid-June, he tried to hang himself on the door of his cell. He was in his wheelchair at the time, and slumped over by the door. The officer came by to do the pipe check. The officer put his hand through the food slot, cut the rope, and moved on. The officer did not refer Person 42 to medical or mental health, and did not check to see if he was OK. Person 42 does not know who the officer was, as he (Person 42) was facing into the cell.

LAC conducted an inquiry into this allegation(s) by referencing various documents, databases, and records to procure all useful information regarding the allegations. Based upon the review of the Inmate [redacted] appeal history, LAC determined that Inmate [redacted] did not file an appeal relative to the above allegation. LAC attempted to interview Inmate [redacted] while he was incarcerated at CSP-Corcoran (COR), in order to procure clarification and additional details regarding the above-allegation. However, Inmate [redacted] refused to leave his cell, and refused to participate in the interview.

LAC then determined, based upon the date of the alleged event, that Inmate [redacted] was incarcerated in LAC Administrative Segregation (Ad-Seg.) Cell [redacted]. LAC interviewed the inmate incarcerated in LAC Ad-Seg. Cell [redacted] during June 2017 regarding Inmate [redacted] interaction with LAC Correctional Staff. Based upon that interview, LAC was informed that

Inmate [redacted] was frequently on suicide watch, and that LAC mental health staff was observed talking to Inmate [redacted] frequently. In addition, on multiple occasions, LAC Correctional Staff was observed sitting in front of Cell [redacted] monitoring Inmate [redacted] on suicide watch. When LAC read the above-referenced allegation to the inmate incarcerated in Cell [redacted], he denied ever witnessing the events as described in the above-referenced allegation.

Based upon the review of documentation, and the information derived from the attempted and conducted interviews, LAC determined that the allegations of staff misconduct were unfounded. As such, the inquiry into this matter has been closed.

Should you have any questions, please contact the undersigned at [redacted].

Sincerely,

/s/ Alan L. Sobel

ALAN L. SOBEL
Attorney IV
Legal Liaison, High Security Mission
Office of Legal Affairs

cc: D. Asuncion, Warden

OFFICE OF LEGAL AFFAIRS
Patrick R. McKinney II
General Counsel
P.O. Box 942883
Sacramento, CA 94283-0001

March 19, 2018

VIA EMAIL ONLY

Ms. Tania Amarillas
Ms. Rita Lomio
Attorneys
Prison Law Office
tania@prisonlaw.com
rlomio@prisonlaw.com

Re: *Armstrong | August 2017 LAC Staff Misconduct Report*

Dear Ms. Amarillas and Ms. Lomio:

This letter is in response to the allegations raised in your August 2017, *Armstrong* Monitoring Tour report concerning California State Prison- Los Angeles County (LAC) regarding the allegation of staff misconduct involving Person 31.

The California Department of Corrections and Rehabilitation (CDCR) takes every allegation seriously, and as such has conducted an inquiry into the allegation as stated below:

> "Person 31 (Anonymous) reported that on 7/27/17, Person 32 (Officer [redacted] spelling name unknown) pushed Person 33 (I/M [redacted] No CDC# provided) without justification."

LAC conducted an inquiry into this allegation by referencing various documents, databases, and records to procure all useful information regarding the allegations. Although not factually as presented in the allegation, LAC determined that the issue involved was originally addressed in Incident Log No.: LAC-D[redacted]. It was also determined that the incident involved Correctional Officer (CO) [redacted]

LAC reviewed the materials in Incident Log No.: LAC-D[redacted], and the corresponding materials, including the Institutional Executive Review Committee. The matter was reviewed at the time of the incident, and the force employed was determined to be within policy. However, in order to complete the inquiry into the allegations presented, LAC also interviewed Inmate [redacted] and Inmate [redacted] regarding the alleged incident.

Based upon the review of the materials secured by LAC, combined with the inconsistent information derived from the interviews of the inmate(s), LAC was unable to substantiate the above allegation(s) of staff misconduct. As such, LAC's inquiry into this matter has been closed.

Should you have any questions, please contact the undersigned at [redacted].

Sincerely,

/s/ Alan L. Sobel

ALAN L. SOBEL
Attorney IV
Legal Liaison, High Security Mission
Office of Legal Affairs

cc: D. Asuncion, Warden

OFFICE OF LEGAL AFFAIRS
Patrick R. McKinney II
General Counsel
P.O. Box 942883
Sacramento, CA 94283-0001

March 19, 2018

VIA EMAIL ONLY

Ms. Tania Amarillas
Ms. Rita Lomio
Attorneys
Prison Law Office
tania@prisonlaw.com
rlomio@prisonlaw.com

Re: *Armstrong | August 2017 LAC Staff Misconduct Report*

Dear Ms. Amarillas and Ms. Lomio:

This letter is in response to the allegations raised in your August 2017, *Armstrong* Monitoring Tour report concerning California State Prison- Los Angeles County (LAC) regarding an anonymous allegation of staff misconduct in responding to individuals with mental health issues.

The California Department of Corrections and Rehabilitation (CDCR) takes every allegation seriously, and as such has conducted an inquiry into the allegation as stated below:

> "Person 40 (Anonymous) reported that officers do not deal with people with mental health issues well; officers "pick at" or "aggravate" such people to "get a rise out of them." Officers reportedly ignore people when they say they have mental health problems. Officers reportedly put people in the shower for 3-4 hours when they say they are suicidal. The doctor visits the person in the shower and evaluates the person there."

The allegation presented does not provide sufficient specificity or detail to permit LAC to identify the inmate who presented the allegation, or identify the specific instance of staff misconduct allegedly observed.

Based upon the dearth of information, LAC attempted to conduct an inquiry into this allegation by referencing various documents, databases, and records to procure all useful information regarding the allegations. LAC reviewed a number of Incident Logs, and interviewed five inmate(s) regarding the allegation of inappropriate correctional staff response to inmate(s) with mental health issues.

Through the review of the documentary materials, and the information derived from the aforementioned interviews, LAC was unable to substantiate the above allegation(s) of staff misconduct. As such, LAC's inquiry into this matter has been closed.

Should you have any questions, please contact the undersigned at [redacted].

Sincerely,

/s/ Alan L. Sobel

ALAN L. SOBEL
Attorney IV
Legal Liaison, High Security Mission
Office of Legal Affairs

cc: D. Asuncion, Warden

OFFICE OF LEGAL AFFAIRS
Patrick R. McKinney II
General Counsel
P.O. Box 942883
Sacramento, CA 94283-0001

March 19, 2018

VIA EMAIL ONLY

Ms. Tania Amarillas
Ms. Rita Lomio
Attorneys
Prison Law Office
tania@prisonlaw.com
rlomio@prisonlaw.com

Re: *Armstrong | August 2017 LAC Staff Misconduct Report*

Dear Ms. Amarillas and Ms. Lomio:

This letter is in response to the allegations raised in your August 2017, *Armstrong* Monitoring Tour report concerning California State Prison- Los Angeles County (LAC) regarding the allegation from Inmate [redacted] ([redacted]

The California Department of Corrections and Rehabilitation (CDCR) takes every allegation seriously, and as such has conducted an inquiry into the allegation as stated below:

> "The medical record of Person 41 ([redacted] [redacted] includes a 7362 dated 5/4/17 (when he was in D1), on which he reported: "I was told by a CO if I'd suck his dick he would give me a cell phone, so now I'm thing [sic] about killing myself." The response states that staff called the "psych hotline and left a messages at 0754. I/p is placed in the shower awaiting psych evaluation. Called psych hotline again at 0845 and left a message….Dr. [redacted] called back at 0859, stated pt will be seen by Dr. [redacted]." According to the record, Dr. [redacted] spoke with Person 41 at 0930 during which time Person 41 said about the officer, "he might have been joking, I don't know."

LAC conducted an inquiry into this allegation(s) by referencing various documents, databases, and records to procure all useful information regarding the allegations. LAC interviewed Inmate [redacted] regarding the presented allegation. Inmate [redacted] denied authoring or submitting the Health Care Services Request Form (CDCR 7362), and further denies communicating the above-referenced allegation to the Prison Law Office (PLO). Inmate [redacted] communicated that he only made comments regarding ADA showers to the PLO.

LAC also interviewed CDCR Dr. [redacted] regarding her interactions with Inmate [redacted] regarding the allegation(s) presented in the CDCR 7362. Dr. [redacted] indicated that on May 4, 2017, Inmate [redacted] confirmed the allegation(s) that were presented in the CDCR 7362, but

also requested Dr. [redacted] assistance in securing a housing change. LAC determined that on May 5, 2017, Inmate [redacted] was moved from LAC D1 to LAC D3.

Based upon the review of the documentation, and the information derived from the interviews conducted, LAC determined that the allegations of staff misconduct were unfounded. As such, the inquiry into this matter has been closed.

Should you have any questions, please contact the undersigned at [redacted].

Sincerely,

/s/ Alan L. Sobel

ALAN L. SOBEL
Attorney IV
Legal Liaison, High Security Mission
Office of Legal Affairs

cc: D. Asuncion, Warden

OFFICE OF LEGAL AFFAIRS
Patrick R. McKinney II
General Counsel
P.O. Box 942883
Sacramento, CA 94283-0001

March 19, 2018

VIA EMAIL ONLY

Ms. Tania Amarillas
Ms. Rita Lomio
Attorneys
Prison Law Office
tania@prisonlaw.com
rlomio@prisonlaw.com

Re: *Armstrong | August 2017 LAC Staff Misconduct Report*

Dear Ms. Amarillas and Ms. Lomio:

This letter is in response to the allegations raised in your August 2017, *Armstrong* Monitoring Tour report concerning California State Prison Los Angeles County (LAC) regarding the allegation from Inmate [redacted]

The California Department of Corrections and Rehabilitation (CDCR) takes every allegation seriously, and as such has conducted an inquiry into the allegation as stated below:

> "Person 46 ([redacted] reported through another 1824 that on 6/14/17, an unnamed lieutenant attempted to pressure him into withdrawing a staff complaint on 5/30/17 and said to Person 46, "I'll beat you f-ckin' ass, you f-cking baby raper! Bitch! Get out!" and started walking toward Person 46. Another officer reportedly appeared, stepped in between the two men, and led Person 46 out. Person 46 attached a signed declaration from Person 47 ([redacted] who states that Person 48 (Lt. [redacted] attempted to dissuade him from filing a staff complaint on 6/1/17 by making him wait an hour in the 100-degree weather and then being "very, extremely aggressive." The response, issued on 6/21/17, states that the allegation would be reviewed as a staff complaint."

LAC conducted an inquiry into this allegation(s) by referencing various documents, databases, and records to procure all useful information regarding the allegations. Based upon the review, LAC determined that Inmate [redacted] had presented the allegations through the filing of a Reasonable Accommodation Request (CDCR 1824) on June 7, 2017. LAC interviewed Inmate [redacted] as to the allegation presented. Based upon the interview, LAC determined that there were inconsistencies as Inmate [redacted] alleges the staff misconduct occurred during the Rules Violation Report (RVR) hearing occurring on May 30, 2017. A review of Inmate [redacted] disciplinary file reflected that Inmate [redacted] did not have an RVR hearing on that date.

LAC was unsuccessful in the attempt to interview former Inmate [redacted] who has been discharged from CDCR custody. LAC also conducted interviews of the involved correctional staff as to the allegations. In addition, LAC also reviewed SOMS, ERMS, and Inmate Appeals Tracking System as to Inmate [redacted] and determined that Inmate [redacted] had filed over 150 appeals within the past two years.

Based upon the review of the documentation, and the information derived from the interviews conducted, LAC determined that the allegations of staff misconduct were unfounded. As such, the inquiry into this matter has been closed.

Should you have any questions, please contact the undersigned at [redacted].

Sincerely,

/s/ Alan L. Sobel

ALAN L. SOBEL
Attorney IV
Legal Liaison, High Security Mission
Office of Legal Affairs

cc: D. Asuncion, Warden

OFFICE OF LEGAL AFFAIRS
Patrick R. McKinney II
General Counsel
P.O. Box 942883
Sacramento, CA 94283-0001

March 19, 2018

VIA EMAIL ONLY

Ms. Tania Amarillas
Ms. Rita Lomio
Attorneys
Prison Law Office
tania@prisonlaw.com
rlomio@prisonlaw.com

Re: *Armstrong | August 2017 LAC Staff Misconduct Report*

This letter is in response to the allegations raised in your August 2017, *Armstrong* Monitoring Tour report concerning California State Prison- Los Angeles County (LAC) regarding Inmate [redacted] ([redacted] allegation of staff misconduct.

The California Department of Corrections and Rehabilitation (CDCR) takes every allegation seriously, and as such has conducted an inquiry into the allegation as stated below:

> "Person 37 ([redacted] reported that two to three nights before the Armstrong tour, Person 38 (Black man in his 20s, who was housed in cell [redacted] at the time, but in cell [redacted] during the week of August 28, 2017) had a plastic bag over his head. The floor officer, who was conducting count, shouted to control, "This guy has a plastic bag on his head." The control officer responded, "Deal with that shit later. Continue your count." Person 38 later was placed on suicide watch. Person 38 later reported to Person 37 that he tried to hang himself while on suicide watch, and the officer just watched him but did not try to stop him.

LAC conducted an inquiry into this allegation by referencing various documents, databases, and records to procure all useful information regarding the allegations. LAC interviewed Inmate [redacted] to seek clarification, and regarding the substance of the presented allegation. Through such interview, LAC determined that Inmate [redacted] did not have any first-hand knowledge of the incident, but was relaying on what he had been told had occurred. Inmate [redacted] admitted that as he was incarcerated in LAC D4[redacted], and the inmate in question was housed in LAC D4-[redacted] it was physically impossible for him to witness the alleged incident.

With that being said, based upon the documentary review, LAC determined the identity of the inmate who had been placed on suicide watch, and that the event was addressed in Incident Log No. LAC-D[redacted]. LAC also interviewed the involved inmate as to the allegations presented. Further, LAC also interviewed inmate(s) who were celled next to the subject involved to seek information as to correctional staff's response to the allegation presented.

Based upon the review of the materials secured by LAC, combined with the inconsistent information derived from the interviews of five inmate(s), LAC was unable to substantiate the above allegation(s) of staff misconduct. As such, LAC's inquiry into this matter has been closed.

Should you have any questions, please contact the undersigned at [redacted].

Sincerely,

/s/ Alan L. Sobel

ALAN L. SOBEL
Attorney IV
Legal Liaison, High Security Mission
Office of Legal Affairs

cc: D. Asuncion, Warden

OFFICE OF LEGAL AFFAIRS
Patrick R. McKinney II
General Counsel
P.O. Box 942883
Sacramento, CA 94283-0001

March 19, 2018

VIA EMAIL ONLY

Ms. Tania Amarillas
Ms. Rita Lomio
Attorneys
Prison Law Office
tania@prisonlaw.com
rlomio@prisonlaw.com

Re: *Armstrong | August 2017 LAC Staff Misconduct Report*

This letter is in response to the allegations raised in your August 2017, *Armstrong* Monitoring Tour report concerning California State Prison- Los Angeles County (LAC) regarding Inmate [redacted] allegation of staff misconduct.

The California Department of Corrections and Rehabilitation (CDCR) takes every allegation seriously, and as such has conducted an inquiry into the allegation as stated below:

> "Person 37 ([redacted] reported that officers taunt or ignore people who say they are suicidal. He reported that Person 39 ([redacted] housed in D4-[redacted] at the time of the Armstrong interview) is taunted by officers and has to say he is suicidal 10- 15 times before they respond."

LAC conducted an inquiry into this allegation by referencing various documents, databases, and records to procure all useful information regarding the allegations. LAC interviewed Inmate [redacted] to seek clarification, and regarding the substance of the presented allegation. Through such interview, Inmate [redacted] admitted that he did not have any first-hand knowledge or observation of the allegation as it pertained to Inmate [redacted] and further admitted that he never observed Correctional Officers taunt or ignore Inmate [redacted] after he expresses suicidal ideation. Based upon the interview with Inmate [redacted] he indicated that he observed LAC correctional staff acting appropriately when an inmate expresses suicidal ideation by calling mental health staff.

Based upon the documentary review of materials secured by LAC, combined with the information derived from the interview of Inmate [redacted] LAC was unable to substantiate the above allegation(s) of staff misconduct. As such, LAC's inquiry into this matter has been closed.

Should you have any questions, please contact the undersigned at [redacted]

Sincerely,

/s/ Alan L. Sobel

ALAN L. SOBEL
Attorney IV
Legal Liaison, High Security Mission
Office of Legal Affairs

cc: D. Asuncion, Warden

OFFICE OF LEGAL AFFAIRS
Patrick R. McKinney II
General Counsel
P.O. Box 942883
Sacramento, CA 94283-0001

April 9, 2018

VIA EMAIL ONLY

Ms. Tania Amarillas
Ms. Rita Lomio
Attorneys
Prison Law Office
tania@prisonlaw.com
rlomio@prisonlaw.com

Re: *Armstrong | August 2017 LAC Staff Misconduct Report*

Dear Ms. Amarillas and Ms. Lomio:

This letter is in response to the allegations raised in your August 2017, *Armstrong* Monitoring Tour report concerning California State Prison- Los Angeles County (LAC) regarding the allegation from Inmate [redacted] (F-[redacted]

The California Department of Corrections and Rehabilitation (CDCR) takes every allegation seriously, and as such has conducted an inquiry into the allegation as stated below:

> "Person 56 ([redacted] [redacted] reported that his legal mail to OIA reporting staff misconduct has not been logged. He reportedly has written to the OIA about staff inciting violence and paying certain people to physically assault other people."

LAC conducted an inquiry into this allegation(s) by referencing various documents, databases, and records to procure all useful information regarding the allegations. LAC also interviewed Inmate [redacted] to gather clarity and further detail(s) regarding the allegation(s) presented. According to [redacted] while house at LAC, he mailed approximately three to four letters to the Office of Internal Affairs (OIA). According to [redacted] OIA has not received his letters, as Inmate [redacted] did not receive a response from OIA. [redacted] stated that he did not file any appeals regarding his allegation while housed at LAC. According to [redacted] there were no issues with the processing of his regular mail while at LAC. Lastly, Inmate [redacted] did not provide any information relevant to his claim that staff was paying inmates to assault other inmates.

In conducting the documentary review into Inmate [redacted] allegation(s), LAC was able to determine through the Strategic Offender Management System (SOMS) and a review of the Inmate Appeals Tracking System (IATS) that Inmate [redacted] had made similar allegations in the past when seeking a transfer from R.J. Donovan. In addition, on September 12, 2017, Inmate [redacted] filed an appeal alleging that LAC failed to forward correspondence to the Prison Law Office (PLO), and was somehow involved in a cover up. The 602 reflects that Inmate [redacted]

withdrew his appeal on September 26, 2017 when he received a letter from the PLO confirming that they receive his legal mail.

In addition, LAC also interviewed a number of LAC correctional staff as to the allegation(s) presented by Inmate [redacted] Specifically, it was determined that any back log, if any existed, as to the processing of legal mail was caused by staffing shortages. LAC also determined that the staffing shortage issue has since been resolved. There was no evidence or information that LAC legal mail on Facility "B" was being intentionally being delayed or held by LAC correctional staff. In addition, as to Inmate [redacted] specific claim as to the correspondence to OIA, LAC also confirmed that OIA had received Inmate [redacted] correspondence.

Based upon the review of documentation, and the information derived from the interviews of Inmate [redacted] and LAC correctional staff, LAC determined that allegations of staff misconduct could not be substantiated. As such, the inquiry into this matter has been closed.

Should you have any questions, please contact the undersigned at [redacted]

Sincerely,

/s/ Alan L. Sobel
ALAN L. SOBEL
Attorney IV
Legal Liaison, High Security Mission
Office of Legal Affairs

cc: D. Asuncion, Warden

OFFICE OF LEGAL AFFAIRS
Patrick R. McKinney II
General Counsel
P.O. Box 942883
Sacramento, CA 94283-0001

April 10, 2018

VIA EMAIL ONLY

Ms. Tania Amarillas
Ms. Rita Lomio
Attorneys
Prison Law Office
tania@prisonlaw.com
rlomio@prisonlaw.com

Re: *Armstrong | August 2017 LAC Staff Misconduct Report*

Dear Ms. Amarillas and Ms. Lomio:

This letter is in response to the allegations raised in your August 2017, *Armstrong* Monitoring Tour report concerning California State Prison- Los Angeles County (LAC) regarding the allegation from an anonymous class member on B Yard..

The California Department of Corrections and Rehabilitation (CDCR) takes every allegation seriously, and as such has conducted an inquiry into the allegation as stated below:

> "Person 57 (Anonymous Class member on B Yard) reported that his legal mail is being held. He reported that he attempted to mail a writ about six months ago. When he turned it in, the officer said, "Why are you trying to go home? They feed you ice cream here." Regular mail has taken two months to reach his family."

This allegation does not have sufficient detail and specificity to permit LAC to determine the identity of the inmate or the involved LAC Correctional staff. Despite the lack of specificity and detail, LAC still attempted to conduct an inquiry into the above-referenced allegation(s) by referencing various documents, databases, and records to procure all useful information regarding the allegation(s). LAC also interviewed, used information from interview(s) of inmate(s) and correctional staff, as to similar allegations to determine that any back log as to legal mail on "B" Yard, if any existed, was caused by staffing shortages. LAC also determined that the staffing shortage issue has since been resolved. In addition, based upon the information available to LAC, there was no evidence or information that legal mail on Facility "B" was being intentionally being delayed or held by LAC correctional staff improperly. As to the allegation of the alleged comment by the Correctional Officer to the unidentified inmate, based upon the lack of specificity or detail, LAC was unable to secure any evidence or information to substantiate that such comment was made. In any event, without more specificity and detailed information, LAC was unable to substantiate allegations of staff misconduct. As such, the inquiry into this matter has been closed.

Should you have any questions, please contact the undersigned at [redacted].

Sincerely,

/s/ Alan L. Sobel

ALAN L. SOBEL
Attorney IV
Legal Liaison, High Security Mission
Office of Legal Affairs

cc: D. Asuncion, Warden

OFFICE OF LEGAL AFFAIRS
Patrick R. McKinney II
General Counsel
P.O. Box 942883
Sacramento, CA 94283-0001

April 10, 2018

VIA EMAIL ONLY

Ms. Tania Amarillas
Ms. Rita Lomio
Attorneys
Prison Law Office
tania@prisonlaw.com
rlomio@prisonlaw.com

Re: *Armstrong | August 2017 LAC Staff Misconduct Report*

Dear Ms. Amarillas and Ms. Lomio:

This letter is in response to the allegations raised in your August 2017, *Armstrong* Monitoring Tour report concerning California State Prison- Los Angeles County (LAC) regarding the allegation from an anonymous class member on B Yard..

The California Department of Corrections and Rehabilitation (CDCR) takes every allegation seriously, and as such has conducted an inquiry into the allegation as stated below:

> "Several class members reported misconduct by medical staff. For example, Person 58 (Anonymous class member) reported that Person 59 is disrespectful and says things like: "If it was up to me, I'd give none of you meds," and "Get the f-ck out of my office.

This allegation does not have sufficient detail and specificity to permit LAC to determine the identity of the inmate involved with the LAC medical staff. Further, based upon the lack of detail and specificity, LAC was unable to determine if there were any witnesses to the alleged comment attributed by Person 59. Despite the lack of specificity and detail, LAC still attempted to conduct an inquiry into the above-referenced allegation(s) by referencing various documents, databases, and records to procure all useful information regarding the allegations directed against LAC medical staff for staff misconduct issue(s). Based upon that review, LAC reviewed a number of staff complaints filed against LAC medical staff over the past two years and was unable to secure any information that substantiated the above allegation directed against Person 59, or any other LAC medical staff.

LAC also interviewed randomly selected inmate(s) on each yard as to their own specific interactions with LAC medical staff, and observations of inmate interactions with LAC medical staff. Based upon such interviews, LAC was unable to substantiate the allegation(s) presented above. As LAC was unable to substantiate allegations of staff misconduct, the inquiry into this matter has been closed.

Should you have any questions, please contact the undersigned at [redacted].

Sincerely,

/s/ Alan L. Sobel

ALAN L. SOBEL
Attorney IV
Legal Liaison, High Security Mission
Office of Legal Affairs

cc: D. Asuncion, Warden

OFFICE OF LEGAL AFFAIRS
Patrick R. McKinney II
General Counsel
P.O. Box 942883
Sacramento, CA 94283-0001

April 12, 2018

VIA EMAIL ONLY

Ms. Tania Amarillas
Ms. Rita Lomio
Attorneys
Prison Law Office
tania@prisonlaw.com
rlomio@prisonlaw.com

Re: *Armstrong | August 2017 LAC Staff Misconduct Report*

Dear Ms. Amarillas and Ms. Lomio:

This letter is in response to the allegations raised in your August 2017, *Armstrong* Monitoring Tour report concerning California State Prison- Los Angeles County (LAC) regarding the allegation that inmate(s) in segregation units are being required to shower with their cellmate..

The California Department of Corrections and Rehabilitation (CDCR) takes every allegation seriously, and as such has conducted an inquiry into the allegation as stated below:

> "In May 2017, Person 45 reported through two separate 1824s that staff had locked him in a single shower with his cellmate. On 7/3/17, we raised this concern in a letter to CDCR. During the tour, ADA staff informed us that Warden Asuncion has said that this practice would "never happen again.
>
> Allegation #20: Unfortunately, we continue to receive reports that this practice currently is in effect in the segregation units"

The allegation presented does not provide detail and specificity to determine the exact location, date and identity of the inmate(s) who have allegedly been required to shower with their cellmate. Despite the lack of specificity, LAC conducted an inquiry into the above-referenced allegation(s) by referencing various documents, databases, and records to procure all useful information regarding the allegations. LAC specifically reviewed LAC's Local Operating Procedure (OP) 505.18 which provides that "Inmates will shower with their cell partner". LAC determined that the shower rooms in the Short Term Restricted Housing (STRH) contain shower rooms with only one shower nozzle or shower head, while the Enhanced Outpatient Program (EOP) Ad-Seg unit currently has four shower rooms that have only one shower nozzle or head, and two shower rooms where two shower nozzles or heads exist.

Based upon discussion(s) with LAC STRH and EOP correctional staff, LAC ISU determined that LAC correctional staff in these units does not require more than one inmate to shower in a room with only one shower nozzle at the same time. With that being said, based upon the allegation presented, LAC determined that OP 505 would be amended to clarify only one inmate per shower head.

Based upon the lack of specificity and detail provided in the allegation, and the information derived from discussions with LAC correctional staff, LAC was not able to substantiate allegation(s) of staff misconduct. As such, the inquiry into the above allegation will be closed at this time.

Should you have any questions, please contact the undersigned at [redacted].

Sincerely,

/s/ Alan L. Sobel

ALAN L. SOBEL
Attorney IV
Legal Liaison, High Security Mission
Office of Legal Affairs

cc: D. Asuncion, Warden

OFFICE OF LEGAL AFFAIRS
Patrick R. McKinney II
General Counsel
P.O. Box 942883
Sacramento, CA 94283-0001

April 16, 2018

VIA EMAIL ONLY

Ms. Tania Amarillas
Ms. Rita Lomio
Attorneys
Prison Law Office
tania@prisonlaw.com
rlomio@prisonlaw.com

Re: *Armstrong | August 2017 LAC Staff Misconduct Report*

Dear Ms. Amarillas and Ms. Lomio:

This letter is in response to the allegations raised in your August 2017, *Armstrong* Monitoring Tour report concerning California State Prison- Los Angeles County (LAC) regarding the allegation from an anonymous inmate class member..

The California Department of Corrections and Rehabilitation (CDCR) takes every allegation seriously, and as such has conducted an inquiry into the allegation as stated below:

> "Person 53 (C3- Anonymous class member) reported that Person 54 (Officer [redacted] and Person 55 (Officer [redacted] constantly harass him. Person 54 and Person 55 tell him that they are going to get him kicked out of their building, saying things like "don't get too comfortable" or "pack your stuff."

This allegation is vague in nature, as it does not provide sufficient detail and specificity to permit LAC to determine the identity of the inmate allegedly being treated inappropriately by LAC correctional staff. Further, based upon the lack of detail and specificity, LAC was unable to determine if there were any witnesses to the alleged comment(s) attributed Correctional Officers (CO) [redacted] and [redacted] Despite the lack of specificity and detail, LAC attempted to conduct an inquiry into the above-referenced allegation(s) by referencing various documents, databases, and records to procure all useful information regarding the similar allegations directed against LAC correctional staff in Housing Unit C3.

As part of the review, LAC also reviewed the inmate appeals filed against CO [redacted] and CO [redacted] Further, as part of the review, LAC also interviewed randomly selected inmate(s) in C3 regarding their interaction with CO [redacted] and CO [redacted] and observations of inmate interactions with LAC correctional staff. Based upon LAC's reviews of inmate appeals filed against COs [redacted] and [redacted] and the information derived from the interview(s) of

inmates housed in C3, LAC was unable to substantiate the allegation(s) presented above. As such, the inquiry into this matter has been closed.

Should you have any questions, please contact the undersigned at [redacted].

Sincerely,

/s/ Alan L. Sobel

ALAN L. SOBEL
Attorney IV
Legal Liaison, High Security Mission
Office of Legal Affairs

cc: D. Asuncion, Warden

Exhibit C

ROSEN BIEN GALVAN & GRUNFELD LLP

50 Fremont Street, 19th Floor
San Francisco, California 94105-2235
T: (415) 433-6830 ▪ F: (415) 433-7104
www.rbgg.com

Thomas Nolan
Email: tnolan@rbgg.com

September 7, 2017

VIA ELECTRONIC MAIL ONLY

PRIVILEGED AND CONFIDENTIAL

SUBJECT TO PROTECTIVE ORDERS

Nick Weber
Attorney
California Department of Corrections and Rehabilitation, Office of Legal Affairs
Nicholas.Weber@cdcr.ca.gov

Re: *Coleman v. Brown*
CSP-Lancaster Issues: Concerns About Non-Designated Yard Status, Staff Misconduct, and the Three Recent Suicides in D-Yard EOP Programs.
Our File No. 0489-3

Dear Nick:

Thank you for helping us schedule *Coleman* interviews with our clients last week at California State Prison – Lancaster ("CSP-Lancaster" or "LAC"). We write about three serious issues that were highlighted during our interviews with class members last week on D-Yard and in the STRH at CSP – Lancaster.

The three issues are (1) the imposition of non-designated yard status on D-Yard at LAC and increases in violence between prisoners, suicide attempts, and possibly homicides on D-Yard since the status was introduced, (2) ongoing reports about custody staff misconduct on D-Yard from class members and clinical staff on D-Yard, and (3) related concerns about the three troubling suicides that have taken place involving D-Yard EOP prisoners at LAC since March 2017.

I. Non Designated Yard Status:

First, based on the interviews at LAC last week, we are very concerned about how the imposition of "non-designated yard status" on the D-Yard EOP is proceeding. We

have heard reports of at least one possible homicide on D-Yard as a result of the change to non-designated yard status (although no homicides are reported through June on the CDCR COMPSTAT website, and the sole non-suicide death report we have received for LAC this year does not sound like a homicide from the death notice). In addition, we heard many reports of violence between prisoners since the yard became non-designated.

Moreover, most of the *Coleman* class members we interviewed last week at LAC were either concerned for their own personal safety on D-Yard, or concerned about their safety in the future on mainline yards given their time on the non-designated yard at LAC.

We request a written response from Defendants setting forth your analysis of how the change in the custody designation of the D-Yard EOP from mainline to "non-designated" status is proceeding. What steps have Defendants taken to study and evaluate the transition at LAC that might be used in future institutions' transitions? Are there concerns unique to the Level IV setting? Is the institution continuing to place formerly SNY prisoners into these programs? Has the Department learned any lessons from the experience of making D-Yard non-designated that would prove helpful in expanding the non-designated status to all EOP programs?

In addition, many of GP interviewees expressed concern that they will be targeted by other mainline prisoners if they ever move to a mainline yard for having programmed on the non-designated yard at LAC. Have Defendants tracked the departure of prisoners from the non-designated yards, and whether departing prisoners have experienced violence or reported safety concerns on their return to GP yards?

We also request that Defendants provide us with detailed information about the number of homicides and assaults on D-Yard at LAC since the change was made in approximately April of 2017. We note that current CDCR COMPSTAT data for LAC dated August 18, 2017 indicates that batteries on prisoners at the institution have nearly doubled in the last year – increasing from an average of 5.3 per month in the last six months of 2016 to an average of 9.6 per month in the first six months of 2017. The LAC COMPSTAT data also records a sharp increase in the number of attempted suicides at LAC in the same period – doubling from an average of 1.0 per month in the last six months of 2016 to an average of 2.0 per month in the first six months of 2017. These statistics are very concerning. How has the Department analyzed and responded to these increases, and how does the Department plan to monitor these possible effects of the non-designated transition going forward?

We also note that serious ongoing concerns remain about the plan to make all EOPs non-designated. Most of the mainline status prisoners we spoke with at LAC on D-Yard were under the false impression that SNY prisoners are no longer being placed on D-Yard. How is the Department communicating about implementation of the non-designated yards to prisoners? What will happen with the EOP programs that are currently on SNY yards, such as C-Yard at LAC?

We are concerned that in trying to keep EOP programs from serving a protective custody function, Defendants' non-designated yard plan for EOPs will create a dis-incentive for truly mentally ill people to seek treatment they need, and will also create a strong incentive for individuals who could otherwise transfer to a lower level of mental health care to stay in EOP programs permanently for safety reasons. We look forward to discussing these issues further.

II. Staff Misconduct at LAC:

Second, our visit to LAC confirmed that there are ongoing problems with staff misconduct in the EOP units on D-Yard and that Defendants need to take additional steps to combat these problems. The issue of staff misconduct and generally punitive conditions for EOP patients in D-Yard EOP program at CSP-Lancaster is not new. The same issue was raised last year during the CQIT tour at LAC in October of 2016 in the course of patient and staff interviews on D-Yard and in the STRH. During the exit following the CQIT, the regional team reported on a variety of serious staff misconduct concerns, including complaints from front line clinical staff about serious staff misconduct in the D-1 EOP and the D-5 EOP ASU.

One particularly egregious example of staff misconduct that was highlighted by clinical staff in interviews in the CQIT process was an incident where a prisoner in the D-5 EOP ASU was kept housed for 14 days in a cell without a working toilet, such that human waste was pouring out from under the cell door in a steady flow. The CQIT monitors reportedly confirmed this incident had taken place. Has there been an investigation into this incident, including into the failure of clinical and supervisory staff to note and report the problem while it was occurring? What was the result? Were any staff disciplined? What is the name of the prisoner who was held in this manner?

During the October 2016 CQIT tour, clinical staff also reported that most of the time patients were not getting their radios in the EOP ASU or the STRH within 14 days and that other property issues were causing unnecessary and harmful stress for segregated patients on their caseloads. The CQIT review team also noted that they heard many reports of staff abuse in the D-5 EOP ASU from both patients and clinical staff there,

including reports of withholding property, failing to refer suicidal prisoners, verbal abuse and physical staff abuse. When one clinical staff member approached custody staff responsible for property about radios for her patients newly arrived to the EOP ASU, she reportedly was told to stop treating the prisoners "like babies." There were also reports of custody staff failing to refer suicidal patients in both the mainline EOP units on D-Yard and in the STRH to clinical staff and failing to remove them from their cells when they reported being suicidal. The CQIT exit also reported that clinical staff in D-1 and other mainline EOP units stated that custody staff behaved abusively towards prisoners and withheld property and forms from them.

These staff misconduct reports from the October 2016 CQIT visit to LAC were mostly detailed and confirmed (albeit in a somewhat understated fashion and more narrowly than warranted given the ample reports on the tour and clinical staff confirmation of many of the problems) in the recent draft CQIT report for that tour provided by Defendants.[1]

The next time that the staff misconduct issue at LAC was clearly raised was five months later, following the Prison Law Office's visit to CSP-Lancaster in *Armstrong* in February of 2017. Following that tour, the Prison Law Office staff members involved in the tour issued a special report on staff misconduct at LAC. They reported finding serious problems on D-Yard, particularly in the D-5 EOP ASU, as well as in the mainline EOP units on D-Yard, including: (1) excessive use of force, (2) failures to respond to medical emergencies and suicidal ideation reports, (3) harassment and verbal abuse, and (4) denial of access to forms and grievances. *See* **Exhibit B** hereto (Prison Law Office's *Armstrong* report on Staff Misconduct at LAC based on February 2017 visit, mostly concerning D-Yard class members and staff).

In our interviews last week on D-Yard, class members continued to consistently report problems with staff misconduct in each of these different areas. Two differences were that although there continued to be reports of excessive use of force on D-Yard, there were perhaps somewhat fewer reports of this than during the CQIT tour. Second, in part because of the perception that no significant corrective action had been taken in response to the Prison Law Office's February report or in response to prisoners appeals

[1] *See* **Exhibit A** hereto (Draft LAC CQIT Report) at 2 ("Staff and patients both report patterns of unprofessional treatment by custody staff in both the ASU EOP and ML CCCMS programs."), 5 (in staff survey of CCCMS/EOP staff report that "a patient in the ML EOP was retained in a cell for up to 14 days without a working toilet."), 5 ("Patients in the ASU EOP program report that staff assault them and then write 115s for assaulting staff or speak to them in belittling and demeaning ways.").

and other direct complaints about staff misconduct, fewer class members were willing to let us use their names to report misconduct.

As discussed in more detail below, many EOP class members we interviewed expressed concern about the three suicides of EOP (or recently downgraded from EOP) patients from D-Yard in recent months. There was widespread concern among EOP patients about how LAC staff responded to and treated these three individuals when they reported being suicidal in the days and hours before taking their lives. The result of this cluster of EOP suicides in a few short months is a pervasive sense among EOP patients at CSP-Lancaster that they will not be kept safe if they become suicidal and tell staff about it. We heard reports of continuing custody staff misconduct around the reporting of suicidal ideation, including: multiple reports of officers ignoring prisoners who said or even shouted to the tier that they were feeling suicidal, including reports from D-1, D-2, D-4, D-5 EOP, and the STRH.

The few class members willing to be named reported other serious instances of staff misconduct including:

- Multiple prisoners reported seeing Correctional Officer [redacted] hit inmate [redacted] ([redacted] a D-2 EOP patient, in the stomach with his baton as Mr. was being escorted across the yard in handcuffs several weeks ago (sometime in or around the second week in August). **Please provide Plaintiffs with copies of all incident reports and any RVR paperwork for the incident which resulted in Mr. [redacted] being led across the yard. Please also preserve and produce to Plaintiffs any yard camera video of the incident.**

- Two prisoners we interviewed reported being assaulted by an inmate named [redacted] ([redacted] They reported that he had attacked 5 or 6 other, mostly older prisoners on D-Yard, and they theorized that he was being used by custody to punish people on the yard.

- We asked to interview [redacted] [redacted] ([redacted]) during the visit to LAC. In the set-up letter, I pointed out that DECS indicates that Mr. [redacted] has a lower bunk chrono but he was listed as housed on an upper bunk. As is the case in many instances, DECS was apparently wrong about this chrono, which has since expired and which Mr. [redacted] says he does not need. When Mr. [redacted] tried to explain this to D-5 EOP staff, he was told to move and given an RVR for refusing to do so. This action alone suggests a serious problem with the punitive custody staff attitude on the unit.

- [redacted] a class member currently housed in the STRH, reported various acts of retaliation against him because he assisted others in filing appeals about misconduct when he was in the D-Yard EOP program earlier this year in Building D-2. He asserts that on May 25, 2017, a weapon was planted in his cell by correctional officers in retaliation for this activity. He points out and the RVR paperwork confirms that the weapon was found in a suspiciously prominent place in his cell – out in the open on an empty bunk on the part of the bed closest to the door. He also reports seeing an officer using inappropriate force in late April 2017 against a fellow EOP prisoner. Mr. [redacted] also reports that he was discharged from EOP a few weeks after filing paperwork about this incident. He also asserts that excessive force was used against him in his cell in the STRH on August 4, 2017, but that no video was made of his injuries from the use of force incident until August 25, 2017. He also reported that radios are not given to all new arrivals in the STRH.

Prisoners also reported serious custodial issues and violations of important *Coleman* policies.

- There were numerous complaints about heat issues and its impact on programming. Because prisoners on D-Yard are given dayroom or yard on rotating days, when the yard is closed due to heat (most days), prisoners cannot be given extra dayroom instead. LAC should investigate whether it could use the gym for air conditioned recreational activities during heat alerts.

- Multiple prisoners in the EOP ASU reported that they have not been able to obtain property to which they are entitled under suicide prevention or NDS policies and procedures. Multiple prisoners in both the EOP ASU and the STRH reported that they were not given radios when they first arrived in the ASU unit.

Clearly, whatever steps LAC has been taking to reduce incidents of staff misconduct have not been successful. We request a more detailed plan by defendants to address ongoing staff misconduct on D-Yard at LAC.

III. Related Concerns About Recent Suicides of D-Yard EOP Inmates at LAC

Since March 26, 2017, there have been three suicides of D-Yard EOP prisoners at CSP-Lancaster, along with one suspicious death where the cause of death is not yet known. The deaths of these four individuals has caused serious anguish for other mentally ill prisoners in their housing units, and the collective impact of these four deaths has been to make many EOP prisoners on D-Yard at Lancaster believe that they will be unsafe if they are suicidal and need to seek help.

This is particularly concerning given the consistent reports discussed above in the October 2016 CQIT tour, the Prison Law Office's February 2017 *Armstrong* tour, and the interviews Plaintiffs conducted last week at LAC that many members of the D-Yard custody staff will not act or seek help when prisoners report that they are suicidal.

From class member interviews, and record reviews, a persistent and troubling theme in each of these deaths is the use of showers and regular cells to hold suicidal prisoners while they are waiting to be evaluated and possibly after they are evaluated. LAC must come up with a better way of handling individuals who need to be safely housed while waiting for a psychiatric evaluation. The other theme in class members' interviews and letters about these deaths is delay or inaction in the face of all three individuals' calling out that they were suicidal and asking for help. Finally, in all three cases there was a failure to move the patient to an MHCB bed in response to strongly asserted suicidal ideation.

On March 26, 2017, EOP patient [redacted], was found hanging in his cell in the D-1 EOP housing unit on D-Yard. Mr. [redacted] had a release date of July 31, 2017. After his death we received more than 10 letters from distraught class members in his housing unit. The theme of many of these letters was that Mr. [redacted] reports of being suicidal were not adequately addressed. In the days before his death, while acutely suicidal, he was housed for a period of time in a shower in the D-1 housing unit where prisoners reported that he used a portion of the drain to seriously cut himself. Class members on his unit at the time felt staff were indifferent to his mental health needs when they returned him to his cell rather than taking him to an MHCB after this incident. As described in more detail in Krista Stone-Manista's June 15, 2017 email regarding the many distressed reports we have received from class members about this death, the series of events preceding Mr. [redacted] suicide has seriously traumatized patients in this unit. This trauma, and the sense among D-Yard EOP prisoners that they are not safe if they become suicidal is a clinical issue EOP mental health staff need to address.

On May 18, 2017, [redacted] was found dead in his cell in the stand-alone STRH ASU unit at CSP-Lancaster. He had been transferred to the STRH shortly before his death, after smearing feces on the officer's station in D-2 EOP in an effort to remain in the EOP after his level of care was lowered to CCCMS. We are concerned by a progress note from his treatment team on the day of his death reporting that they had threatened to also remove him from CCCMS level of care if he continued to smear feces and act out in the STRH program. We are also concerned by the indication in the initial suicide paperwork in his medical records that he was in a holding cell when he hung himself. We were told by other prisoners in the STRH at the time of his death that Mr. [redacted] was in a cell without any of his property, and that he had reported being suicidal and that staff had contacted psychiatric staff. Was Mr. [redacted] supposed to be on suicide watch at the time of his death? Where exactly was he housed, and why?

On August 4, 2017, [redacted] was found dead in his cell in the D-5 EOP ASU shortly after second watch officers started work. We were told by many different prisoners in the D-5 EOP that when [redacted] was brought to the EOP ASU the evening before he took his own life, he was initially held in a holding cell, after reporting being suicidal. Prisoners indicated that mental health staff never came to see him, but that he was placed into a regular cell. Many prisoners told us that once back in his cell, [redacted] reportedly cried out repeatedly well into the overnight hours stating that he was suicidal and needed help, and no one responded to him. He was found dead the next morning. (We are willing to ask these prisoners if they are willing to talk to the suicide reviewer if Defendants believe that would help with the review of his death.)

Finally, on June 10, 2017 in the D-4 EOP unit at CSP-Lancaster, EOP patient [redacted] was found dead in his cell. The death report we received indicated his death was from unknown causes and it also indicated we would be notified once the cause of death was known. Within days of Mr. [redacted] death, we received a letter from another patient in the D-4 unit indicating that Mr. [redacted] hung himself on the door of his cell and that custody staff cut off the noose and hid it after they discovered his body. Has a final cause of death been established for Mr. [redacted] What is the status of the investigation into the circumstances of his death?

//

//

//

We remain very concerned about these issues and we look forward to discussing what can be done to improve care, restore therapeutic relationships in the wake of the multiple suicides, and reduce staff misconduct on D-Yard at LAC.

Sincerely,

ROSEN BIEN
GALVAN & GRUNFELD LLP

/s/ Thomas Nolan

Thomas Nolan
By: Of Counsel

TN:dvc
Encl. Exhibits A and B
cc: *Coleman* Special Master Team
Amy Eargle
Angela Ponciano
Elise Thorne
Christine Ciccotti
Tyler Heath
Coleman co-counsel
Russa Boyd
Katherine Tebrock
Laura Ceballos
Kelly Mitchell
Jeff Macomber

Exhibit D

OFFICE OF LEGAL AFFAIRS
Patrick R. McKinney II
General Counsel
P.O. Box 942883
Sacramento, CA 94283-0001

October 6, 2017

Tom Nolan
Rosen Bien Galvan and Grunfeld, LLP
50 Fremont Street, 19th Floor
San Francisco, CA 94105

Dear Tom,

I write in response to your September 7, 2017, letter regarding concerns at California State Prison, Los Angeles County's (LAC) Facility-D.

1. Non-Designated Yard Status

Defendants' conversion of Facility-D at LAC was closely monitored by headquarters leadership to ensure a smooth transition as well as to prepare for the conversion of other yards to non-designated status. Defendants had previously converted yards to either non-designated (as at R.J. Donovan Correctional Facility) or programing (as at California Health Care Facility) and believe that the conversion can be safely implemented at all other Enhanced Outpatient Program (EOP) yards.

a. The Transition to Non-Designated Status Has Been Successfully Implemented and Monitored on Facility-D

The transition of LAC's Facility D to Non-Designated status has generally been positive. Staff has analyzed effective messaging of the conversion to the inmate population, tracked inmates who have asked to leave the program (see Section I(b), *supra*), observed custody and mental health staff while on site, and have gathered feedback from the inmate population.

Since before the conversion started, Defendants have been in communication with the inmate population on Facility-D to discuss how a non-designated yard works. Prior to conversion, the facility captain spoke to line staff as well as the Inmate Advisory Council Executive Body about the plan to convert. The Warden toured each housing unit impacted by the change to speak to the inmate population. Defendants are also reaching out to the inmate population via institutional town-halls to increase communication and received more direct feedback.

As with any implementation of a new program, Defendants continually monitor and evaluate the impact of the changes on inmates and staff with the goal of ensuring access to programing and institutional safety and security. Leadership from the Statewide Mental Health Program and the Division of Adult Institutions have conducted interviews with inmates, custody and mental

health staff at LAC and no fundamental issues have been discovered suggesting the program is not successful. Many inmates have expressed that they are satisfied with the programming opportunities available on Facility D. Others have spoken positively of the non-designated status and have suggested it should be expanded elsewhere as it reduces the focus on inmate politics and affords greater attention to mental health needs. As part of its review, Defendants have not found that EOP inmates on Facility-D are more likely to oppose a level of care change than other inmates in EOP.

Defendants have not found that custody level is a barrier to conversion of yards to non-designated status. While Level IV populations may have a heightened concern violence risk and gang behavior, custody level is not a deterrent to converting yards to non-designated. In inpatient settings, Level IV inmates successfully program together in a non-designated treatment environment already. Therefore, Defendants do not believe custody level should negatively impact the conversion of yards to non-designated.

b. Departures of Inmates from Non-Designated Yards to General Population Yards

Defendants have tracked departures from Facility-D but are unaware of any adverse outcomes for inmates who have left Facility-D.

Between April 26, 2017, and September 18, 2017, there have been 273 new inmates placed on Facility-D. Of those, 202 were prior Sensitive Needs Yard (SNY) inmates. Eighty-six of those inmates are still housed in the non-segregated section of Facility-D.[1] The remaining 116 were either placed directly into an Administrative Segregation Unit EOP Hub and never programmed on Facility-D, were layovers to another institution, or were on orientation status prior to placement into Facility-C's SNY.[2]

Also between April 26 and September 18, 2017, seventy-one new general population inmates were placed on Facility-D. Thirty-four remain on Facility-D. The other thirty-seven were either placed directly into the ASU-EOP Hub, were layovers, or were courtesy parole inmates. One of the thirty-seven was removed from D-Facility for intimidating prior-SNY inmates. He is currently housed in a Mental Health Crisis Bed.

c. Homicides and Batteries

There have been no homicides on Facility-D since its conversion to non-designated status.

Data on batteries will be provided separately.

[1] LAC's Facility-D has an ASU EOP Hub.
[2] Facility C is an EOP SNY at LAC. Upon statewide conversion, scheduled for late 2017, it too will become non-designated.

d. Attempted Suicides

Plaintiffs' letter notes that "COMPSTAT data" identified a "sharp" increase in suicide attempts between the last six months of 2016 and the first six months of 2017 in that the average changed from one suicide attempt per month to two per month.

First, it should be noted that LAC's Facility-D did not convert to non-designated until late April 2017 so a correlation between non-designated status and suicide attempts cannot be reasonably made.

Second, between June 2016 and April 2017, LAC's Facility-D doubled its capacity of EOP inmates. Building D-3 began activating 150 new EOP beds in June 2016. And on April 26, 2017, Facility-D added an additional 150 beds, bringing the facility's EOP capacity to 600. So while data may show that suicide attempts increased on Facility-D, that data should be read in the context of a sharp population increase on the same facility.

Third, COMPSTAT data on suicide attempts does not always denote whether a self-harm act was made with intent to die. Incidents may later be determined to be self-harm incidents without intent to die by mental health staff. Mental health data shows that there were thirteen incidents with intent to die in the first six months of 2017, three by the same inmate.

2. Staff Misconduct Allegations at LAC

On September 22, 2017, the headquarters Mental Health Compliance Team met with LAC executive staff as part of its monitoring to discuss allegations related to staff misconduct and appropriate corrective action. Discussed below are responses to allegations outlined in Plaintiffs' September 7, 2017, letter.

a. Allegation of an Inmate in D-5 Without a Working Toilet for Fourteen Days.

There is no record of an inoperable toilet in D-5 for an extended period of time in October 2016. The Continuous Quality Improvement report for LAC, at page 5, mentions staff reporting a broken toilet in mainline EOP. There was a work order placed for a toilet in D-1, a mainline unit, in early October 2016. The toilet was repaired the same day the work order was issued; however, the plumber did not close the work order for sixteen days leading to the appearance that the work was not done.

b. Allegation that Clinical Staff Stated that ASU EOP Inmates Were not Receiving Property or Radios for up to Fourteen Days.

LAC has worked to remedy the delay in issuing radios to inmates in their lock up units. LAC has ordered sixty new radios and will also be transitioning from radios to tablets in the ASU EOP Hub and Short Term Restricted Housing unit. With respect to property, LAC's property officers have been directed to release property to inmates as soon as they are cleared with classification

committee. Regional lieutenants will continue to monitor LAC in order to ensure compliance with property and appliance policies.

c. Allegations of Staff Misconduct Regarding Withholding Property

A review of LAC's property logs did reveal some instances of delayed property issuance. Regional lieutenants will continue to monitor compliance with the property issuance policy.

d. Allegations that Staff Fail to Refer Inmates to Mental Health for Suicidal Ideation

Defendants deny that staff at LAC ignores inmates who state they are suicidal. In the first nine months of 2017, LAC referred 794 inmates to a mental health crisis bed, 598 (or 75%) of whom were in the EOP. (See attached as Exhibit A.) Of those 794 inmates, 772 (or 97%) of them were referred for either being dangers to themselves or voicing suicidal ideation. According to crisis bed data provided to Plaintiffs on August 2, 2017, LAC was the third highest referrer of inmates to crisis beds for the first six months of 2017, behind just Corcoran and Mule Creek State Prisons. (See attached as Exhibit B.) As borne out by the data, staff at LAC follow, and continue to follow, policies requiring referrals to mental health when inmates voice suicidal ideation.

e. Allegation Regarding Inmate [redacted] ([redacted])

On July 27, 2017, inmate [redacted] exited his cell during group release on Facility-D, building two, and began yelling at Officer [redacted] Officer [redacted] gave inmate [redacted] a lawful order to return to his cell which inmate [redacted] refused. The building alarm sounded and all inmates got to the ground, with the exception of inmate [redacted] Inmate [redacted] continued to advance toward Officer [redacted] An officer in the control booth fired a direct impact sponge round from a 40mm launcher. The round missed [redacted] and all other inmates and staff but had the desired effect of causing inmate [redacted] to comply and get to the ground. Inmate [redacted] was searched, handcuffed, and removed from the housing unit. A copy of the incident report and Rules Violation Report is attached as Exhibit C.

f. Allegation Regarding Inmate [redacted] ([redacted])

Defendants deny that LAC staff used another inmate to attack other inmates on the yard as punishment.

Inmate [redacted] (identified as [redacted] in Plaintiffs' September 7, 2017, letter) was housed on Facility-D from March 2 to March 19, 2017, and from March 21, to June 23, 2017. He was known to staff as having behavioral problems often influenced by his mental illness. He is currently in the intermediate inpatient level of care.

While housed on the facility, inmate [redacted] received six Rules Violation Reports for fighting dated March 6, March 11, March 14, March 19, April 29, and June 2, 2017. Based on the Mental

Health Assessments for these Rules Violation Reports, which determined that inmate [redacted] behavior was influenced by his mental illness, the facility captain elected to reduce these offenses to counseling chronos in accordance with Title 15 section 3317.1. Inmate [redacted] also received a Rules Violation Report for fighting on April 22, 2017 and another Rules Violation Report for fighting on May 21, 2017.

g. Allegation Regarding Inmate [redacted] ([redacted]

Inmate [redacted] did receive a Rules Violation Report for disobeying a direct order to use the bed he was assigned. It is irrelevant that he may no longer need a lower bunk. He refused to use the bunk he was assigned. Nonetheless, his Rules Violation Report was reduced to a counseling chrono.

h. Allegation Regarding Inmate [redacted] ([redacted]

Inmate [redacted] allegations that staff planted a weapon in his cell are untrue. A weapon was found in his sweatshirt on May 25, 2017.

Likewise, mental health staff did not conspire to discharge inmate [redacted] from the EOP on May 11, 2017, as a result of allegations he made against custody staff. He was placed back in the EOP level of care on September 20, 2017.

Inmate [redacted] was involved in a use of force incident on August 4, 2017, wherein staff made an emergency medical entrance into his cell as he appeared unresponsive toward staff. When staff entered the cell, inmate [redacted] charged staff and battered two correctional officers. Inmate [redacted] did submit a 602 alleging excessive an unnecessary use of force. A videotaped interview was conducted on August 17, 2017. A second videotaped interview was conducted on August 25, 2017. As of September 28, 2017, the Institutional Executive Review Committee has not reviewed the case. Mr. [redacted] is currently in the ASU EOP Hub on Facility-D.

i. Heat Plan Related Allegations

LAC's heat plan compliance is being monitored by regional lieutenants and compliance with the heat plan has been addressed with executive staff and through subsequent retraining.

All housing units at LAC have been audited to ensure compliance with the institutional heat plan during past monitoring by regional compliance teams. Monitoring teams found that all housing units had a working thermometer and that heat logs were current as custody staff were documenting the highest recorded temperature. Housing unit staff that was interviewed had knowledge of the institutional heat plan. Mainline staff informed us that when temperatures reach ninety degrees outside, and stage one is activated, inmates prescribed heat-risk medication are returned to their housing units (unless in an air conditioned area) and allowed access to dayroom activities as an alternative to yard. Monitoring teams found, however, that the alternative programs offered to inmates were not properly documented in the Daily Activity

Report. This issue has been brought to the attention of LAC leadership and will continue to be monitored by regional lieutenants to ensure appropriate reasonable accommodations are made for inmates affected by heat alerts.

j. Property for Inmates on Non-Disciplinary Segregation (NDS)

Aside from a shortage of available loaner radios, headquarters monitoring teams that visited LAC in January and April 2017 did not find an issue with property distribution to inmates on NDS status. NDS binders were reviewed at both site visits and monitoring teams found that NDS inmates were issued their allowable property at both the ASU EOP Hub and the Short Term Restricted Housing Unit.

3. Concerns Related to Recent Suicides at LAC

Defendants have extensively reviewed the suicide deaths of inmates [redacted] ([redacted] [redacted] ([redacted] and [redacted] ([redacted] The final suicide reports for these inmates were issued on July 10, August 3, and October 6, 2017, respectively. Those reports are attached as Exhibits D through F. The Quality Improvement Plan (QIP) report for inmate [redacted] is also attached as Exhibit G. The QIP report for inmate [redacted] is not yet final and the QIP report for inmate [redacted] is not yet due. Defendants' suicide reports for inmates [redacted] [redacted] and [redacted] represent the complete findings and conclusions for each of those cases. The QIPs have resulted in corrective actions in each case including referrals to the Office of Internal Affairs.

With respect to the death of inmate [redacted] ([redacted] there is no indication that his death was a suicide, nor is there any indication a noose was found within his cell. Inmate [redacted] was found during a welfare unresponsive, lying face up on his cell bunk. An alarm was sounded and several officers and staff immediately responded to inmate [redacted] cell. Despite attempts at lifesaving measures, inmate [redacted] was declared deceased on June 10, 2017. Inmate [redacted] had a history of hyperlipidemia, morbid obesity (Body Mass Index of 53), and glucose intolerance. A final cause of death cannot be determined. An autopsy is pending. The institution's Inmate Death Report (For 7229-A) and Institution Death Review Summary are attached as Exhibit H.

Sincerely,

/Nick Weber/

Nick Weber
Attorney
Office of Legal Affairs

Exhibit E

ROSEN BIEN GALVAN & GRUNFELD LLP

50 Fremont Street, 19th Floor
San Francisco, California 94105-2235
T: (415) 433-6830 ▪ F: (415) 433-7104
www.rbgg.com

Thomas Nolan
Email: tnolan@rbgg.com

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Nick Weber
Andrea Moon
Melissa Bentz
Jerome Hessick
CDCR Office of Legal Affairs
Nicholas.Weber@cdcr.ca.gov
Andrea.Moon@cdcr.ca.gov
Melissa.Bentz@cdcr.ca.gov
Jerome.Hessick@cdcr.ca.gov

Re: *Coleman v. Brown*
CSP-Lancaster: Plaintiffs' Concerns About Recent Suicides, Excessive Use of Force, Lack of Structured Group Treatment, and Other Issues
Our File No. 0489-03

Dear Nick, Andrea, Melissa and Jerome:

Thank you for helping us schedule *Coleman* interviews with our clients on April 19, 2018 at California State Prison-Los Angeles County ("LAC"). We write to report on a number of critical issues raised by our clients during these interviews, along with related reports in correspondence from our clients at the prison.

We wanted to visit LAC to follow up on our investigation of staff misconduct against *Coleman* class members and other problems that we identified in our visit to CSP-LAC last August. *See* Letter from Tom Nolan to Nick Weber Re CSP-Lancaster Issues (Sept. 7, 2017), attached hereto as **Exhibit A**. Although in some respects the reports of staff misconduct we received during our visit seemed to be slightly less pervasive as compared to last year, we once again received a large number of very concerning reports about staff misconduct and other problems affecting *Coleman* class members at LAC, particularly for class members on D-Yard.

Of particular concern were the multiple reports we received of problems in the following areas: (1) excessive use of force, (2) continued yard lockdowns and limited yard time even when not on lockdown, (3) a lack of substantive mental health treatment, and (4) the many recent suicides that have taken place at LAC, which are deeply concerning to us and to our clients housed there. We describe the findings we gleaned on each of these issues below in detail.

Where class members authorized use of their names, we have included them below. **However, we ask that this report not be directly shared with lower level staff members at LAC to minimize chances of retaliation taking place against those reporting misconduct**.

1. Excessive Force at LAC

a. Use of Force and Other Staff Misconduct on D-Yard

Our visit to LAC revealed that the well-documented staff misconduct problems in the EOP units—particularly in the D5 ASU Hub—continue at LAC. These problems were previously detailed in Defendants' own October 2016 CQIT Report on LAC, during the exit call from the CQIT, and in my September 7, 2017 letter regarding conditions at LAC. *See* **Exhibit A** (copy of my Sept. 7, 2017 letter).

During our interviews on April 19, 2018, multiple class members reported recent incidents where custody staff used excessive force on them. The staff misconduct discussed below is concerning not only because it constitutes abuse of some of CDCR's most vulnerable prisoners by those charged with protecting them, but also because it negatively impacts the mental health of these prisoners. As described below, many of the class members who were subjected to excessive force by custody officers decompensated mentally, engaging in serious acts of self-harm and requiring the stabilizing presence of inpatient care. Moreover, many of these incidents occurred after the class member had reported—sometimes multiple times—severe emotional distress and mental health decompensation.

For instance, [redacted] ([redacted]), reported an excessive use of force incident that happened to him on January 6, 2018. That morning, he said that he was "feeling really bad and had not slept for three days," so he told custody staff that he was struggling and needed help around 10:00 AM. Mr. [redacted] reported that custody staff ignored his reports, which continued throughout the day. He stated that, at around 7:30 PM, he showed custody staff a razor he had but was still ignored, so he cut himself in front of a psychiatric technician during pill call. The psychiatric technician retrieved the

Sergeant, who asked Mr. [redacted] to come out of his cell. Mr. [redacted] stated that because he was ignored the whole day, he refused. In response, custody staff formed an emergency response team, and at 8:30 PM, extracted Mr. [redacted] from his cell. During the extraction, Officer [redacted] allegedly hit Mr. [redacted] with a shield and broke two of his teeth, then rolled him over and pushed him into the ground, bruising his head and four to five of his ribs. He reported that he was sent to the hospital for his injuries, then taken back and housed in the CTC, and from there sent to a crisis bed. He then went to CHCF-APP for 30 days. Following the incident, Mr. [redacted] was written up for Battery on a Peace Officer with Serious Bodily Harm, because Officer [redacted] claimed that he cut him with a razor during the extraction.

Incredibly, the mental health assessment for the RVR Mr. [redacted] received, attached hereto as **Exhibit B**, found that his mental health did not contribute to his behavior and recommended no mitigation of assessed penalties. The assessment, which Mr. [redacted] received three days past timeframes, stated that the "reviewed/collected data suggests that … [Mr. [redacted] mental illness would [not] have contributed to the documented / alleged behaviors," even as it simultaneously notes that the incident occurred following "his recent engagement in serious self-harm (cutting himself with a razor blade) and observation of active bleeding." *Id*. The assessment's conclusion—that Mr. [redacted] has "a documented history of engaging [in] aggressive and resistive behaviors that have … required use of force to gain compliance", and that the incident on January 6, 2018 is continuous with that history—is glaringly at odds with Mr. [redacted] mental health records, which note that he "had refused to leave his cell hoping he would bleed out" and that "force was used to extract IP to get him to safety and ensure he would not cut deeper or commit suicide." *Id;* **Exhibit C hereto** (Master Treatment Plan)**.** This jarring conclusion—that Mr. [redacted] mental health played no role in a write-up he received during a serious suicide attempt—strains credulity.

Another class member, [redacted] [redacted] ([redacted]), wrote that on March 13, 2018, while housed in the D5 ASU Hub, he was hearing voices and feeling suicidal, so he told custody officers and asked for assistance. He reported that he told five different custody officers, but was repeatedly ignored. He then told a member of mental health staff, who had him placed in a holding cage. While in the cage, he attempted to hang himself, but Officer [redacted] came up to him, called him a "stupid nigger," and pepper-sprayed him in the face until he passed out. Mr. [redacted] records document that he was pepper-sprayed while in a holding cage. *See* **Exhibit D**. After this incident, he was placed in alternative housing and then into a crisis bed, after telling mental health staff "I am full of sins. God tells me to end it. I need to purify my soul." *Id.*

Mr. [redacted] ([redacted] wrote to our office to report that on January 1, 2018 he was escorted out of his D5 cell in handcuffs by third watch custody Officer [redacted] He reported that when he complained to the officer that the cuffing hurt his arm and asked for a different escort, Officer [redacted] slammed him into the ground and punched and kneed him in the back. The next day Mr. [redacted] was taken to the hospital, as the assault from Officer [redacted] broke three of his ribs.

Another inmate, [redacted]), whom we interviewed on April 4, 2018 when he was in the SVSP PIP, told us that in October 2017 while in the D5 ASU Hub, he was feeling suicidal and asked for help from custody staff. Officers [redacted] and [redacted] denied his requests to see mental health staff and told him that they "wanted to see blood" before they would allow him access to mental health staff. Mr. [redacted] reports that during his stay in the ASU Hub, the following occurred: (1) Officer [redacted] told him that if he cut himself he would be pepper-sprayed, (2) Officer [redacted] told him he was too scared to cut himself, (3) Officer [redacted] woke him up repeatedly and asked him if he had cut himself yet, and (4) Officer [redacted] refused to call a doctor after he had cut himself. After these incidents, Mr. [redacted] decompensated and was eventually sent to the SVSP PIP for more intensive mental health treatment.

These incidents do not appear to be limited to the D5 ASU Hub. For instance, [redacted] ([redacted] reported that on April 18, 2018 he saw Officer [redacted] run into an inmate's cell in the D4 EOP unit, beat him up, and then pepper-spray him after the inmate reported hearing voices. Mr. [redacted] reported that the inmate was written up for Battery on a Peace Officer and Officer [redacted] took his property and distributed it to other inmates. Similarly, an EOP class member in D3—who did not want his name used in this report due to fear of retaliation—reported that in February 2018 he saw an inmate in a holding cage get beaten up by Officers [redacted] and [redacted] after he had screamed for help for the prior two hours. This class member reported to us that the three officers emptied two cans of pepper spray into the inmate's cage to "quiet him down."

Mr. [redacted] ([redacted] wrote from the D4 unit that custody officers deliberately abuse inmates, and that mental health staff in the unit turn a blind eye to this misconduct. He wrote that Sergeant [redacted] and Lieutenant [redacted] assaulted an EOP inmate named "[redacted] in the Program Office after he was written up for indecent exposure. He reported that Lieutenant [redacted] grabbed [redacted] by the neck with both of his hands and slammed him against the ground, then Sergeant [redacted] grabbed his feet and slammed his head into a desk. The two officers then dragged him down the hall to a holding cell, only to return to tell Mr. [redacted] that he "hadn't seen anything" and that he should "lose his 1083

and throw away all of his property." After Mr. [redacted] that he may report this incident, he was removed from his job assignment as a program office clerk.

Other prisoners on D-Yard reported additional troubling incidents of staff misconduct. [redacted] ([redacted] D5, EOP, wrote to our office that custody officers regularly ignored him when he was suicidal and refused to get mental health staff when he engaged in acts of self-harm. [redacted] ([redacted] D4, EOP, reported that he recently went to get medications and asked for his medications through the medication window. He was then told by a custody officer to "get your head out of the fucking window." Another inmate on the D3 yard, who did not want our office to use his name regarding his reports about staff misconduct, said that custody officers make fun of inmates who are suicidal and tell them to kill themselves.

We ask that Defendants investigate each of these incidents in full. We also ask that Mr. [redacted] RVR be fully re-issued and re-heard, including a new mental health assessment performed by headquarters clinical staff. We also request that Defendants develop a corrective action plan in order to prevent future excessive use of force incidents from occurring in the EOP units at LAC, particularly in the D5 ASU Hub.

b. <u>Excessive Use of Force and Staff Misconduct Against *Coleman* Class Members on Other Yards</u>

We also received multiple disturbing reports of excessive use of force incidents on other yards at LAC. These reports are similarly concerning, and evince that the problems at LAC permeate beyond D-Yard.

[redacted] ([redacted] a CCCMS patient currently housed in the STRH at LAC, described a disturbing incident that occurred to him on March 1, 2018 on C-Yard, prior to his placement into the STRH (the incident is what led to his STRH placement). When Mr. [redacted] returned from a medical appointment, custody staff told him he could not enter his building (C4) because officers were conducting a search. Mr. [redacted] reported that he panicked and ran into the building. He quickly realized his mistake and stopped in the dayroom, putting his hands behind his back. Officers [redacted] and [redacted] allegedly threw him to the floor and then cuffed him behind his back. Sergeant [redacted] instructed the custody officers to take Mr. [redacted] to the building entranceway where they repeatedly hit and kicked him in the back of the knee and body with their batons. Mr. [redacted] reported that use of force often occurs in the entranceway because nobody can see what is happening there.

After the assault, custody staff restrained Mr. [redacted] in leg irons and put him in a wheelchair. Staff took him to the gym, where Mr. [redacted] refused a Form 7219. After a couple of hours, staff took Mr. [redacted] back to C4. He reported that around 8:45 PM, he went to pill call where he reported his injuries to a nurse who documented the incident on a Form 7219. He reported that he was feeling suicidal and was then moved to D4. He was soon cleared to go back to C4 and while Officer [redacted] and another custody officer were performing an unclothed body search so that he could go back to his regular cell block, the custody staff stopped the search because they received a call. Custody staff then escorted Mr. [redacted] to the ASU because he had been charged with assault on staff from the incident.

Since March 1, 2018, Mr. [redacted] has been on suicide watch multiple times, has overdosed, and has made a noose. During our interview with him on April 19, 2018, Mr. [redacted] informed us that he has been told by the Lieutenant that the RVR would be dismissed due to conflicting incident reports from custody staff, but that the dismissal was still processing. He later sent our office the fully adjudicated RVR, attached hereto as **Exhibit E**, which was, in fact, dismissed in full due to the "testimony of witnesses and [the] inconsistencies [in the] officer's reports."

In addition, [redacted] ([redacted]), D5, reported that Officer [redacted] called him a "nigger" on February 28, 2018 while he was housed in the C5 EOP unit. After he filed an appeal about this, he was placed in segregation, which he feels was retaliation for his appeal. Similarly, [redacted] ([redacted] STRH, CCCMS, reported that Officer [redacted] calls him "faggot" and other homophobic epithets. He also reported that Officer [redacted] tells other inmates on the tier that he is a sex offender, putting him at great risk of assault. Since interviewing with our office, Mr. [redacted] also reports that he has been retaliated against—custody officers have not let him out to shower, have refused to take his mail, and his property has been taken away.

As stated in our September 7, 2017, letter, clearly the attempts CDCR has taken to reform the pervasive conditions of staff misconduct at LAC have not worked. We request that Defendants develop a more detailed corrective action plan to address ongoing staff misconduct by custody officers at LAC, particularly in the D5 ASU Hub. We hope to soon discuss the contours of this plan in the workgroups.

2. Limited Yard and Other Programming Deficiencies on D-Yard

Multiple class members on D-Yard reported that access to the yard is still very limited, even though the yard returned to normal programming in January 2018 following a prolonged lockdown. Many class members reported that the amount of out-of-cell time

they receive is similar to or even less than that offered in segregation and that they only receive yard every other day.

For instance, [redacted] ([redacted] D2, reported that he only receives yard from 8:45 to 10:00 AM. Similarly, [redacted] ([redacted] D4, informed us that inmates only receive yard every other day. Mr. [redacted] told us that he filed a group 602 about the lack of yard time with fifty to one hundred other EOP inmates requesting a return to normal programming, but the response they received explained that the modified programming was permanent. Both Mr. [redacted] and Mr. [redacted] reported that the prolonged cell time and isolation caused by the lack of yard time was having a negative effect on their mental health.

Multiple other inmates reported similar consistent issues:

- [redacted] ([redacted] D3, EOP, reported that they only receive four to five hours of yard every week, and that some weeks it is only one to two hours due to cancellations.
- [redacted] ([redacted] D3, EOP, reported that they only receive yard every other day for 45 minutes at a time.
- [redacted] ([redacted] D3, EOP, reported that yard time is limited to a few hours a day.
- [redacted] ([redacted] D1, EOP, wrote to our office that inmates only receive a few hours of out-of-cell time every day.

Why is yard time on D-Yard so limited in duration? Is there a way to schedule more yard time for D-Yard? Is it true that the modified programming is permanent? If so, why? We are concerned about the deleterious effect the small amount of out-of-cell time is having on the stability of EOP class members on D-Yard. We request an explanation for the limitations placed on yard time and other programming on D-Yard.

We have also heard reports that lifers cannot attend ABE programs on D-Yard because the classrooms are behind the wall and they cannot go through work change due to their custody status. Is that true? If so, is there some way to move the ABE programs to a location where lifers can have access to them?

3. Lack of Substantive Treatment Offerings in the D-Yard EOP and C-Yard EOP Programs

Multiple class members reported problems with their group therapy treatment. Specifically, they reported that some of their groups are held in the visiting room and that during these groups they just stand or sit around, with no planned topic or leadership from a therapist. Multiple class members also reported that up to half of their groups are cancelled every week.

In general, there was little indication from interviewed class members on D-Yard or in the C5 unit that "[g]roup therapy and psycho-educational groups provide inmate-patients with an opportunity to express, explore, and resolve issues with the assistance of clinical staff and other inmate-patient group participants who have similar problems or experiences" or that "[p]sycho-educational groups focus on cognitive/behavioral skill building as a means of improving inmate-patient interpersonal skills and problem solving abilities," as the Program Guide requires. *See* Program Guide, 12-4-9. The group therapy offerings are instead almost exclusively recreation groups, which do not provide inmates with the opportunity to get the treatment that they sorely need.

- [redacted] ([redacted] D3, reported that four to five of the groups every week are cancelled. He also said that they do not learn anything in groups—they just sit around reading magazines or playing dominoes. He said that a recreation therapist sits in the room but does not lead anything. His mental health records show that he was offered less than ten hours of group treatment for the first three weeks of April 2018, and that the majority of his groups were leisure or relaxation groups.

- [redacted] ([redacted] D3, reported that groups are cancelled four times a week and that the inmates just sit in a room during groups without any treatment. His mental health treatment records show that, in April 2018, he received only five groups the first week and six groups the second. His records also show that only three of his groups over the course of the month were led by a clinician—the rest were led by recreation therapists or nurses.

- [redacted] ([redacted] C5, reported having groups in the visiting room led by a recreation therapist. During these groups, the recreation therapist does not lead the groups at all. A review of Mr. [redacted] records shows that the majority of his groups are recreation or leisure groups and that he did not receive ten hours of groups in any week during April 2018.

- [redacted] C5, reported that many of his groups are cancelled. He also reported that all of his groups are recreation therapist leisure groups, with only one substantive coping skills group for an hour a week. In the leisure groups, the recreation therapist is not engaged unless an inmate goes up and talks to him. His mental health records show that the majority of his groups are recreation or leisure groups and that he did not receive ten hours of groups in any week during April 2018.

Similarly, many EOP inmates reported that they only receive very brief one-on-one contacts with their clinicians, which do not afford them enough time to work on their mental health issues.

- [redacted] D5, said that he sees his clinician for only 10 minutes every week.

- [redacted] C5, reported that after he got out of the D5 ASU EOP in September 2017, he did not have any contact with a primary clinician for two months. His records confirm this: a November 7, 2017 progress note from his primary clinician, attached hereto as **Exhibit F**, states that "IP is a 20 year old AA man who presented for his fist [*sic*] PC contact since his transfer from Ad-Seg to EOP-SNY [on] 9/8/2017."

- [redacted] D4, reported that his one-on-ones are only 15 minutes long.

- [redacted] D3, reported that his one-on-ones are only 10 to 15 minutes long.

- [redacted] D3, reported that his one-on-ones are only 15 to 25 minutes long, and mostly involve his clinician trying to discharge him from EOP. He also reported that his clinician told him he must engage in self-injurious behavior in order to remain in EOP.

- [redacted] C5, reported that his one-on-ones are only 20 minutes long.

- [redacted] CCCMS ASU, said that his one-on-ones are only 10 minutes long.

The Program Guide requires that "[i]ndividual therapy provide[] inmate-patients with the opportunity to discuss personal problems that may not be adequately addressed in a group setting." Program Guide, 12-4-9 . Although the Program Guide does not set forth the length of a typical one-on-one session, ten to fifteen minutes clearly does not allow for personal problems to be adequately addressed, especially in the absence of structured therapeutic group activities, as discussed above.

Moreover, the *Plata* Receiver's Dashboard Reports (available at https://cchcs.ca.gov/reports/) support these accounts, as the reports show that LAC has "EOP Structured Treatment" rates far below the rates shown statewide.

The below table shows the percentage of EOP inmates offered ten hours of structured therapeutic activities over the course of each month. In March 2018—the most recent data—only 64% of EOP inmates at LAC were afforded their full ten hours of structured treatment. Even more concerning is that this represented a large improvement over the previous four months.

Month	Statewide	LAC
Sep-17	57%	85%
Oct-17	63%	67%
Nov-17	50%	16%
Dec-17	60%	30%
Jan-18	59%	33%
Feb-18	67%	39%
Mar-18	78%	64%

The most recent dashboard data for LAC, for March 2018, also shows trouble at the prison with a number of metrics for mental health care management, including the following measures coded red in the dashboard:

- 30-day MHCB or PIP readmission rates of 26% suggest there are lapses in follow up care at LAC.
- EOP/MHCB Treatment Plans were only present for 53% of cases.
- Suicide watch discharge plans were present in 0% of the cases.
- Continuity of Clinicians for Psychiatrists was only 73%.
- The quality of Suicide Risk Evaluation Documentation was at 83%.

- Only 74% of medications are timely received at LAC.

A copy of the March 2018 Dashboard for LAC is attached hereto as part of **Exhibit G**.

What explains the low number of treatment hours offered at LAC? What is being done to correct the obvious deficiencies in mental health treatment at LAC? The most recent staffing data, also attached hereto as part of **Exhibit G**, shows that LAC's case manager positions (i.e., clinical social workers and clinical psychologists) are largely filled, although there are continued problems with psychiatrist staffing. We also note that LAC rolled out its EHRS in November 2017, which appears to have impacted clinical efficiency (the average number of encounters per day for primary mental health clinicians fell from 6.3 in October 2017 to 4.9 in February 2018). If the explanation for the deficiencies in mental health treatment at LAC is the EHRS rollout, what is being done to mitigate these impacts?

4. Troubling Recent Suicides at LAC

There have been seven suicides at LAC in roughly the last two years, a deeply disturbing trend. In light of the pervasive culture staff misconduct and inadequate mental health care at LAC described above, the high number of suicides intensify our concerns about current conditions there. We describe each suicide below, beginning with the most recent:

- [redacted], *in an A-Yard Cell on* [redacted]: Mr. [redacted] was found hanging in his single cell on A-Yard, a GP Level III programming facility. The Suicide Report found some medication issues. He was CCCMS.

- *Mr.* [redacted], *in the MHCB on* [redacted]: Mr. [redacted] was in the MHCB unit at LAC and on December 5, 2017, he hung himself from a smoke detector in his CTC cell. The Suicide Report included 12 recommendations for corrective action, many of them relating to very serious care problems. Due to a medication delivery issue, Mr. [redacted] was not given any psychiatric medication from November 28 until [redacted] 2017, the day before he hung himself. Also, at the time of his suicide, he had been returned to suicide watch but the order on his door was not clear about what property he was allowed to have in his room. At the time of his suicide attempt he had a razor in his cell which he used to make the ligature.

- [redacted] *in the D-5 EOP ASU unit on* [redacted]: Mr. [redacted] was found in his administrative segregation cell hanging from a vent. The Suicide Report found two mental health and two custody concerns, for which the Report issued correction actions. Specifically, the Report found that Mr. [redacted] did not receive a suicide risk assessment upon his arrival to LAC on May 22, 2017, nor did he receive one on July 25, 2017 after he made suicidal statements to his clinician, nor the day prior to his death after he expressed mental health decompensation to his treatment team. He was also discovered alone in a non-retrofitted intake cell within 12 hours of his initial placement, and was discovered cyanotic and cold to the touch despite documentation that Guard One checks occurred in the unit the night of his death.

- [redacted], *in the STRH on* [redacted]*:* Mr. [redacted] was found hanging from a module in a holding cell, which he was placed in a half hour earlier after reporting he was suicidal. The Suicide Report listed seven custody concerns, five nursing concerns, and thirteen mental health concerns. In particular, mental health staff underestimated his suicide risk and erroneously attributed his behavior to secondary gain. For instance, the Report notes that on the morning of his death he was threatened with discharge from the CCCMS program by his treatment team if he continued smearing feces in his cell. His psychotropic medications were also discontinued a few weeks prior to his death.

- [redacted] *in a D-Yard Cell on* [redacted]*:* Mr. [redacted] was found hanging from a bed sheet tied to an air vent in his cell. Multiple concerns were found regarding his suicide, including the fact that he was held in a shower for a total of five hours and twenty five minutes while awaiting a suicide risk assessment. The suicide report also found that, while Mr. [redacted] received two SREs on March 22, 2017 that documented multiple chronic and acute risk factors, Mr. [redacted] was not referred to a crisis bed. Lastly, the suicide report found a total of seven nursing staff concerns, including a lack of documentation of Mr. [redacted] self-injurious behaviors.

- [redacted], *in a C-5 Cell on* [redacted]*:* Mr. [redacted] was found in his C5 unit cell with a plastic bag around his head. The suicide report issued five recommendations for corrective action, including a lack of documentation of his most recent treatment plan and a three-

minute delay between when he was found unresponsive and the sounding of an alarm notifying additional staff of the emergency.

- [redacted] *in the STRH on* [redacted]*:* Mr. [redacted] was found in the STRH unit with his headphones wrapped tightly around his neck. The suicide report included six recommendations for corrective action. In particular, it found that Mr. [redacted] treatment team had not listed his frequent treatment refusals as a problem in his treatment plan. Mr. [redacted] was also found in possible rigor mortis, despite Guard One documentations.

We remain deeply concerned that the conditions underlying these suicides continue to blight the mental health treatment system at LAC. These conditions both seriously impact the mental health of our clients and create clear disincentives to the access of mental health care. We request an investigation and a prompt written response to the issues raised in this letter.

Sincerely,

ROSEN BIEN
GALVAN & GRUNFELD LLP

/s/ Thomas Nolan

Thomas Nolan
By: Of Counsel

TN:DVC:cg
Encls.: Exhibits
cc: Co-Counsel
Coleman Special Master Team
Coleman Attorney General Team
Katherine Tebrock

Exhibit F

OFFICE OF LEGAL AFFAIRS
Patrick R. McKinney II
General Counsel
P.O. Box 942883
Sacramento, CA 94283-0001

July 13, 2018

Tom Nolan
Rosen Bien Galvan and Grunfeld, LLP
50 Fremont Street, 19th Floor
San Francisco, CA 94105

Tom,

I write in response to your June 5, 2018, letter regarding concerns about allegations of excessive force, mental health access and treatment, and recent suicides at California State Prison, Los Angeles County (LAC). The California Department of Corrections and Rehabilitation (CDCR) has investigated the allegations brought forward in your letter, to the extent that they were not already known, and responds accordingly.

I. Allegations of Staff Misconduct at LAC

Most of the misconduct allegations raised in Plaintiffs' letter were known to the LAC Investigative Services Unit (ISU) staff that investigated the complaints when they were originally brought forward. As outlined below, those allegations were found to be unsubstantiated. LAC ISU will immediately investigate the few allegations brought to CDCR's attention for the first time. A corrective action plan is unnecessary given that these allegations have largely been found to be unsubstantiated following the appropriate investigative process.

A. [redacted]

Plaintiffs' letter alleges that Mr. [redacted] was a victim of excessive force and that a Rules Violation Report he subsequently received was mishandled. (Plaintiffs' letter at pages 2-3.) LAC was already aware of the allegations raised by Mr. [redacted] regarding excessive force. LAC's ISU investigated the allegation and closed the investigation as unfounded.

Headquarters has also reviewed the Rules Violation Report (RVR) for battery on a peace officer and agrees with the disposition. LAC conducted a mental health assessment per policy and concluded that even though he was subsequently admitted to a crisis bed, mental illness did not contribute to Mr. [redacted] behavior when he battered the officer. This conclusion is supported by the fact that his primary motivation for crisis bed placement was because his pain medication had been discontinued. (See, for example, Exhibit C to Plaintiffs' letter at pages 10-11.) And although he cut himself prior to battering staff, the cut was described by LAC as superficial. (*Id*.) In fact, the discharge paperwork from the community hospital emergency department did not treat or mention the cut. The RVR will not be reissued or reheard.

B. [redacted]

Plaintiffs' letter alleges that Mr. [redacted] was called a racial slur and then pepper sprayed by custody staff when he tried to hang himself. (Plaintiffs' letter at page 3.) LAC was aware of this allegation via a 602 appeal Mr. [redacted] filed earlier this year. Mr. [redacted] later withdrew his appeal and recanted his allegation that a correctional officer referred to him by a racial slur.

Mr. [redacted] also alleges the improper use of pepper spray, which was used in an emergency to stop him from hanging himself. (*Id.*) The use of force incident was reviewed by the incident commander, first level manager, and second level manager. All reviews concurred that the actions of staff prior to, during, and following the use of force were in compliance with policy, procedure and training.

C. [redacted]

Plaintiffs' letter alleges that Mr. [redacted] was a victim of excessive force. (*Id.* at page 4.) LAC investigated Mr. [redacted] allegation in April and May 2018. The allegation was closed as unfounded.

D. [redacted]

Plaintiffs' letter alleges that custody staff denied Mr. [redacted] access to mental health staff, encouraged Mr. [redacted] to harm himself, threatened the use of pepper spray on him, taunted him, and refused to send Mr. [redacted] to medical after he cut himself. (*Id.*) This allegation of misconduct has been referred to LAC's ISU for investigation.

E. Unidentified Inmate Reported by [redacted]

Plaintiffs' letter alleges Mr. [redacted] observed an officer enter another inmate's cell, beat him up and pepper spray him. (*Id.*) LAC was aware of Mr. [redacted] allegation as it was part of a 602 he filed earlier. LAC investigated the allegation and determined there was no staff misconduct.

F. Unidentified Inmate (Page 4)

Plaintiffs' letter alleges that an unidentified inmate informed Plaintiffs that in February 2018 another inmate was in a holding cage and was beaten up by three officers. (*Id.*) While LAC's ISU will conduct an investigation into this allegation, investigating anonymous complaints[1] is especially difficult. The allegation does not correspond to any known incident or complaint within the timeframe identified.

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[1] In this case, not only does CDCR not know the complainant's name, the complainant reported staff misconduct against another unnamed inmate.

G. [redacted]

Plaintiffs' letter alleges that Mr. [redacted] witnessed a staff assault of an inmate named "[redacted] (*Id.*) Additionally, Mr. [redacted] states that he was removed from his job assignment for mentioning that he may report the incident. (*Id.*) LAC ISU will investigate Mr. [redacted] allegations.

H. [redacted]

Plaintiffs' letter alleges that Mr. [redacted] reported that he was suicidal and staff refused to intervene. (*Id.* at page 5.) Mr. [redacted] allegation has been captured in multiple appeals. Despite his allegations, Mr. [redacted] has been admitted to a crisis bed eleven times since July 1, 2017, and has spent a cumulative 117 days in that setting since that date. Under such circumstances, it is difficult to conclude that staff is not responsive to Mr. [redacted] suicidal ideations.

I. [redacted]

Plaintiffs' letter alleges that Mr. [redacted] was spoken to impolitely during medication pass. (*Id.*) LAC ISU will investigate this allegation.

J. Unidentified Inmate (Page 5)

Plaintiffs' letter alleges that an unidentified inmate on D3 said that custody officers make fun of suicidal inmates and "tell them to kill themselves." (*Id.*) LAC ISU investigated this allegation, although the actual inmate who made the allegation remains unknown. LAC ISU interviewed numerous inmates and staff. Information gathered during the course of the investigation did not substantiate a claim of staff misconduct.

K. [redacted]

Plaintiffs' letter alleges that Mr. [redacted] was thrown to the floor, cuffed and attacked by custody staff after he entered a building that was being searched. (*Id.*) LAC investigated this allegation in April 2018. During the course of the investigation ISU interviewed Mr. [redacted] and reviewed the disposition of the Rules Violation Report he received. While the Rules Violation Report was dismissed, the ISU investigation was closed as the allegations were deemed to be unfounded.

L. [redacted]

Plaintiffs' letter alleges that Mr. [redacted] was called a racial slur on February 28, 2018. (*Id.* at page 6.) LAC is aware of this allegation via a 602 appeal Mr. [redacted] filed. The appeal was reviewed at the second level and appeals staff determined that staff did not violate policy. In the course of the 602 appeal review, staff interviewed Mr. [redacted] staff witnesses, and the subject of the complaint.

Mr. [redacted] was placed in administrative segregation due to his expressed safety concerns, not due his 602 appeal. On April 2, 2018, Mr. [redacted] informed staff of the names of two inmates on

C-Facility to which he owed a debt. In addition, on April 10, 2018, while still in administrative segregation, he expressed safety concerns over two other inmates on D-Facility. These safety concerns made it impossible to rehouse Mr. [redacted] at LAC and resulted in his transfer to Mule Creek State Prison in early June 2018.

M. [redacted]

Mr. [redacted] alleges officers used homophobic slurs, that officers told other inmates that Mr. [redacted] is a sex offender, and that officers have impeded his access to showers, mail, and personal property. (*Id.*) Most of this allegation was known to LAC via a 602 appeal filed by Mr. [redacted] Those issues that were raised in the 602 were investigated at the second level. The review included interviews with Mr. [redacted] the subject of the complaint, and multiple staff and inmate witnesses. The appeal found no evidence of staff misconduct. LAC ISU will conduct an inquiry into the allegation not raised in the original 602, namely, the use of homophobic slurs.

II. Yard on D-Facility and Programming Opportunities for Lifers

Recreational yard is currently offered seven days per week on D-Facility from 0800 to 0950 and from 1330 to 1530, though yard schedules are in the process of being updated. In late 2017, there was an attempted murder of a correctional officer on D-Facility. As a result LAC reviewed how the yard was being implemented and began making changes in order to ensure adequate yard time and the safety of staff and inmates. Yard recall time has been adjusted so that there is no inmate movement at shift change. LAC has also eliminated the requirement for a yard recall to conduct a close custody count. Once fully implemented, these changes should increase available yard time by 90 to 120 minutes each day.

Lifers on D-Facility are not excluded from Adult Basic Education (ABE). Every inmate is evaluated during the Unit Classification Committee process and assigned programming in accordance with their case factors. The following inmate programs are available to the lifer population on D-Facility: ABE I, II, III, Computer Literacy, two mental health groups solely for lifers, Turning Point correspondence program, Partnership for Re-Entry Program, Substance Abuse, Veteran's group, Alcoholics Anonymous and Narcotics Anonymous.

III. Mental Health Treatment at LAC

Addressed below are allegations related to group treatment, individual treatment, thirty-day readmission rates, treatment plans, suicide watch and discharge plans, psychiatry continuity of care, quality of suicide risk evaluations, and medications. LAC is aware of the issues outlined in Plaintiffs' June 5, 2018, letter and has steadily worked to improve the quality and access to care.

Additionally, regional administrators frequently work with LAC to ensure compliance with mental health policies. LAC will be audited via the Continuous Quality Improvement (CQI) tool in July 2018 and a report will issue outlining the regional team's findings and recommendations shortly thereafter.

A. Group Treatment

In order to address group treatment quality, Enhanced Outpatient Program (EOP) supervisors began soliciting feedback from EOP group members in February 2018. LAC began improving group quality by using a structured curriculum and by providing training to staff. Regional staff conducted a pre-CQI audit visit as well as a sustainable process evaluation last month. The regional team determined that the groups were of sufficient quality to warrant a positive review and that group therapy provided within the Administrative Segregation Unit EOP hub and Short Term Restrictive Housing unit was excellent. Patient feedback from those groups was also positive.

In addition to addressing quality, LAC has worked to reduce cancellations in order to assure that patients are offered at least ten hours of structured group therapy each week. In early 2018, multiple program shut down as a result of EOP gang activity which temporarily resulted in higher than normal cancellation rates. Construction related to ADA retrofits on C and D-Facilities over the past several months has also resulted in the temporary loss of treatment space.

Following the adoption of the Electronic Health Records System (EHRS), a communication issue with the Strategic Offender Management System prevented EHRS from accurately producing a master list. This issue, along with another EHRS issue that reports an incorrect group schedule rate (see table below for June 2018), has been elevated for repair and is expected to be remedied soon.

Month	Jan. 2018	Feb. 2018	Mar. 2018	Apr. 2018	May 2018	June 2018
Percent Cancelled	78%	34%	53%	54%	12%	9%
Percent Scheduled	77%	62%	96%	95%	90%	83%*
Percent Offered	33%	39%	64%	61%	85%	80%

*June 2018 was ninety-nine percent scheduled as of June 15 but an EHRS technological issue caused it to report eighty percent when queried on June 18. An EHRS repair is in progress.

B. Individual Treatment

LAC investigated complaints raised in Plaintiffs' letter regarding "very brief one-on-one contacts." (Plaintiffs' letter at page 9.) Like at all CDCR institutions, individual treatment at LAC focuses on the patient's needs, which are determined by the clinician in conjunction with the interdisciplinary treatment team. It is CDCR's expectation that individual sessions are offered in a confidential setting and last at least fifteen minutes.

Many factors determine the length of one on one sessions including where the encounter takes place and patient participation. Cell front contacts, for instance, are generally briefer than out-of-cell contacts because the focus is on assessing the patient's mental status and understanding

the patient's reason for refusing a confidential session. In other situations, patients may be unwilling to participate longer than fifteen minutes.

LAC is committed to ensuring that its patients receive individual treatment that addresses their particular needs.

C. Thirty-Day Readmission Rates

Plaintiffs misinterpret the thirty-day readmission rates when stating that LAC's rate of twenty-six percent suggests there are lapses in follow-up care at LAC. (Plaintiffs' letter at page 10.) The readmission rate tracks discharges from LAC's crisis bed who were readmitted within thirty days. Between April and June 2018, twenty-three patients were readmitted. However, only thirty-percent of those patients were readmitted by LAC as the remaining seventy-percent had discharged to different institutions prior to their readmission to a crisis bed.

Month	Total Readmits	Readmits from LAC	Readmits from Other
April 2018	5	1 (20%)	4 (80%)
May 2018	9	3 (33%)	6 (66%)
June 2018	9	3 (33%)	6 (66%)
TOTAL	23	7 (30%)	16 (70%)

LAC's thirty-day readmission rate over the past year has exceeded the statewide average (the statewide thirty-day readmission rate was twenty-three percent compared to LAC's thirty-day readmission rate of twenty-two percent over that same timeframe.)

Month	March 2018	Apr. 2018	May 2018	June 2018
LAC Rate	26%	16%	25%	23%
Statewide Rate	24%	22%	21%	24%

D. EOP and Crisis Bed Treatment Plans

The EOP and crisis bed treatment plan indicator measures not whether the plans were "present" but, rather, whether the audited charts received at least a satisfactory score on the treatment plan quality tool. The tool measures the extent to which diagnosis, clinical summary, problems, and treatment goals and interventions are consistent. LAC has identified this as an area of quality improvement and expects to see progress at its next quarterly audit.

E. Suicide Watch Discharge Plans

Like the EOP and crisis bed treatment plan audit, this indicator does not measure whether plans were "present." Instead, it measures the percentage of plans in which the primary clinician documented the reason for admission and a review of whether the discharge/follow-up plan was implemented. While LAC's score increased in April 2018, LAC recognizes that this is an area for quality improvement. LAC expects to see progress reflected in the next audit.

F. Continuity of Care for Psychiatrists

LAC has been able to recruit and hire additional psychiatrists over the past few months. As a result, the following compliance indicators have significantly improved:

Indicator	Jan. 2018	Feb. 2018	Mar. 2018	Apr. 2018	May 2018	June 2018
Timely Contacts	57%	73%	90%	99%	99%	99%
Poly Pharm	80%	99%	99%	99%	99%	100%
IDTT Staffing	70%	72%	75%	81%	95%	94%
Timely Referrals	68%	80%	94%	96%	93%	90%

G. Quality of SRE Documentation

The March 2018 audit of Suicide Risk Evaluation quality was eighty-three percent (see *Id.*), however, the most recent audit has measured compliance at one-hundred percent.

H. Medications Received Timely

LAC is aware of issues with its timely delivery of medications and has worked diligently to remedy this issue. In June 2018, for instance, LAC was compliant with eighty percent of its deliveries for the 54,830 doses of medications it delivered that month.

IV. Suicide Response at LAC

LAC has taken several steps to improve suicide prevention practices in 2018. LAC has focused on improving training compliance and implementing new processes to reduce suicide risk.

Among the initiatives undertaken, LAC has:

- Implemented a plan to increase compliance with Suicide Risk Assessment Proctor and Mentoring Training to at least ninety-five percent by September 2018.
- Required all treatment teams to utilize the high risk list for every patient seen. Patients on the high risk list are also reviewed each month during the local Suicide Prevention and Response Focused Improvement Team (SPRFIT) meetings.
- Implemented the crisis intervention team (CIT) model and provided after-hour coverage.
- Implemented one-on-one trainings linked with the CIT in order to improve clinical decision making and documentation.

- Ensured that LAC's SPRFIT coordinator, senior psychologist specialist and senior psychologist supervisor have all received root cause analysis training to assist with analyses of recent suicides.

Local leadership, regional administrators and headquarters staff continue to monitor LAC's progress in improving and sustaining quality suicide prevention practices.

V. CQI Monitoring will Ensure that LAC Continues to Provide Adequate Care

CDCR's July 2018 CQI audit of LAC will examine the same access to and quality of care indicators addressed in this letter. By utilizing the CQI process, regional custody and mental health oversight, and regular local and headquarters quality management meetings, CDCR will ensure that deficiencies in care are identified, documented, and promptly corrected.

Sincerely,

/s/ Nick Weber

Nick Weber
Attorney
Office of Legal Affairs

Cc: Special Master Lopes
Co-Counsel

Exhibit G

ROSEN BIEN GALVAN & GRUNFELD LLP

101 Mission Street, Sixth Floor
San Francisco, California 94105-1738
T: (415) 433-6830 ▪ F: (415) 433-7104
www.rbgg.com

Thomas Nolan
Email: tnolan@rbgg.com

April 10, 2019

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Nick Weber
Melissa Bentz
Dillon Hockerson
Jerome Hessick
CDCR Office of Legal Affairs
Nicholas.Weber@cdcr.ca.gov
Melissa.Bentz@cdcr.ca.gov
Dillon.Hockerson@cdcr.ca.gov
Jerome.Hessick@cdcr.ca.gov

Re: *Coleman v. Newsom*: Plaintiffs' Renewed Concerns About Excessive Use of Force and Staff Misconduct Incidents at LAC
Our File No. 0489-03

Dear OLA Team:

We write to raise concerns about multiple new incidents of serious staff misconduct targeting *Coleman* class members at LAC. We have received numerous complaints from class members at LAC over the past year that custody staff have used unreasonable or excessive force on them, ignored their requests for assistance during mental health crises, subjected them to demeaning and racially abusive language, and retaliated against them for filing 602 complaints or sending letters to LAC supervisory staff. These complaints have come most heavily from the EOP units at LAC, particularly the D5 ASU Hub and the C5 Unit.

These complaints are especially concerning given that they continue to multiply despite our numerous, seemingly unheeded, reports over the last few years that staff misconduct against *Coleman* class members at LAC is particularly pervasive. Most recently, we sent a letter to CDCR's Office of Legal Affairs on June 5, 2018 about staff

misconduct, deficient treatment, and use of force at LAC.[1] This letter, attached hereto as **Exhibit A**, raised twelve separate reported incidents of staff misconduct at LAC, including five reports of excessive or unreasonable force. Defendants' response, on July 13, 2018, dismissed ten of the twelve reports as unsubstantiated following investigations by LAC's Investigative Services Unit (ISU). (The remaining two reports were submitted to the ISU for investigation, and we have not received any information as to the outcomes.)

As Defendants are no doubt aware, the Office of the Inspector General (OIG) recently found "that the dependability of the staff complaint inquiries [at Salinas Valley State Prison] was significantly marred by inadequate investigative skills that reviewers demonstrated—notably, by their deficiencies in interviewing, collecting evidence, and writing reports." Office of the Inspector General, Special Review of Salinas Valley State Prison's Processing of Inmate Allegations of Staff Misconduct ["OIG Report"] at 3 (Jan. 2019).[2] The OIG "found at least one significant deficiency in 173 of the 188 staff complaint inquiries (92 percent)." *Id*.; *see also id*. at 89 ("Although this special review focused only on Salinas Valley, the process we reviewed is in place at prisons statewide. Therefore, the conditions we found may also exist to some degree at other institutions."). In a subsequent California State Assembly Budget Subcommittee hearing, Inspector General Roy Wesley bluntly informed state legislators that CDCR's staff complaint inquiry process is "entirely driven by the purpose to exonerate staff." *See* 3/4/19 Hr'g Audio Recording at 1:53:53.[3]

Given these findings, we are concerned that our previous reports of staff misconduct at LAC were improperly disregarded and dismissed without any rigorous investigation of our reports. This concern is heightened by the fact that almost every incident described in this letter, *infra*, involves significant problems regarding LAC's staff complaint process. We therefore request that Defendants disclose the contours of the LAC ISU investigations conducted in response to our June 5, 2018 letter.

---

[1] Plaintiffs' counsel in *Armstrong v. Brown* also raised concerns about staff misconduct at LAC in their March 19, 2019 Monitoring Report, which described numerous incidents involving prisoners who are both *Armstrong* and *Coleman* class members. Relevant excerpts of that report are attached hereto as **Exhibit B**.

[2] *Available at* https://www.oig.ca.gov/media/reports/Reports/Reviews/2019_Special_Review_-_Salinas_Valley_State_Prison_Staff_Complaint_Process.pdf.

[3] *Available at* https://www.assembly.ca.gov/media/assembly-budget-subcommittee-5-public-safety-20190304/audio.

We further request that any future investigations into staff misconduct as a result of this letter be completed by non-LAC personnel. We are concerned that any local investigation will cause class members' complaints to be inappropriately dismissed, like the prior complaints we provided to you. Lastly, we have only included in this letter the names of class members who have given us permission to do so. However, due to widespread reports of retaliation and harassment from class members for filing 602 complaints, we also ask that this letter **not** be shared with line staff at LAC. We also want to underscore the fact that many more class members have reported detailed accounts of staff misconduct issues to our office, but were too fearful of retaliation to allow us to use their information in this letter.

1. Troubling Use of Force Disparities and Complaints at LAC

Unconstitutional use of force against class members has a long history in this case, beginning with the *Coleman* Court's original finding more than twenty years ago that prisoners with serious mental illnesses are subjected to punitive measures by custody staff "without regard to the cause of the [inmate's] behavior, the efficacy of such measures, or the impact of those measures on the inmates' mental illnesses." *Coleman v. Wilson*, 912 F. Supp. 1282, 1320 (1995). In 2014, the Court again found that Defendants subjected class members to unconstitutional use of force and ordered Defendants to revise their policies accordingly. 4/10/14 Order, ECF No. 5131 at 72. In response, Defendants filed policies and procedures meant to foster a "sweeping culture change for CDCR as it expects staff to step back and evaluate the totality of the circumstances, whenever circumstances permit, before using force." ECF No. 5190 at 10.

Five years later, culture change has yet to arrive at LAC in any meaningful way. CDCR's publicly posted COMPSTAT data shows that from January 2018 to January 2019, 85% of LAC's reported use of force incidents involved prisoners with mental illnesses. In December 2018 and January 2019, 90% and 88% of use of force incidents, respectively, involved mentally ill prisoners. This rate was eight to ten times higher than the equivalent rate for prisoners without mental illnesses in these months. The below table shows use of force disparities at LAC over the last thirteen months.[4]

[4] The COMPSTAT reports, *available at* https://www.cdcr.ca.gov/COMPSTAT/, provide data on "Documented Use of Force," "UOF Incidents Involving MH Inmates," and "UOF Incidents Involving MH Inmates Per 100 MH Inmates," as well as population figures for each level of mental health care. Using these figures, we calculated the remaining columns in this table.

	Documented Use of Force (UoF)	Documented UoF Per 100 Prisoners	UoF Incidents Involving Non-MH Prisoners	UoF Incidents Involving MH Prisoners	UoF Incidents Involving MH Prisoners Per 100 MH Prisoners	UoF Incidents Involving Non-MH Prisoners Per 100 Non-MH Prisoners	How Many Times Higher is the UoF Rate Against MH Prisoners?
Jan-18	44	1.30	8	36	2.22	0.46	4.88
Feb-18	45	1.36	6	39	2.41	0.36	6.77
Mar-18	41	1.26	4	37	2.31	0.24	9.57
Apr-18	41	1.27	4	37	2.39	0.24	10.07
May-18	56	1.73	7	49	3.20	0.41	7.77
Jun-18	41	1.30	3	38	2.49	0.18	13.46
Jul-18	51	1.59	9	42	2.72	0.54	5.00
Aug-18	54	1.69	12	42	2.83	0.70	4.04
Sep-18	56	1.75	9	47	3.17	0.53	6.03
Oct-18	47	1.47	5	42	2.75	0.30	9.21
Nov-18	48	1.51	13	35	2.35	0.77	3.07
Dec-18	31	0.97	3	28	1.83	0.18	10.11
Jan-19	51	1.61	6	45	3.02	0.36	8.42

These figures are especially troubling because the Court noted this very issue five years ago in its April 10, 2014 Order, finding "plaintiffs' evidence suggests that force is used against mentally ill inmates at a rate greatly disproportionate to their presence in the overall inmate population. … [I]n several [prisons], 87 to 94% of the use of force incidents were against mentally ill inmates. … this is evidence, at least, of a systemic failure to understand 'what a mentally ill person might be experiencing before or during a use of force incident, or of how mental illness may make it difficult for an inmate to immediately conform his or her behavior in response to an order.'" 4/10/14 Order, ECF No. 5131 at 17-18 (quoting Plaintiffs' expert).

The Court's concerns—that a large disparity between the rates of use of force on *Coleman* versus non-*Coleman* prisoners evinces a continued disregard for the underlying causes of mentally ill prisoners' behavior—are reflected in our class members' recent complaints about use of force incidents at LAC. And if abusive, unwarranted use of force were not bad enough, numerous class members reported being subjected to improper, excessive force while they were already experiencing extreme mental distress, including anxiety, suicidality, and psychosis. Others reported that the use of force seriously exacerbated their mental health decompensation. Many of these complaints are verified in class members' mental health treatment files.

For example, [redacted] (who was EOP at the time of this incident and housed in D5-[redacted] reported a troubling incident that occurred in the early morning hours of June 29, 2018 while he was under extreme mental duress.[5] The previous day, he had been sent to Antelope Valley Hospital ("AVH") to receive an MRI to identify why he had been unable to urinate for two days. Mr. [redacted] suffers from extreme anxiety and was unable to relax and sit still during the MRI (despite the administration of Vistaril to help calm him). He was returned from the hospital with his urinary problem unresolved. Mr. [redacted] requested and received a copy of his AVH treatment files so he could show them to his LAC physician. He was anxious that without this documentation his urine retention issue would go unaddressed at LAC. When he returned to the LAC D5 unit at around 1:00 a.m. on June 29, 2018, a nurse asked him what he was holding (in reference to his medical papers) and told him he could not hold the papers. This made Mr. [redacted] extremely agitated. In response, Officer [redacted] told him to stop moving and grabbed his arms (Mr. [redacted] was double-cuffed at the time). Sergeant [redacted] then came out and reportedly said to Mr. [redacted] "you better go [back to your cell], or it will be bad for you – look at you [referencing his double-cuffing]." Because Mr. [redacted] was agitated about losing his medical paperwork, he refused to return to his cell. Officer [redacted] then threw Mr. [redacted] against the sink, causing him to hit his head, and punched him to the ground while telling him "we don't give a fuck about your bladder." Officer [redacted] then punched and kicked him repeatedly in his distended bladder. Mr. [redacted] also reported that Officer [redacted] got on top of him and pressed his knee into his back. Due to this force, Mr. [redacted] defecated on himself. Mr. [redacted] reported that he filed a staff misconduct appeal about this incident, but was never interviewed by staff for his complaint.

Mr. [redacted] medical records document that he was seen by nursing staff at LAC on June 29, 2018 for "right side rib pain" and "pain on the right mid back" after an "assault." His records further note that "he was assaulted by the custody 628/18 [sic]." On July 2, 2018, Mr. [redacted] was seen by mental health staff in his unit, who documented that he informed them that he wanted to cut himself "very much" and would do it the first chance he got. That same day, his clinician noted that he reported significant anxiety and expressed a restricted range of affect, which was congruent with his reported mood. On October 22, 2018, Mr. [redacted] received a mental health assessment (MHA) for an RVR for "resisting staff" from the incident, which found that his mental health did not play any role in his actions. We raised our concerns regarding

[5] Unless medical records, RVR documentation, or another source is indicated, the class member accounts described in this letter arise from reports from the class members themselves who contacted our office.

this assessment in our recent letter regarding the MHA process for disciplinary write-ups, noting that the assessor filled out the MHA form incorrectly and gave sparse, superficial responses. *See* Letter from Cara E. Trapani to Defs. Re: Plaintiffs' Concerns Regarding RVR Process ["RVR Letter"] at 9 (March 1, 2019).

[redacted] who was EOP at the time of this incident, reported an incident involving his refusal to take his court-ordered involuntary medication. After refusing his medication on October 5, 2018, he was taken to the medical building by Officers [redacted] and [redacted] in order to receive the medication as an injection. Once there, Mr. [redacted] reportedly told staff that he did not want to take any medications. Mr. [redacted] informed us that Officer [redacted] then slammed his head against the window and threw him—while handcuffed—to the ground. Officers [redacted] and [redacted] then repeatedly punched Mr. [redacted] in the face, splitting his lip open. The officers then held him face down on the ground while the nurse administered his shot. His medical records documented that he was then taken to the TTA, where he was treated for a "small laceration to the right lower lip" which he received after "an altercation." Another class member, [redacted] reported speaking to an individual (who we believe is Mr. [redacted] around the time of this incident and seeing injuries on that individual's face and mouth. After the incident, Mr. [redacted] was written up for the charge of "Resisting Staff." As in the case of Mr. [redacted] discussed *supra*, we cited the MHA that Mr. [redacted] received for his write-up in our March 1, 2019 RVR Letter, noting that the assessor did not adequately document the clinical rationale for his conclusions. *Id.* at 7-8.

Mr. [redacted] medical records document that on October 4, 2018, the day prior to the incident described above, his clinician noted that he "continues to present as mildly paranoid, [with] ongoing issues concerning custody" and that he reported ongoing command hallucinations directing him to hurt himself or others. These symptoms may have affected his behavior the next day. Later, on November 1, 2018, Mr. [redacted] informed his clinician, who documented it in a treatment note, that his "voices keep telling me that I must have enjoyed the abuse by my father because then why didn't I stop it. It really gets to me. The voices tell me something and I start responding back, then when an officer starts talking to me, I allow the voices to control me and I end up getting into trouble."

[redacted] (who was EOP and housed in D5-[redacted] at the time of this incident), reported that he was beaten up by staff during a cell extraction on June 3, 2018 in the midst of a mental health crisis. Mr. [redacted] reported that the incident ensued following his mental decompensation, which itself came to a head when he swallowed two razor blades and some unknown pills in a suicide attempt on May 27, 2018. That same day, he was admitted to Antelope Valley Hospital (AVH), where tests showed he

had foreign bodies in his stomach. Due to his suicidality, however, Mr. [redacted] refused treatment, so he was returned from the hospital the next day and placed in a holding cell. While in the holding cell, Mr. [redacted] requested that he be placed in the CTC and referred to the crisis bed. In response to his requests, Officer [redacted] came to Mr. [redacted] cell and reportedly told him "you wanted to commit suicide, this is what you get." On May 28, 2018, Mr. [redacted] was taken off of suicide watch by psychologist [redacted] and housed in cell D2-[redacted], even though he had reported suicidality during his appointment with Dr. [redacted] On May 29, 2018, Mr. [redacted] informed Officer [redacted] that he was still suicidal. Officer [redacted] placed him in a holding cell, where Mr. [redacted] then cut his wrist. Mr. [redacted] was referred to the CTC and had an IDTT on May 30; the IDTT discharged him back to EOP. Mr. [redacted] remained at the EOP level of care until June 2, 2018, when he swallowed 40 pills in front of Officers [redacted] and [redacted] and was sent back to the hospital. Mr. [redacted] returned from the hospital six hours later, and repeatedly told staff he was suicidal upon his return. On June 3, 2018, Mr. [redacted] was placed on suicide watch during third watch. When he entered the suicide watch cell, Mr. [redacted] put his mattress under the bunk and pulled the blanket over himself so he was covered from view in an attempt to avoid talking to anyone or be seen nearly naked. Officers [redacted] and [redacted] then told Mr. [redacted] he had to come out from under the bunk, to which he did not respond. The officers then entered the cell and performed a cell extraction and pulled Mr. [redacted] from underneath the bed. Once he was on the ground, Officer [redacted] slammed a shield on Mr. [redacted] head and body and then Officers [redacted] and [redacted] kicked, punched, and pepper-sprayed him repeatedly. Mr. [redacted] reported that the officers then dragged him naked out of his cell and into the yard. He was then placed into D5-[redacted], where he was allowed to decontaminate himself. On June 7, Mr. [redacted] filed a staff misconduct 602 about the incident, for which he received an interview by a D5 staff sergeant on June 21. During the interview, the sergeant strongly implied Mr. [redacted] would suffer retaliation if he continued with his 602. Mr. [redacted] was also written up for the incident (battery on a peace officer) on June 12, for which he was found guilty on July 20.

Mr. [redacted] records document that he went to AVH on May 27, 2018 after ingesting a foreign body, and was placed on suicide watch upon his return on May 28, 2018. That same day, Mr. [redacted] was discharged from suicide watch following a SRASHE by Dr. [redacted] On May 30, 2018, Mr. [redacted] again reported suicidality, made superficial scratches to his wrist, and reported that he had swallowed a razor, and was admitted to the MHCB that afternoon. Mr. [redacted] records show that he was discharged the next day to the CCCMS level of care. On June 2, 2018, he went out to AVH due to a drug overdose and was returned the next morning; from there he was placed into segregation. That night, a "First Medical Responder" note reads:

> 2326: The institutional alarm and radio call for a Mandown in D2 Building regarding I/P, but code 4.
>
> 2330: Arrived D2 Building via Mary 3 ambulance with medical emergency equipment and gurney escorted by custody, I/P received at the main entrance into D2 building seated on the floor with custody officers with him. Sgt. [redacted] states no issues for medical and that Mary 3 can leave.
>
> 2340: The watch command called Mary 3 back for 7219 form completion and MH7, stated I/P will be transferring to D5 building. On assing [sic] and evaluating I/P, now in D5 building in the holding tank, I/P noted with minor abrasion/scratch on the left side of the forehead and cut/laceration to the left hand. I/P stated, "I refused to respond to the officer's call and they jumped on me." I/P further states the O.C. spray in the cell room, had a scratch in the head and the left hand cut was from previous suicidal attempt from the other day. I/P verbalized suicidal thoughts and refused wound care, stated "I don't need that." I/P educated on infection risk and need for medical attention, I/P continue to refused stated "I have no issue."

Mr. [redacted] records document that he was not evaluated by mental health staff prior to his cell extraction on June 3, 2018.

Please provide us with a copy of the videotape taken of Mr. [redacted] June 3, 2018 cell extraction within 15 days.

[redacted] who was CCCMS at the time of this incident, reported that he was assaulted by multiple custody officers on B-Yard after an altercation with an officer during breakfast. Mr. [redacted] reported that on October 13, 2018, Officer [redacted] approached him during breakfast and told him to sit between two prisoners. Mr. [redacted] reported that, as he did not know the two prisoners, he refused the officer's request. When Mr. [redacted] walked outside the chow hall after finishing breakfast, the officer reportedly asked Mr. [redacted] "what's your issue?" to which Mr. [redacted] replied "I don't have an issue." The two then proceeded to argue. Officer [redacted] then reportedly asked "the next time I tell you to sit somewhere are you going to do it?" Mr. [redacted] said he would refuse if the order was unnecessary. Officer [redacted] then told Mr. [redacted] to turn around so that he could pat him down. Mr. [redacted] turned around and held his arms up, as the officer continued to admonish him for not following the order. Then another custody officer, Officer [redacted] appeared and told him to follow orders. Mr. [redacted] reported that at this point, his arms had grown tired and he put them down. Officer [redacted] then told Mr. [redacted] to put his arms back up. Mr. [redacted] said he could not because his arms

were tired, at which point Officers [redacted] and attacked him, followed by Officers [redacted] and [redacted] All of these officers hit, kicked, and stomped Mr. [redacted] while he was on the ground, breaking his leg, ribs, and scarring his head and face. Mr. [redacted] medical records document that he suffered right rib fractures to his eighth, ninth, and tenth ribs, as well as a fracture to his right fibula.

Over the next few weeks, Mr. [redacted] quickly decompensated, expressing increasing paranoia and anxiety about custody staff to his clinician. On October 24, 2018, his clinician noted that he was "ruminating over how he was 'set up' by custody" and reported feeling "stressed out" due to the recent altercation. Mr. [redacted] refused his next few mental health contacts, but he was seen by his clinician on November 21, 2018, the clinician noted that he "appears paranoid and ruminates excessively over his perceived conspiracies between medical and custody, difficult to redirect, TC paranoid. *Appears to be slowly decompensating over the past month, evidenced by his changes in presentation and TC*." (emphasis added).[6] Mr. [redacted] clinician noted the same troubling symptoms a week later. On November 29, 2018, his treatment team raised his level of care to EOP during an emergency IDTT.

[redacted] who was at the EOP level of care at the time of this incident, reported that he arrived at LAC on November 8, 2018 and immediately experienced problems with getting ducats for his mental health groups. Mr. [redacted] records show that he reported this issue to his clinician as early as November 27, 2018, and then reported it again on December 4, 2018. On December 5, 2018 Mr. [redacted] told his clinician, Dr. [redacted] that he might decompensate from being locked in his cell all day when Dr. [redacted] walked by his cell. Mr. [redacted] mental health records document that he informed his clinician during that contact that "he was not getting called out for groups" and that "being locked up all day is detrimental to his mental health." Later that day, Mr. [redacted] received another contact from his clinician. Midway through the encounter with Dr. [redacted] another clinician, Dr. [redacted] and Sergeant [redacted] came into the room while Mr. [redacted] was in the midst of telling his clinician that he might need a higher level of care. Mr. [redacted] reported Dr. [redacted] whispered something to Sergeant [redacted] who then cuffed Mr. [redacted] up and took him out of the appointment. Dr. [redacted] progress note from the encounter records that Mr. [redacted] had an "agitated presentation" during the appointment and that "[a]fter some attempt to deescalate IP, the contact was terminated" and "the IP was escorted out of the interview." Mr. [redacted] reported that Sergeant [redacted] took him to the gym where a number of officers, including Officers [redacted] and [redacted] beat him up. Mr. [redacted] reported asking the officers why they were doing this and whether it was due to his complaints

[6] We are unfamiliar with the meaning of "TC" in this treatment note.

about treatment. Sergeant [redacted] reportedly replied "yeah, welcome to Lancaster." Mr. [redacted] reported that he received a write-up for battery on a peace officer on December 12, 2018. The RVR claimed that force was required because Mr. [redacted] refused to go back to his cell after his appointment. Dr. [redacted] later conducted the MHA for this write-up. Dr. [redacted] claimed that Mr. [redacted] was interviewed for the assessment, even though Mr. [redacted] refused to talk to him.[7]

Three days after the incident, Mr. [redacted] filed a 7362 in which he wrote that he "was involved in a[n] excessive force incident that caused intensive pain in back and shoulder from being kicked and arms bent in opposite direction of bone joint." The same day, he filed another 7362, in which he wrote that he would "appreciate talking to someone about current mental health status particularly about decompensation and fear of interacting with officers on 'D' Yard." Two days later, Mr. [redacted] received an initial assessment from his new clinician, who recorded that he had "challenges with depression, anxiety, anger, and agitation …. due to a recent conflict with custody and recent housing change to Ad-Seg." The next day, his clinician again noted that Mr. [redacted] "has been ruminating about recent RVR and interactions with MH staff and custody."

[redacted] reported that when he was housed in C5 at the EOP level of care, he saw another EOP class member in that housing unit get assaulted by custody officers after reporting safety concerns. Specifically, Mr. [redacted] told us that on July 7, 2018 he heard the other class member's report from inside his cell to C5 Officers [redacted] and [redacted] that he was afraid he would be jumped by other prisoners if he left his cell. Mr. [redacted] reported seeing the officers ignore the other class member's concerns, to which the class member responded by starting to call for assistance from inside his cell. Mr. [redacted] then saw Officer [redacted] open the other class member's cell, grab him by the throat, and throw him against a locker. According to Mr. [redacted] Officer [redacted] then briefly left the class member's cell, only to re-enter it with Officer [redacted] at which point they both proceeded to repeatedly punch and kick the class member while he was on the ground. [redacted] and [redacted] who were housed in C5 at the EOP level of care at the time, also reported witnessing this incident.

[redacted] a different EOP class member housed in C5, also reported a troubling use of force incident involving Officer [redacted] Specifically, Mr. [redacted] reported that after he was found with heroin inside his cell on August 24, 2018, he was grabbed by Officer [redacted] slammed into the ground of his cell, cuffed up, then hit on

[7] We note that Dr. [redacted] is the same clinician who conducted the deficient MHA for Mr. [redacted] write-up, *supra*.

the head with a baton by Officer [redacted] Mr. [redacted] was then escorted to the C-Yard gym by Officers [redacted] and [redacted] While being escorted, Mr. [redacted] heard a voice on the loudspeaker say "staff assault." Mr. [redacted] reported that he then stated, "wow you all beat me up then charge me? Wow you guys are bitches." In response, he reported that Officer [redacted] grabbed him by the neck and slammed him down in the middle of the yard in full view of other officers and prisoners. Mr. [redacted] medical records document that he suffered from right shoulder pain and lacerations to his face and scalp from this incident.

After this altercation, Mr. [redacted] was placed into segregation, where his clinician noted the effect that the incident had on Mr. [redacted] mental health. In her initial assessment following his segregation placement, Mr. [redacted] clinician documented that he "states that he is depressed, has a lot of negative thoughts about the situation, has lost interest in food, can't sleep and was prescribed Remeron and Vistaril by the doctor, can't concentrate enough even to read a book."[8]

Reports of staff misconduct against class members are not limited to EOP units. For instance, [redacted] reported that on September 19, 2018 at around 7:00 a.m. ASU second watch Officers [redacted] and [redacted] approached his cell and told him that transportation officers were on their way to pick him up from LAC to transfer him to SATF. Mr. [redacted] informed the officers that he refused to transfer until staff responded to his pending property and medical appeals. For the next hour, Officers [redacted] and [redacted] each reportedly threatened Mr. [redacted] with physical harm if he continued to refuse to leave his cell to transfer. They all told him they were members of the "Green Wall" gang and would give him a "special treatment" inside his cell (i.e., circumvent the cell extraction procedures) if he continued to refuse to move. At around 8:00 a.m., the officers returned to Mr. [redacted] cell and told him they would harm him if he continued to refuse to move. Officer [redacted] then announced over the radio the unresponsive inmate code and Mr. [redacted] cell was opened by the control officer, Officer [redacted] Officers [redacted] and [redacted] then rushed into his cell and beat and sexually assaulted him (details discussed, *infra*). Mr. [redacted] records do not reflect that he received an assessment from mental health staff prior to this cell extraction.

[8] We note that Officer [redacted] was named in the complaints of Mr. [redacted] and Mr. [redacted] discussed in Section 2, *infra*, as well as in the *Armstrong* Plaintiffs' December 2018 LAC Monitoring Report, *see* Ex. B at 2. We discuss an additional group complaint involving Officer [redacted] in Section 4, *infra*.

Mr. [redacted] reported that during the extraction he was pushed to the ground and then punched and kicked by the officers while they made racially degrading remarks towards him. Officers cuffed Mr. [redacted] arms behind his back and he heard one officer say, "We have to do a body cavity contraband check." Officers [redacted] and [redacted] then tore off Mr. [redacted] clothes, and then while he was held down on his stomach Officer [redacted] forcefully penetrated Mr. [redacted] rectum with a hard foreign object (possibly a stick baton). Mr. [redacted] was then turned over onto his front and subjected to further sexually degrading actions, as Officers [redacted] used his stick baton to move Mr. [redacted] genitals around while reportedly making sarcastic degrading statements. After the assault, Mr. [redacted] was transferred to SATF, where he was placed on a 5-day follow-up due to his distress from the incident. Mr. [redacted] also filed a staff misconduct appeal and PREA complaint about the incident, for which he was interviewed on October 5, 2018. After the interview, administrators at SATF did not forward that appeal to LAC staff for review, but instead had their ISU staff interview Mr. [redacted] for his appeal.

Other class members reported that staff at LAC threatened them with force for minor infractions, such as refusal to comply with an order or accept assigned housing. [redacted] reported that he arrived to LAC from MCSP at around 2:30 p.m. on Friday, November 30, 2018. Mr. [redacted] was at the EOP level of care at the time. Mr. [redacted] reported that when he arrived at LAC, he told custody staff that he would not cell up with anyone due to his paranoia and history of in-cell fights. He was then placed into a holding cell. Within two minutes of being placed into the holding cell, Sergeant [redacted] arrived and asked Mr. [redacted] why he was refusing to house. After Mr. [redacted] reiterated he did not want a cellmate, Sergeant [redacted] reportedly said, "You're giving me a battery, you're not going to Ad-Seg without one!" Mr. [redacted] was then evaluated by a nurse in the holding cage. During the evaluation, Lieutenant A. [redacted] arrived and moved Mr. [redacted] to the back of R&R to a holding cage. During the transport, Lieutenant A. [redacted] reportedly said "this guy's going to get his ass beat!" Once in the holding cage, the Lieutenant again told Mr. [redacted] "you're giving us a battery." Mr. [redacted] responded "I don't have to prove anything to you, so go ahead and beat me up." The Lieutenant reportedly replied "you're not going to have a mark on you, but you're giving me a battery ... you're gonna give me a battery, I'm gonna bash my head on this cage or better yet I'll have one of my officers come punch me in the face. Who do you think they're gonna believe – a lieutenant with 25 years or some punk convict, wait you're not even a convict, a punk inmate! I'll make sure you spend the rest of your life in here." Mr. [redacted] did not clarify in his report to us what happened immediately after this exchange. Ultimately, it appears Mr. [redacted] was placed into

segregation, where he remained until he was moved to a different cell on D-Yard a few days later.

[redacted] a CCCMS class member at the time of this incident, also reported that excessive force was used against him when he refused to accept assigned housing. He informed us that staff used force on him after he refused to accept a cellmate on December 7, 2018, shortly after arriving at LAC.[9] During his PREA screening, Mr. [redacted] informed the Inmate Housing Assignment sergeant and lieutenant that he had mental health issues, suffered from trauma from sexual harassment, and that as a result he required a single cell. The sergeant reportedly told Mr. [redacted] that he would be housed by himself. However, Mr. [redacted] was then taken to a cell occupied by another individual who was a known gang member. Mr. [redacted] refused to enter this cell. Upon hearing his refusal, B-Yard Sergeants [redacted] and [redacted] reportedly told Mr. [redacted] that if he wanted to be housed by himself then he needed to kill his cellmate. Mr. [redacted] was then handcuffed and officers attempted to force him into the cell. Because he continued to refuse to enter the cell, the officers slammed Mr. [redacted] to the ground while handcuffed and then kneed him in the back. He was then taken to segregation with a charge of battery on staff. That night, Mr. [redacted] reported the incident to Lieutenant [redacted], the commanding officer on shift. On December 9, 2018, Mr. [redacted] also reported this incident to LAC's warden. On December 13, 2018, Associate Warden [redacted] wrote to inform Mr. [redacted] that his statements were being reviewed regarding the use of force incident. Mr. [redacted] recently reported that he has yet to receive a final response to his appeal.

We reviewed Mr. [redacted] treatment files. From his clinician's notes, the incident appears to have had a significant effect on his mental health. Five days after the incident, Mr. [redacted] was seen by his psychiatrist, who noted that he reported a "long trauma history," that he was struggling with a recent death in his family, that he was "readily tearful during [the] exam," and that he recently had a "battery on an officer bc he had safety concerns about who he was supposed to be cell with." His psychiatrist emphasized that "[g]iven his tearfulness and marked dysphoria in affect he was thoroughly screened for suicidality." Despite this documentation of his presentation, the RVR MHA stemming from the incident, received six days later, inexplicably found that "I/P appears well adjusted and would not destabilize as the result of assessing penalties." This finding was directly belied by Mr. [redacted] treatment team's decision only eight days later to raise his level of care to EOP. Over the ensuing weeks, the use of force incident and its aftermath continued to weigh heavily on Mr. [redacted] Forty days after the incident, Mr.

[9] Plaintiffs' counsel in *Armstrong* raised concerns regarding LAC's problematic Single-Celling Status LOP in their December 2018 *Armstrong* Report. *See* Ex. B at 7.

[redacted] told his clinician, "I ain't good. I got no sleep since Tuesday maybe one hour. I can still replay the incident in my head and that bothers. I have a fear of becoming desensitized."

As these incidents document, the use of force on class members with serious mental illnesses can have serious decompensatory effects. The fact that LAC custody staff not only use force against prisoners with mental illnesses, but use it at far higher rates as compared to prisoners without mental illnesses is especially concerning.

2. Custodial Indifference to Urgent Medical and Mental Health Needs Including Reports of Suicidal Ideation and Suicide Attempts

In addition to suffering the physical abuses described above, class members also report that custody staff ignore their requests for assistance during medical and mental health emergencies, or otherwise demean them after suicide attempts.

[redacted] reported that he attempted suicide sometime in early March 2019 by hanging in his cell (D5-[redacted] early in the morning. He was at the EOP level of care at this time. Officers discovered him, cut him down, and placed him onto his stomach with a shield over him. Because he was on his stomach, Mr. [redacted] could not tell who the officers were, although he stated that they were the first watch D5 staff. While Mr. [redacted] was on the ground, one of the officers reportedly threatened him "don't say anything [to nursing staff]. We will talk to them." When nursing staff arrived, they asked the custody staff whether Mr. [redacted] was found hanging, to which the officers replied "No" and claimed that he had been found unresponsive on the floor of his cell. Mr. [redacted] was then taken to the CTC. During a brief period of the transport during which he was unsupervised by officers, Mr. [redacted] took the opportunity to tell nursing staff that he was suicidal. He was then returned to his cell and placed on suicide watch in D5. The next morning, Mr. [redacted] informed the assessing clinician, Ms. [redacted] that he was suicidal. She reportedly asked him, "Do you have a desire to die right now?" He replied "yes." However, Ms. [redacted] decided to clear him anyway and Mr. [redacted] was returned to his cell. Mr. [redacted] informed us that he has been continually suicidal since this incident, but that he feels lethargic and lacks energy due to his depression. Mr. [redacted] has been housed in C-section of D5 as punishment since then, which he said is where officers house problematic ASU Hub patients—those who act out or "go suicidal"—because that area lacks heating and is not cleaned by officers.

[redacted] (an EOP patient housed in C5 at the time of this incident), reported witnessing an unidentified prisoner attempt suicide on September 12, 2018 by jumping off of the second tier in C5. The prisoner was housed in C5-[redacted] at the

time; Mr. [redacted] was housed in C5-[redacted] Mr. [redacted] reported that he was in his cell, and witnessed the prisoner walk up the stairs and jump off the tier. He reported that officers [redacted] [redacted] and [redacted] then walked over to the suicidal prisoner. Officer [redacted] told the prisoner to lay down, but Officer [redacted] told him to get up, and then picked him up. Officer [redacted] was also reportedly saying things like "get your bitch ass up, you wanna die, well we'll kill your fucken ass, get your fucking ass up." Mr. [redacted] saw that Officer [redacted] was holding the prisoner by the throat and that he pushed him backwards into a holding cage. After he placed the prisoner into the cage, Officer [redacted] started joking about the suicide attempt, saying things like "this motherfucker thought he could fly." Twenty minutes later, nursing staff arrived and attended to the prisoner, and then returned him to the holding cage. Shortly afterwards, the unidentified prisoner asked Officer [redacted] for his dinner tray, to which Officer [redacted] reportedly replied "I thought you wanted to kill yourself, now you wanna eat, no, you can't have shit." Mr. [redacted] estimated that the prisoner stayed in the holding cage for another twenty minutes before being taken out to a crisis bed. Mr. [redacted] reported that this incident was investigated by an outside office, who interviewed him and the unidentified prisoner. He added that the prisoner was sent something to sign for this investigation. Mr. [redacted] reported that when the unidentified prisoner showed the document to the officers, they threatened him if he pursued it, so the prisoner decided not to pursue the complaint. Unlike the unidentified prisoner, Mr. [redacted] decided to report the incident. But since then, Mr. [redacted] has had his cell searched multiple times by officers in what appears to be retaliation. Another prisoner, who did not want his name to be used in this letter out of fear of retaliation, reported to us that he had also witnessed this incident, and told us that "[t]he 3rd watch C/Os ruffed him up Bad, as if he was resisting. But the inmate wasn't combative, or anything. He wanted to die."

[redacted] reported that on October 12, 2018, he told staff on first watch in his unit (C5) that he was suicidal, but they refused to help him or contact mental health staff. He was EOP at the time. Later that night, Mr. [redacted] told multiple officers on first watch, including Officer [redacted] [redacted] that he was suicidal and showed them his arm, which was bleeding profusely from a cut he made. He was refused help again. Mr. [redacted] was kept in his cell until second watch, when he was taken to see mental health staff. Following this experience, Mr. [redacted] filed a 602 appeal, which found that staff had not violated policy.

Other class members reported that custody staff actively discouraged them from going to a crisis bed because they did not want to deal with the paperwork involved. For instance, [redacted] reported that D4 second watch Officer [redacted] told him in late October 2018 that if he "went suicidal" and was admitted to a crisis bed, all of his property would be "lost" or that he would be "jumped" upon his return. Mr. [redacted] was

at the EOP level of care at that time. Mr. [redacted] reported that this threat made him afraid to ask mental health staff for assistance or share any information with staff that might lead to his placement into a crisis bed. Another class member who did not give us permission to use his name out of fear of retaliation reported that it is "impossible" to get help if you are feeling suicidal during third watch in C5, and that if you do report suicidality, you run the risk of getting assaulted by staff or having your cell searched and property confiscated in retribution. [redacted] likewise reported that when he was at the EOP level of care and housed in C5, third watch Officers [redacted] and [redacted] actively discourage EOP patients from reporting suicidality, as they do not want to have to complete the paperwork associated with suicide watch.

C5 custody staff's failure to assist class members in the throes of suicidal ideation likely contributed to the recent suicide death of EOP class member [redacted], in C5 on October 14, 2018. Two class members, neither of whom gave permission for us to share their names due to fears of retaliation, reported that second watch officers in C5 ignored Mr. [redacted] requests for assistance that afternoon. One class member reported that Mr. [redacted] told Officer [redacted] on second watch that he was feeling suicidal, to which the officer responded "wait until third watch." Another class member similarly reported that Officer [redacted] ignored Mr. [redacted] requests for assistance. Mr. [redacted] was found hanging in his cell later that day by third watch.

Still other class members reported an overarching custody-dominated culture that deters patients from opening up to their clinicians about their mental health symptoms. For example, Mr. [redacted] reported seeing nurses show their computers to custody officers. Whether true or not, this sends a message to class members that anything they tell nurses or their clinician may be inappropriately relayed to custody staff. Another patient who requested to remain anonymous for fear of retaliation told us that his mental health clinician in the ASU EOP Hub divulged confidential information he had shared in a 1-on-1 to custody staff. [redacted] reported similar concerns about seeing mental health staff sharing information with custody staff.

We are seriously troubled by these reports, which indicate that custody staff not only ignore class members' requests for urgent attention but also actively discourage and belittle these requests. These actions by staff only serve to create a demeaning and traumatizing environment for *Coleman* class members, which appears to permeate through all of the EOP units at LAC.

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3. Racially Targeted Discrimination and Harassment of African-American Prisoners

We have also received multiple troubling complaints from African-American class members who state they were subjected to repeated demeaning abuse from custody staff—most often Hispanic officers—at LAC, particularly in the D5 ASU EOP Hub. In our June 5, 2018 letter, we raised two similar incidents. *See* Ex. A at 3-6. In one report, [redacted] stated that he was called a "stupid nigger" by D5 second watch Officer [redacted] who pepper-sprayed him during a suicide attempt. Mr. [redacted] was in the EOP program at the time. Another EOP patient, [redacted] stated that C5 [redacted] called him a "nigger" on February 28, 2018 while he was housed in that unit. These reports were dismissed by Defendants in their response to our letter, who reported that both Mr. [redacted] and Mr. [redacted] had withdrawn the allegations that they made in 602 appeals regarding their reports.

That both Mr. [redacted] and Mr. [redacted] withdrew their reports is unsurprising, as we have received multiple reports from class members about the extensive retaliation class members experience when they file staff misconduct complaints.

For instance, [redacted] reported that on December 7, 2018 he handed Lieutenant [redacted] a group 602 about racial discrimination that prisoners in D5 have faced from officers. Mr. [redacted] was at the EOP level of care at this time. The group 602, which was signed by six other prisoners, is enclosed hereto as **Exhibit C**.[10] In the 602, Mr. [redacted] claims that Sergeant [redacted] and Officers [redacted] and [redacted] (D5 second watch), along with Officers [redacted] and [redacted] (D5 third watch) subject African-American prisoners in D5 to racist slurs, calling them "niggers, monkeys, and coons, along with several other dorogatory [sic] racist comments." In his letters to our office, Mr. [redacted] has also reported that Sergeant [redacted] refers to African-American prisoners as "you people," "your kind," and makes comments like "I thought you were one of the good ones."

Instead of turning in Mr. [redacted] group 602, Lieutenant [redacted] held it for two days. Mr. [redacted] reported to us that on December 9, 2018, Lieutenant [redacted] and Officer [redacted] brought him into the sergeant's office and tried to intimidate him into dropping the appeal. Lieutenant [redacted] told him "if you want to turn this 602 in I will but just know this I'm going to label you a snitch and to sabotage this 602 I'm going to have my black officer start fucking with you…. I want you to know that for one it's going

[10] We have redacted the names of the other prisoners in this 602 as they have not given us permission to disclose their names in this letter.

to get rejected because I got pull like that, for two I'm going to make sure all my staff put you on the shit list, and for three I'm going to be pissed." Officer [redacted] then brought Mr. [redacted] back to his cell and told him during the escort "prison is like Vegas what goes on in prison stays in prison nobody that doesn't work in prison needs to know what goes on in here especially D5 [LAC's EOP ASU Hub]." The appeal was ultimately turned in on December 13, 2018 (after the D5 Officers had all read it), and since then Mr. [redacted] has been subjected to repeated reprisals from officers:

- On December 16, 2018, Sergeant [redacted] came to Mr. [redacted] cell door while he was sleeping, kicked it loudly, called him a snitch, and told him that "when the time is right you will be getting fucked up for filing that 602 with my name on it."

- That same day, Officer [redacted] came to Mr. [redacted] door and told him he was on the "shit list" for writing the 602 and that he would "get what was coming to him," and that other officers had cell extracted Mr. [redacted] (discussed, *supra*) as retaliation for signing the group 602 about racial discrimination.

- On Monday, December 17, 2018, Sergeant [redacted] told Mr. [redacted] "I know it's your dead mother's birthday – fuck that bitch's grave."

- Sergeant [redacted] also told Mr. [redacted] that he would "work hard on Dr. [redacted] [the EOP D5 Supervisor] to get her to CCC you," i.e., drop his level of care from EOP to CCCMS.

- On December 18, 2018, Officer [redacted] made loud monkey noises and said the word "nigga" as Mr. [redacted] was escorted down the stairs for groups.

- On December 21, 2018, Officer [redacted] conducted a cell search of Mr. [redacted] cell, leaving his cell "trashed and disorganized" with two pictures of his mother ripped on the floor. Shortly after Mr. [redacted] arrived back at his cell, Officer [redacted] came to his cell-front and told him "you need to quit writing bullshit 602s on my co-workers and stop causing issues for us or else things are going to get worse for you." The cell search slip for this incident is enclosed hereto as **Exhibit D**.

- On December 26, 2018, Mr. [redacted] reported the cell search incident through a 602 form.

- That same day, Officer [redacted] threatened to kill Mr. [redacted] when he "least expected it" for writing the 602 about racial discrimination.

- On December 30, 2018, Sergeant [redacted] told Mr. [redacted] that when he came out of his cell he was going to "kill him."

- On December 31, 2018, Sergeant [redacted] told Mr. [redacted] that he would talk to Dr. [redacted] about taking him off of EOP, because Mr. [redacted] "didn't fit the criteria in [Sergeant [redacted] eyes."

- On January 2, 2019, Officer [redacted] slammed a door blocker in front of Mr. [redacted] cell and stated to him "this is to make sure you don't fish any food, since you're on a hunger strike, I'm going to make sure you starve to death you fat nigger."[11]

- On January 2, 2019, Officer [redacted] kicked his door open at around 12:30 p.m. during group release and stated "wake your bitch ass up."

- On January 3, 2019, Officer [redacted] walked by his door and kicked it, stating "wake up no sleep for snitches."

- On January 7, 2019, he said that Lieutenant [redacted] came to his door [he was still on a hunger strike at the time] and said, "Come on [redacted] I know your big ass is hungry… do you really think we're taking this hunger strike serious?"

- That same day, Officer [redacted] walked by his cell during medication pass and stated "your door blocker looks like a dead body in front of it. If you come out to yard this morning it's going to be yours."

- Later that day, Officer [redacted] and other officers conducted a cell extraction on Cell [redacted] in D5 (the EOP ASU Hub) and beat up the class member in that cell, dragging him down the stairs and cuffing him to a wheelchair. Following the incident, Officer [redacted] looked at Mr. [redacted] cell and stated, "If you come out of your cell, you're next."

[11] Mr. [redacted] reported that he went on a hunger strike on December 24, 2018 to protest the abuse that guards subjected him to in the D5 Unit.

- On January 16, 2019, Sergeant [redacted] called Mr. [redacted] a "fat black nigger." That same day, his cell was searched again and Mr. [redacted] was extracted to another cell without his property – only his t-shirt and boxers. Mr. [redacted] reported that staff used pepper spray on him during the cell extraction, and did not allow him to fully rinse-off afterwards. Specifically, Mr. [redacted] was placed into a cell without a working sink or toilet after the extraction, prohibiting him from rinsing off the pepper spray, and left there. The cell was in the C-Section of D5, where Mr. [redacted] reported officers place patients that they do not like, as the section is not cleaned or heated.

- On January 17, 2019, Sergeant [redacted] walked by his cell, kicked his door, and stated "you bitch ass is stuck in that shitty ass cell till you leave fuck you you fat piece of trash."

- On January 23, 2019, while Mr. [redacted] was on the way back from his shower, Sergeant [redacted] grabbed his butt and told him "since you play with shit, I want to play with your shit." Mr. [redacted] filed a PREA complaint about this the next day.

- On January 24, 2019, Officer [redacted] walked by his cell, kicked it, and stated "you know you done fucked up by now by lying on my sergeant with that sexual harassment bullshit."

- That same day, Officer [redacted] searched his cell during groups and took away his copy of the PREA complaint.

- On January 26, 2019, Sergeant [redacted] told Mr. [redacted] "when I grabbed your ass yesterday that made my dick hard keep it wet and moist for me baby."

Mr. [redacted] reported that this abuse has caused him to become suicidal and repeatedly consider harming himself, and that he repeatedly refused his mental health contacts because he was afraid to leave his cell. Mr. [redacted] records document that he first reported being harassed by officers in the EOP ASU Hub building to his clinician on December 19, 2018. On December 21, 2018, he was urgently seen by his clinician after reporting distress arising from "negative interactions with custody and torn pictures of his decease[d] mother found in his cell following a cell search." Mr. [redacted] told his clinician that "his cell was searched by Officer [redacted] and two pictures of his mother were ripped." In the treatment note, Mr. [redacted] clinician documented that he "was visibly distraught by the idea that [Officer [redacted] would tear up pictures of his mother whose birthday had just passed and whose death anniversary is approaching. I/P was tearful and

trying to compose himself while relaying what happened." Mr. [redacted] mental health records document that on December 26, 2018, he boarded up in the LAC D5 Mental Health building bathroom because he was "afraid for his life" due to custody officers in his unit, and had to be talked down so that controlled force would not be used. Mr. [redacted] records document that he continued to report distressing encounters with staff up until his transfer to CSP – Sacramento on February 20, 2019.

We have also received concerning reports from other class members in the D5 ASU EOP Hub about racially targeted abuse. For instance, [redacted] reported that Officers [redacted] and [redacted] repeatedly demeaned him with racial epithets while he was housed in the D5 ASU EOP Hub and refused his requests for urgent mental health care.

Another class member who requested to remain anonymous reported that Hispanic custody staff on B-Yard second watch, including Sergeant [redacted] and Lieutenant [redacted] specifically assault and harass African-American prisoners, causing many of them to stay in their cells to avoid being targeted. This results in class members missing out on mental health treatment, the bulk of which is scheduled to occur during second watch. [redacted] a CCCMS class member, similarly stated that Hispanic officers on C-Yard target African-American individuals. Mr. [redacted] reported that no African-Americans have porter jobs on second watch due to this discrimination. He also reported that the majority of patients are reluctant to file 602s out of fear of retaliation, including receiving false RVRs.

4. Retaliation for Participation in the Appeals Process or Letters to Supervisory Staff

Many of the cases detailed above describe instances of retaliation against class members after they spoke out against staff abuse. *See, e.g.*, reports of Mr. [redacted] Mr. [redacted] and Mr. [redacted] *supra*. Most troubling is the report from Mr. [redacted] who reported no less than twenty-two detailed instances of harassment in retaliation for a 602 complaint he filed. In other reports, such as that of Mr. [redacted] class members reported that they were assaulted by staff because they had engaged in the appeals process.

Class members also reported experiencing retaliation for writing letters to supervisory staff at LAC. In particular, we received reports from three different class members that they were retaliated against for signing a petition to the C-Yard Captain to have a C5 second watch Officer, [redacted] reassigned to another unit in September

2018.[12] This petition, enclosed hereto as **Exhibit E**, was signed by approximately 63 prisoners in the C5 Unit and asked that Officer [redacted] be assigned to another unit due to his abusive behavior, which allegedly includes assaulting suicidal individuals and charging them with false write-ups. Ex. E at 1. We have redacted the names of all of the prisoners but the few who gave us permission to write about their involvement in the petition in this letter.

The principal signatory of the petition, EOP class member [redacted] reported that after filing the petition against Officer [redacted] on September 16, 2018, he was placed into segregation on October 20, 2018 after "false confidential information from [redacted] inmate workers" was provided to staff alleging that he was planning to have other prisoners murder Officer [redacted] Mr. [redacted] records document that he informed his ASU EOP Hub clinician that he was "placed in EOP ASU HUB after ISU came to inform him that they were in receipt of an anonymous letter alleging conspiracy to commit murder on an officer" and that "the officer he was allegedly conspiring to murder was an officer he wrote a staff complaint about with regard to a false RVR and the officer setting up inmate fights." In segregation, Mr. [redacted] decompensated, reporting suicidal ideation with a plan on November 28, 2018. After he was found guilty of the allegedly false RVR in early March 2019, his records document that he felt he "has nothing to live for" and that he "created a rope and hid it in his vent." Following this decompensation, Mr. [redacted] was referred to and placed in a crisis bed. He is now in the CHCF PIP.

Another EOP class member who signed the petition, [redacted] reported that he was assaulted by another prisoner on November 4, 2018, who told him during the attack that "this is for Officer [redacted] The other prisoner reportedly punched Mr. [redacted] in the back of the head and then repeatedly kicked him while he was on the ground until other prisoners pulled him off. During the attack, Mr. [redacted] lost consciousness and suffered from deep lacerations to his forehead and face along with a severe concussion. Mr. [redacted] records document that he suffered severe injuries following the assault, which necessitated his placement on a medical lay-in for the following week. Mr. [redacted] reported that Officer [redacted] provided his attacker with information about Mr. [redacted] underlying criminal conviction from his C-File in order to encourage the other prisoner to attack Mr. [redacted] Mr. [redacted] also reported that multiple other prisoners who signed the petition where retaliated against or forced into segregation by Officer [redacted]

[12] As noted in Sections 1 and 2, *supra*, Officer [redacted] was named in numerous other class member complaints. *See also* fn. 8, *supra*.

The attack on Mr. [redacted] appears to have had a severe impact on his mental health. His records reflect that on November 14, 2018, Mr. [redacted] told his clinician that he feels "anxious every time he goes to chow since he was attacked coming back from chow." His clinician noted he "reports lack of sleep and crying spells as well as 'bad dreams'…. [and] was educated regarding PTSD and his symptoms." When seen by his clinician on D-Yard recently, it was clear that the assault and Officer [redacted] role in it continues to weigh heavily on Mr. [redacted] During this contact on March 25, 2019, Mr. [redacted] "reported anxiety because the officer he feels is behind his assault came into D1 recently." His clinician noted that he "continues to talk about the CO on C yard that [he] feels is behind [his] assault and is fixated on that topic. [He] is sometimes difficult to re-direct."

Another EOP class member who signed the petition complaining about Officer [redacted] harassment, [redacted] reported that the day after he signed the petition, his cell was searched by officers. Over the next few weeks, Officer [redacted] repeatedly refused to let Mr. [redacted] out for yard and pod time, and made snide remarks to the effect that Mr. [redacted] had "gone against him." Mr. [redacted] also reported that multiple other prisoners were retaliated against for signing the petition against Officer [redacted]

Other class members also reported retaliation for speaking out against Officer [redacted] For instance, on July 8, 2018, EOP class member [redacted] sent a letter to the LAC Warden and C-Yard Captain raising his concerns about Officer [redacted] behavior. In his letter, Mr. [redacted] added that Officer [redacted] has repeatedly engaged in retaliatory behavior against EOP class members. This letter, which was also sent to our office, is enclosed hereto as **Exhibit F**. The letter reports, *inter alia*, that Officer [redacted] assaulted a an EOP class member "[redacted] housed in cell C5-[redacted], on July 5, 2018 after Mr. [redacted] reported mental distress, auditory hallucinations, and safety concerns on the C5 Unit. Ex. F at 2. Following his July 8 letter to LAC supervisory staff, Mr. [redacted] was assaulted twice by other prisoners, on July 18 and 20, 2018. After suffering these assaults, Mr. [redacted] heard Officer [redacted] tell the other prisoners "thank you" and "good job" in reference to their attacks on Mr. [redacted]

We were especially concerned to hear about this extensive retaliation given the sheer number of class members who signed the petition against Officer [redacted] Did the Warden or C-Yard Captain investigate class members' complaints against Officer [redacted] in response to this petition? If so, what was the nature of this investigation and what were the findings? We also have numerous questions about Officer [redacted] including:

- How many staff misconduct appeals have been filed against Officer [redacted] in the last twelve months? How many of these led to findings of officer misconduct?

- How many documented use of force incidents has Officer [redacted] been involved in in the previous twelve months? How many of these incidents were immediate rather than controlled incidents?

- Has Officer [redacted] been subjected to any CDCR-989 inquiries in the last twelve months? If so, what were the findings?

5. Conclusion

We are immensely troubled by the numerous use of force and staff misconduct allegations by class members at LAC. Over the past year and a half, we have repeatedly raised such concerns, only to be rebuffed by a staff misconduct investigation system that, in the view of the Inspector General Wesley, serves only to exonerate staff. We request that Defendants develop and implement plans to address the pervasive staff misconduct at LAC, including instituting on-site supervision, oversight, and investigation by Headquarters' personnel and investigators from outside of LAC.

We await your responses to these important concerns.

Sincerely,

ROSEN BIEN
GALVAN & GRUNFELD LLP

/s/ Thomas Nolan

By: Thomas Nolan
Of Counsel

TN:CET:DVC
Encl.: Exhibits
cc: *Coleman* Co-Counsel
Coleman Special Master Team
Jay Russell
Elise Thorne
Adriano Hrvatin
Tyler Heath
Tobias Snyder
Ian Ellis
Katherine Tebrock
Amy Eargle
Angela Ponciano
Michael Golding
Brittany Brizendine
Laura Ceballos

Exhibit H

OFFICE OF LEGAL AFFAIRS
Jennifer Neill
General Counsel
P.O. Box 942883
Sacramento, CA 94283-0001

January 15, 2020

Thomas Nolan
Rosen, Bien, Galvan & Grunfeld, LLP
101 Mission Street, Sixth Floor
San Francisco, CA 94105-1738
Via e-mail: TNolan@rbgg.com

Re: *Coleman* Plaintiffs' April 10, 2019 letter "Plaintiffs' Renewed Concerns about Excessive use of Force and Staff Misconduct Incidents at LAC"

Dear Mr. Nolan:

The California Department of Corrections and Rehabilitation (CDCR) writes in response to the April 10, 2019, letter from *Coleman* plaintiffs entitled, "*Coleman v. Newsom*: Plaintiffs' Renewed Concerns About Excessive Use of Force and Staff Misconduct Incidents at LAC." Shortly after receipt of this letter, the CDCR Office of Legal Affairs (OLA) identified those portions of the letter involving issues of mental health care at California State Prison, Lancaster (LAC) and those portions of the letter involving allegations of staff misconduct (primarily by custody staff). Those portions of the letter involving allegations of staff misconduct were referred via the Associate Director to the Warden and to Office of Internal Affairs for further review. OLA attorney Alan Sobel has been working with former Associate Director Alfaro, current Acting Associate Director Lozano, the institution, and the Office of Internal Affairs on addressing the staff misconduct allegations. The following is a response to the portions of plaintiffs' letter involving *Coleman* issues of mental health care. In an attempt to clearly identify which portions of plaintiffs' letter are being responded to, CDCR provides a brief summary of each section of plaintiffs' letter, followed by a response from CDCR. Please also note that for ease of working with CDCR mental health staff, when summarizing the incidents, an effort was made to redact the specific officer names from this letter.

<u>Pages 3 – 4 of Plaintiffs' Letter:</u>
Plaintiffs expressed concern that data suggests a higher rate of use of force incidents involving mentally ill inmates versus non-Coleman inmates. Plaintiffs write, "CDCR's publically posted COMPSTAT data shows that from January 2018 to January 2019, 85% of LAC's reported use of force incidents involved prisoners with mental illnesses. In December 2018 and January 2019, 90% and 88% of use of force incidents, respectively, involved mentally ill prisoners. This rate was eight to ten times higher than the equivalent rate for prisoners without mental illnesses in these months." …¶ "The Court's concerns—that a large disparity between the rates of use of force on Coleman versus non-Coleman prisoners evinces a continued disregard for the underlying causes

of mentally ill prisoners' behavior—are reflected in our class members' recent complaints about use of force incidents at LAC. And if abusive, unwarranted use of force were not bad enough, numerous class members reported being subjected to improper, excessive force while they are already experiencing extreme mental distress, including anxiety, suicidality, and psychosis. Others report that use of force seriously exacerbated their mental health decompensation. Many of these complaints are verified in class members' mental health treatment files."

Defendants' Response:
CDCR is researching the use of force incidents at LAC as part of a larger effort to address plaintiffs' concerns in *Coleman* and the other class action lawsuits. The Office of Legal Affairs is working with Acting AD Jared Lazano and the institution to address the apparent increase in use of force incidents involving *Coleman* class members.

Pages 5 – 6 of Plaintiffs' Letter:
Plaintiffs write, "[redacted] [redacted] (who was EOP at the time of this incident and housed in D5[redacted]), reported a troubling incident that occurred in the early morning hours of June 29, 2018 while he was under extreme mental duress. The previous day, he had been sent to Antelope Valley Hospital ('AVH') to receive an MRI to identify why he had been unable to urinate for two days. Mr. [redacted] suffers from extreme anxiety and was unable to relax and sit still during the MRI (despite the administration of Vistaril to help calm him). He was returned from the hospital with his urinary problem unresolved. Mr. [redacted] requested and received a copy of his AVH treatment files so he could show them to his LAC physician. He was anxious that without this documentation his urine retention issue would go unaddressed at LAC. When he returned to the LAC D5 unit at around 1:00 a.m. on June 29, 2018, a nurse asked him what he was holding (in reference to his medical papers) and told him he could not hold the papers. This made Mr. [redacted] extremely agitated." … [Mr. [redacted] reportedly was worried about losing his paperwork and refused to return to his cell. He alleges he was assaulted by an officer.] ¶ … "on July 2, 2018, Mr. [redacted] was seen by mental health staff in his unit, who documented that he informed them that he wanted to cut himself 'very much' and would do it the first chance he got. That same day, his clinician noted that he reported significant anxiety and expressed a restricted range of affect, which was congruent with his reported mood. On October 22, 2018, Mr. [redacted] received a mental health assessment (MHA) for an RVR for 'resisting staff' from the incident, which found that his mental health did not play any role in his actions. We raised our concerns regarding this assessment in our recent (March 2019) letter regarding the MHA process for disciplinary write-ups, noting that the assessor filled out the MHA form incorrectly and gave sparse, superficial responses."

Defendants' Response:
The alleged assault of Mr. [redacted] by a correctional officer is being addressed separately from this letter. With regard to the October 22, 2018 MHA, defendants agree there are deficiencies. Specifically, the evaluating clinician's response to question #3 of whether mental illness contributed to the RVR was insufficient. The evaluating clinician responded "no" and then seemed to defer to the inmate to address any potential role his mental illness played in his behavior at the hearing, stating, "I/P understood the consequences of his actions but did not

want to speak about the alleged RVR at this time. There are no reasons that will preclude I/P from addressing this issue during his hearing. I/P mentioned that he is addressing this issue via cdcr form 22." Mr. [redacted] was found guilty of the charge of resisting staff, but was not assessed any loss of credit because the hearing was not held within timeframes.

CDCR is working on various efforts to improve MHAs, including updating training and policies. Defendants will keep plaintiffs apprised of these efforts.

Pages 6 – 8 of Plaintiffs' Letter:

Plaintiffs write, "[redacted] (who was EOP and housed in D5-[redacted] at the time of this incident), reported that he was beaten up by staff during a cell extraction on June 3, 2018, in the midst of a mental health crisis. Mr. [redacted] reported that the incident ensued following his mental decompensation, which itself came to a head when he swallowed two razor blades and some unknown pills in a suicide attempt on May 27, 2018. That same day, he was admitted to Antelope Valley Hospital (AVH), where tests showed he had foreign bodies in his stomach. Due to his suicidality, however, Mr. [redacted] refused treatment, so he was returned from the hospital the next day and placed in a holding cell. While in the holding cell, Mr. [redacted] requested that he be placed in the CTC and referred to the crisis bed. … On May 29, 2018, Mr. [redacted] was taken off of suicide watch by psychologist [redacted] and housed in cell D2-[redacted], even though he had reported suicidality during his appointment. [The next day, Mr. [redacted] "cut his wrist."] Mr. [redacted] was referred to the CTC and had an IDTT on May 30; the IDTT discharged him back to EOP." Plaintiffs' letter goes on to describe suicidal behavior on June 2, 2018 when Mr. [redacted] swallowed 40 pills, and then an allegation of staff assault during a cell extraction on June 3, 2018. Plaintiffs write, "Mr. [redacted] records document that he went to AVH on May 27, 2018 after ingesting a foreign body, and was placed on suicide watch upon his return on May 28, 2018. That same day, Mr. [redacted] was discharged from suicide watch following a SRASHE by Dr. [redacted] May 30, 2018, Mr. [redacted] again reported suicidality, made superficial scratches to his wrist, and reported that he had swallowed a razor, and was admitted to the MHCB that afternoon. Mr. [redacted] records show that he was discharged the next day to the CCCMS level of care." Plaintiffs' letter describes the cell extraction on June 3, 2018 and the alleged staff assault. "Mr. [redacted] records document that he was not evaluated by mental health staff prior to his cell extraction on June 3, 2018."

Defendants' Response:

As noted above, the incidents of alleged staff misconduct by custody staff are being addressed separately from this letter. Defendants have reviewed the May 29, 2019 decision to take Mr. [redacted] off of suicide watch, and the IDTT decision on May 30, 2018 to discharge Mr. [redacted] to EOP. Defendants have also researched whether mental health was consulted during the cell extraction on June 3, 2018.

Defendants have reviewed the decision on May 29, 2018 to take Mr. [redacted] off suicide watch, and the decision on May 30, 2018 to discharge Mr. [redacted] from EOP, and agrees with those decisions. The clinical decision to discharge Mr. [redacted] was made after a thorough assessment, which included interview of the patient, consultation with other disciplines, and record review. Mr. [redacted] admitted he was worried about his endorsement to High Desert State Prison, and

admitted to engaging in suicidal gestures to stop the transfer. Mr. [redacted] told the clinician he had no plan or intent to harm himself. The clinician appropriately concluded that Mr. [redacted] was motivated by self-preservation, and that he was future-oriented and goal-directed.

Specifically, Dr. [redacted] provided the following clinical documentation:

> Per the clinician, IP denied SI with no plan or intent to harm himself during this evaluation. He noted a belief he was stressed out regarding his endorsement to High Dessert as this will put him "at distance and I could not see my family." IP denied any safety concerns on the yard. He was encouraged to communicate with his new PC as he recently was deemed appropriate to program at CCCMS LOC instead of EOP LOC and also discuss his concern during his IDTT. IP agreed with the plan to communicate further with his PC and also provide rationale during his IDTT. IP reported medication compliant, however, requested to be seen by Psychiatry in order to be reassessed in regards to his medication regimen.
>
> Mr. [redacted] noted a belief he has a good rapport with his previous PC and requested to continue programing at EOP LOC. Review of his EHRS record revealed, superficial treatment engagement and minimal group attendance as noted in MH Master Treatment on 5-10-18 which was inconsistent with IP's report of past group attendance and benefiting from programing at EOP LOC. Therefore, he was deemed appropriate to program at CCCMS LOC. Additionally, IP has recently been endorsed to another facility due to a recent change in his LOC.
>
> Per CNA Observer, IP slept throughout the night and ate his meal. IP agreed to eat all of his meals and report any medical compliant to staff due to presence of FB, if warranted. He agreed to communicate with staff, if needed.
>
> Acute Risk is moderate at this time. I/P is engaging in behaviors to stop a transfer to HDSP. IP was future-oriented (wants to be near family) and goal-oriented (believes he will win a 602 to stop the transfer). His behaviors may escalate to accomplish not being transferred.
>
> The discharge SRE also noted the following: Aside from his above mentioned risk factors, he reportedly has family support, religious belief, interpersonal social support, future-oriented, exercise regularly, positive coping strategies, children at home (mentioned seven), insight into his problems, goal oriented, and just this morning he was stable and motivated to participate in treatment, per alt housing PC and this PC's step down interview today.

With regard to the decision to remove Mr. [redacted] from suicide watch, the clinician reached a clinical decision to discharge Mr. [redacted] after she consulted the healthcare and custody records (past patterns/behaviors) and after consulting with her supervisor, PIP coordinator, the CCI, nursing, and other team members. The decision to discharge Mr. [redacted] was made by the clinical team who decided his current status did not warrant a MHCB LOC.

Specifically, Dr. [redacted] SRASHE on May 30, 2019 describes the following:

> It appears that IP is using symptom reporting to try to avoid transfer and control his environment - this is also present in his past hx as IP was noted to have done the same when he learned that he was going to go to a level four prison.
>
> IP could not articulate any trigger to the rapid change in his bx or symptoms. When challenged with observations IP became agitated and continued to make conditional threats also stating 'I will show you" IP has no hx of SA, one previous engagement in SIB 2011 also noted to be superficial and appearing to be triggered by environmental changes and movements he was opposed to.
>
> Acute Risk is low to moderate - IP is nearing moderate only due to his likelihood to increase bx to get needs met and to try to control his environment and ensure his quality of life at prison/ being placed where he is comfortable. It was previously noted that IP risk was low 5/28/18: "low at this time. IP denied SI with no plan or intent to harm himself during this evaluation. IP was future-oriented (wanting to program) and goal-oriented (wanting to work with his PC). IP agreed to work collaboratively with his PC and discuss his concerns in regards to his transfer with his PC and with this team during his IDTT. " On his admit it was noted moderate for the following reasons "Acute Risk is moderate at this time. I/P is engaging in behaviors to stop a transfer to HDSP. IP was future-oriented (wants to be near family) and goal-oriented (believes he will win a 602 to stop the transfer). His behaviors may escalate to accomplish not being transferred." as this reads IP was trying to control his environment and active in advocating for this to be changed/ stopped. IP bx and reports or eluding to SI is done to control his environment and meet needs. IP has a documented hx of bx being motivated by desire to control his environment and simply put "to gain a sense of control".

Notably, the SRASHE authored by Dr. [redacted] dated May 31, 2019 for the incident on May 30, 2018 documented Mr. [redacted] scratched himself with his fingernail and did not cut his wrists.

Finally, with regard to the cell extraction on June 3, 2019, Mr. [redacted] was refusing to respond to officers during a welfare check. Because an emergency cell entry was necessary to ensure life saving measures, mental health was not consulted.

<u>Pages 8 – 9 of Plaintiffs' Letter:</u>

Plaintiffs write, '[redacted] who was CCCMS at the time" described an incident on October 13, 2018, involving not following orders from officers in the dining hall. Mr. [redacted] reported being assaulted by the officers. "Over the next few weeks, Mr. [redacted] quickly decompensated, expressing increasing paranoia and anxiety about custody staff to his clinician. On October 24, 2018, his clinician noted that he was 'ruminating over how he was 'set up' by custody' and reported feeling 'stressed out' due to the recent altercation. Mr. [redacted] refused his next few mental health contacts, but he was seen by his clinician on November 21, 2018, the clinician noted that

he 'appears paranoid and ruminates excessively over his perceived conspiracies between medical and custody, difficult to redirect, TC paranoid. Appears to be slowly decompensating over the past month, evidenced by his changes in presentation and TC.' (emphasis added). Mr. [redacted] *clinician noted the same troubling symptoms a week later. On November 29, 2018, his treatment team raised his level of care to EOP during an emergency IDTT."*

Defendants' Response:

As noted above, the incidents of alleged staff misconduct by custody staff are being addressed separately from this letter. Plaintiffs' characterization of Mr. [redacted] decompensation is correct. Mr. [redacted] was reported to be psychotic and decompensating significantly over the last two weeks before this IDTT (hoarding food trays, vomiting PC 2602 medication, etc.) Mr. [redacted] was described as ruminating over how he believed he had been set up by custody who lied about his behaviors.

Pages 9 – 10 of Plaintiffs' Letter:

Plaintiffs write, '[redacted] *who was at the EOP level of care at the time of this incident, reported that he arrived at LAC on November 8, 2018 and immediately experienced problems with getting ducats for his mental health groups. Mr.* [redacted] *records show that he reported this issue to his clinician as early as November 27, 2018, and then reported it again on December 4, 2018. On December 5, 2018 Mr.* [redacted] *told his clinician, Dr.* [redacted] *that he might decompensate from being locked in his cell all day when Dr.* [redacted] *walked by his cell. Mr.* [redacted] *mental health records document that he informed his clinician during that contact that 'he was not getting called out for groups' and that 'being locked up all day is detrimental to his mental health.' Later that day, Mr.* [redacted] *received another contact from his clinician. Midway through the encounter with Dr.* [redacted] *another clinician, Dr.* [redacted] *and [an officer] came into the room while Mr.* [redacted] *was in the midst of telling his clinician that he might need a higher level of care. Mr.* [redacted] *reported Dr.* [redacted] *whispered something to [the officer] who then cuffed Mr.* [redacted] *up and took him out of the appointment. Dr.* [redacted] *progress note from the encounter records that Mr.* [redacted] *had an 'agitated presentation' during the appointment and that '[a]fter some attempt to deescalate IP, the contact was terminated' and 'the IP was escorted out of the interview.'" Mr.* [redacted] *then reported officers assaulted him, and he received a write-up for battery on a peace officer on December 12, 2018. "The RVR claimed that force was required because Mr.* [redacted] *refused to go back to his cell after his appointment. Dr.* [redacted] *later conducted the MHA for this write-up. Dr.* [redacted] *claimed that Mr.* [redacted] *was interviewed for the assessment, even though Mr.* [redacted] *refused to talk to him. ¶ Three days after the incident, Mr.* [redacted] *filed a 7362 in which he wrote that he 'was involved in a[n] excessive force incident that caused intensive pain in back and shoulder from being kicked and arms bent in opposite direction of bone joint.' The same day, he filed another 7362, in which he wrote that he would 'appreciate talking to someone about current mental health status particularly about decompensation and fear of interacting with officers on 'D' Yard.' Two days later, Mr.* [redacted] *received an initial assessment from his new clinician, who recorded that he had 'challenges with depression, anxiety, anger, and agitation …. Due to a recent conflict with custody and recent housing change to Ad-Seg.' The next day, his clinician again noted that Mr.* [redacted] *'has been ruminating about recent RVR and interactions with MH staff and custody.'"*

Defendants' Response:
The incidents of alleged staff misconduct by custody staff are being addressed separately from this letter. Defendants have reviewed the allegation that on December 5, 2018, Dr. [redacted] "whispered something" to an officer. Dr. [redacted] was asked about his recollection of the encounter, and reported he does not recall whispering something to an officer, particularly anything that would be outside of normal policy and procedure. Defendants believe any communications between Dr. [redacted] and custody staff that day would have been necessary and appropriate for the treatment of Mr. [redacted] and for safety and security.

Defendants have also reviewed the MHA for the December 12, 2018 RVR for battery on a peace officer. There are two MH RVR MHAs completed on 12/11/2018: battery on a peace officer and conspire-battery on a peace officer. Both MHAs were completed by Dr. [redacted] They indicate Mr. [redacted] "refused to come out to a confidential setting" and record review and was completed in addition to the interview at cell front (private interview offered for both RVRs were refused by Mr. [redacted] per documentation) to determine MHA results. Defendants do not find an inconsistency in the documentation—contrary to what was insinuated in plaintiffs' letter--that the clinician claimed Mr. [redacted] was interviewed for the assessment, but Mr. [redacted] refused to talk to the clinician.

Finally, defendants address the assistance provided by mental health to Mr. [redacted] in December 2018, especially regarding his fear and anxiety about interacting with custody staff. On December 11, 2018, Mr. [redacted] was seen by his clinician, Ms. [redacted] who educated Mr. [redacted] on the ICC and IDTT process and his upcoming appointments. On December 12, 2018, Ms. [redacted] consulted with Mr. [redacted] previous clinician, Dr. [redacted] regarding Mr. [redacted] "difficulties in programming, behaviors, presentation, and hx of treatment compliance." Prior to that, Mr. [redacted] was seen by the psychiatrist on December 11, 2018 and by his clinician, Ms. [redacted] for an initial assessment on December 10, 2018. He was seen in IDTT by his treatment team on December 18, 2018. The clinician consulted the DBT (Dialectical Behavioral Therapy) clinicians to see if Mr. [redacted] might be appropriate for this track. Per the note on December 20, 2018, by Dr. [redacted] Mr. [redacted] did not "appear to be in acute distress, therefore it is recommended that IP be enrolled in group track that better meets his needs." On December 28, 2018, Ms. [redacted] wrote: "IP appears to be adjusting at this time within the EOP structure. There were no signs of decompensation. He denied current SI/HI. He presented as future oriented as evidenced by looking forward to being transferred to another facility." Mr. [redacted] was seen for weekly contacts and offered 10 hours of treatment (group and individual combined).

Mr. [redacted] primary clinician advocated for him by reaching out to custody. On January 3, 2019, she wrote: "IP has attempted to have officer assistance in the building with little luck. PC spoke with Sgt. [redacted] regrading recent events and was informed the matters were addressed and he spoke with IP." It is noted, Mr. [redacted] was advocating for a PIP referral to get what he deemed "real treatment." Mr. [redacted] was being evaluated for possible need for a referral to a higher level of care, but it was deemed Mr. [redacted] did not meet the criteria for the increase in care. There are additional notes in the healthcare records indicating custody and other disciplines were consulted in the treatment of Mr. [redacted]

Per a note dated February 7, 2019, in observation from other treatment providers in the program, Mr. [redacted] was deemed "to have the ability to regulate his emotions and gain insight and understanding into his elevated mood thus decrease his frustration to circumstance and appears to be more related to IPs core beliefs and depression. IP has learned a state of helplessness and exacerbate his sxs in order to feel as though he has been victimized. IP maintains the ability to advocate for himself and stays steadfast in remaining adamant in requiring a transfer to DSH although it is not warranted at this time."

Pages 11 – 12 of Plaintiffs' Letter:

Plaintiffs write: "[redacted] reported that on September 19, 2018 at around 7:00 a.m. ASU [officers] approached his cell and told him that transportation officers were on their way to pick him up from LAC to transfer him to SATF. Mr. [redacted] informed the officers that he refused to transfer until staff responded to his pending property and medical appeals." Officers allegedly threatened Mr. [redacted] with physical harm if he continued to refuse, and at 8:00 am, an officer announced an unresponsive inmate code and officers allegedly came into the cell and assaulted him. "Mr. [redacted] records do not reflect that he received an assessment from mental health staff prior to this cell extraction."

Defendants' Response:

The incidents of alleged staff misconduct by custody staff are being addressed separately from this letter. With regard to the cell extraction, whenever there is an unresponsive inmate code, it turns into an emergency cell extraction and mental health or other staff are not consulted as the emergency requires officers to enter the cell to provide necessary intervention. Per healthcare records, and in accordance with policy, there is no indication mental health was consulted on this case before the cell extraction or before the reported unresponsive inmate code.

Pages 13 – 14 of Plaintiffs' Letter:

Plaintiffs write, "[redacted] a CCCMS class member at the time of this incident, also reported that excessive force was used against him when he refused to accept assigned housing. He informed us that staff used force on him after he refused to accept a cellmate on December 7, 2018, shortly after arriving at LAC. … Mr. [redacted] informed [officers] that he had mental health issues, suffered from trauma from sexual harassment, and that as a result he required a single cell. The [officer] reportedly told Mr. [redacted] that he would be housed by himself. However, Mr. [redacted] was then taken to a cell occupied by another individual who was a known gang member. Mr. [redacted] refused to enter this cell." Officers allegedly forced him into the cell and assaulted him in the process. ¶ "We reviewed Mr. [redacted] treatment files. From his clinician's notes, the incident appears to have had a significant effect on his mental health. Five days after the incident, Mr. [redacted] was seen by his psychiatrist, who noted that he reported a 'long trauma history,' that he was struggling with a recent death in his family, and that he was 'readily tearful during [the] exam,' and that he recently had a 'battery on an officer bc he had safety concerns about who he was supposed to be cell with.' His psychiatrist emphasized that '[g]iven his tearfulness and marked dysphoria in affect he was thoroughly screened for suicidality.' Despite this documentation of his presentation, the RVR MHA stemming from the incident, received six days

later, inexplicably found that 'I/P appears well adjusted and would not destabilize as the result of assessing penalties.' This finding was directly belied by Mr. [redacted] treatment team's decision only eight days later to raise his level of care to EOP. Over the ensuing weeks, the use of force incident and its aftermath continued to weigh heavily on Mr. [redacted] Forty days after the incident, Mr. [redacted] told his clinician, 'I ain't good. I got no sleep since Tuesday maybe one hour. I can still replay the incident in my head and that bothers. I have a fear of becoming desensitized.'"

Defendants' Response:

The incidents of alleged staff misconduct by custody staff are being addressed separately from this letter. Defendants reviewed the MHA associated with the December 7, 2018 incident to assess whether the clinician took into account all relevant mental health information as part of the assessment. Dr. [redacted] conducted the MHA evaluation for this incident on December 18, 2018. Per the MHA document, Dr. [redacted] indicates he consulted the mental health records and the primary clinician, Ms. [redacted] who had conducted the initial assessment and a suicide risk assessment on December 12, 2018, the same day Dr. [redacted] the psychiatrist, saw Mr. [redacted] The documents on that day indicate inconsistent presentation and recommendations for Mr. [redacted] For instance, in the initial evaluation, Ms. [redacted] documented Mr. [redacted] has used mental health for secondary gain, per records, "no evidence of a clinical disorder" and recommended Mr. [redacted] "be removed from CCCMS at next IDTT since he is able to function and remain stable off psychotropic medication." However, in the risk assessment, she wrote that Mr. [redacted] might benefit from additional services (groups) to keep him busy through the day. Dr. [redacted] assessed Mr. [redacted] for dangerousness given his presentation ("readily tearful").

Ms. [redacted] Suicide Risk Assessment on December 12, 2018 also indicates that Mr. [redacted] has a history of attempting to use mental health to get a single cell. Per the document:

> IP initially appeared dysphoric; however, when this writer started to review information regarding his past treatment history he became agitated stating that nobody wants to help him. IP has been evaluated several times by other PCs to determine if he is appropriate for placement in CCCMS. IP does not have a qualifying diagnosis nor does he have any functional impairment to be included in CCCMS LOC. IP was previously at CCCMS LOC; however, he was DC'd to GP because he was not utilizing treatment or discussing issues related to grief and loss during his contacts. IP has not taken psychotropic medications since 2015. PC noted that IP's main goal was to get a single cell.
>
> IP was seen for IDTT on 1/2/2019 at the EOP LOC by Ms. [redacted] Per the IDTT, IP has attempted to get single cell claiming he was a victim of two incidents (PREA), but the alleged incidents were unfounded. IP was cooperative and participated in treatment per PC note on 1/7/2019. On 1/17/2019, IP made the statement: "I ain't good. I got no sleep since Tuesday maybe one hour. I can still replay the incident in my head and that bothers. I have a fear of becoming desensitized," after he was reportedly found guilty of the 115 that placed him in Ad. Seg. In the sessions that followed on 1/23/2019, 1/28/2019, 1/30/2019, and 2/6/2019, IP was seen to "be

> adjusting at this time within the EOP structure" and no evidence "signs of decompensation" was found.

For the purposes of the RVR MHA, Dr. [redacted] indicates he used consultation (consulted with primary clinician and health care records) to gather pertinent information before reaching his clinical conclusions.

Page 14 of Plaintiffs' Letter:

Plaintiffs write, "[redacted] reported that he attempted suicide sometime in early March 2019 by hanging in his cell (D5-[redacted] early in the morning. He was at the EOP level of care at this time. Officers discovered him, cut him down, and placed him onto his stomach with a shield over him." [Mr. [redacted] reported officers threatened him not to speak to nursing.] "Mr. [redacted] was then taken to the CTC. During a brief period of the transport during which he was unsupervised by officers, Mr. [redacted] took the opportunity to tell nursing staff that he was suicidal. He was then returned to his cell and placed on suicide watch in D5. The next morning, Mr. [redacted] informed the assessing clinician, Ms. [redacted] that he was suicidal. She reportedly asked him, 'Do you have a desire to die right now?' He replied 'yes.' However, Ms. [redacted] decided to clear him anyway and Mr. [redacted] was returned to his cell. Mr. [redacted] informed us that he has been continually suicidal since this incident, but that he feels lethargic and lacks energy due to his depression. …"

Defendants' Response:

The incidents of alleged staff misconduct by custody staff are being addressed separately from this letter. Defendants respond to plaintiffs' concern that Dr. [redacted] cleared Mr. [redacted] to return to his cell when he reportedly stated he wanted to die. The mental health records do not indicate that Dr. [redacted] assessed Mr. [redacted] for suicidality in March 2019. Mr. [redacted] was assessed by Dr. [redacted] on February 23, 2019. Per the records, it appears Mr. [redacted] was placed on suicide watch on February 22, 2019, after being found in his cell with his hands and feet tied together, consciously laying on his cell floor. Dr. [redacted] evaluated Mr. [redacted] and concluded Mr. [redacted] was not a danger to himself at the time and would better receive treatment in the outpatient EOP setting where he was housed. Dr. [redacted] provided information regarding her contact and thorough justification for her clinical decision to release Mr. [redacted] back to the EOP program rather than have him sent to a MHCB. Dr. [redacted] placed Mr. [redacted] on a five-day follow up and made recommendations to the receiving clinician to help Mr. [redacted] with follow-up mental health treatment.

Dr. [redacted] documented the following regarding her contact:

> IP was seen on SWAH where he was placed [overnight] by the [Physician on Call] via telephonic order. Medical note from last night indicates that IP was observed on the ground of his cell, with his hands and feet tied together, lying down, conscious and breathing. Medical note indicates no observation of any [ligature] marks to the neck, as well as no evidence of a possible hanging, nor of a possible trauma to the neck. Medical notes do not mention any findings of a noose, and custody staff in the building deny having found any.

> IP reported that he was "planning to hang myself, made a noose and everything, but then I blacked out and can't remember what happened. All I remember is that I was preparing to tie my hands and feet, but then I blacked out and when I came to it, custody was on my back, telling me not to move". IP made several conditional statements of possible future self harm UNLESS he gets sent to higher LOC, specifically DSH, claiming "I get immediate response to my crisis situations there, and I see my clinician any time I need to, they are always available, it's just a much better treatment environment". IP also stated that his recent ADSEG placement for battery made "my depression much worse, but I have been hiding it from my clinician", as if using it as an emphasis right after he made his conditional statement demanding higher LOC. IP also complained about his mother "giving me the silent treatment since I was sent to ADSEG" as well as expressed his worry about paroling in 2020 "it is hard to be a black male with a prior conviction for a felony, how am I going to get a job or be able to get my own place?"

In the risk assessment, Dr. [redacted] evaluation later describes, “IP endorses vague, passive SI conditional to his demand to be sent to DSH LOC. Denies having plan or intent to engage in self-harm… no evidence of acute distress or psychosis that would warrant a need for a higher LOC at this time. His presentation and behavior are incongruent with that of acute distress, and appear to be more related to personality traits, especially when considering his conditional statements.”

In her justification of risk level, Dr. [redacted] wrote:

> Although IP has been on the high-risk list due to his prior behaviors, in reality this clinician was unable to find any substantiation for his alleged SAs beyond his self reports, as no medical discharge papers provide evidence of those alleged hangings. IP appears to have a pattern of using impression management to obtain his desired higher LOC and documentation review indicates prior MHPCs were taking his word as reported, documenting them as reported, focusing on the subjective reporting instead of available documentation from custody or medical. IP has not engaged in any self-harm behaviors recently, and despite his claims otherwise, he was NOT found hanging in his cell either (confirmed by custody, see first page for more information). IP has a hx of using conditional statements to ensure his demanded LOC placement, where he has no problem programming (as opposed to in prison where he refuses to program). He is clearly future oriented (evidenced by his worry about his mother allegedly not having talked to him over a month due to his ADSEG placement as well as reporting to feel anxiety over his parole in 2020), is focused on self-preservation (evidenced by the fact that medical examination found no evidence of his alleged/claimed hanging), is able and willing to advocate for himself (however inappropriately through the use of conditional statements demanding higher LOC) and is able to list several coping skills, regardless of how much he attempts to minimize them. Although IP is likely to continue with his behavior of engaging in impression management techniques for secondary gain, the likelihood of him engaging in behavior that could lead to SBI/GBI/death is low. His behavior and presentation are incongruent with that of

> genuine acute distress and appear to be related to his personality traits instead. There is no evidence that would warrant a need for placement in higher LOC. IP was DC from SWAH."

Upon discharge, Dr. [redacted] safety/treatment plan included the following:

> IP was DC from SWAH and returned to his prior EOP LOC in ADSEG as this is the least restrictive environment where his MH tx needs can be addressed. IP will be placed on 5-day stepdown with daily PC contact. PC to assist IP with identifying 2-3 reasons for living to address his reported suicidality. PC to look over his past RVRs to assist him in identifying alternative behaviors he could have used, without getting in trouble, to increase insight into his violent, maladaptive behaviors and to motivate him to use appropriate, alternative options instead, with the goal of reducing his maladaptive behavior patterns to zero in the next 30 days. IP would likely benefit from participating in the DBT track and to learn coping skills related to mindfulness techniques and behavior activation, to assist him in regulating his mood and addressing his reported depressive sxs, while also reducing his engagement in impression management and other maladaptive behaviors by increasing his insight. PC to encourage IP to continue trying to contact his mother via correspondence for continued support, as well as to assist IP other support people in his life on whom he could rely on while in ADSEG for encouragement. PC continue to monitor IP for possible decompensation, although recent documentation as well as his current behavior/presentation so far indicate no evidence for it, despite IP's self-reported claims. No warning signs endorsed.

Defendants also provide an update as to how treatment staff have been working with Mr. [redacted] to address his suicidal gestures. Following the discharge from alternative housing, Mr. [redacted] was seen by his clinician for his dailies (high refuser) and for weekly contacts for the remainder of his Ad-Seg stay. He was also seen by the psychiatrist regularly. In the notes by his clinician, other covering clinicians, and the psychiatrist, there was no indication Mr. [redacted] needed a higher level of care following discharge from alternative housing. Mr. [redacted] was being provided regular observation and contacts, and attempts were made to engage him in treatment. Mr. [redacted] discharged to the EOP yard, and later returned to Ad-Seg for an IEX in August. Mr. [redacted] left LAC on September 2, 2019 and was transferred to SAC, where he is receiving treatment for his reported depressive symptoms.

Page 16 of Plaintiffs' Letter:

Plaintiffs write, "Still other class members reported an overarching custody-dominated culture that deters patients from opening up to their clinicians about their mental health symptoms. For example, Mr. [redacted] *reported seeing nurses show their computers to custody officers. Whether true or not, this sends a message to class members that anything they tell nurses or their clinician may be inappropriately relayed to custody staff. Another patient who requested to remain anonymous for fear of retaliation told us that his mental health clinician in the ASU EOP Hub divulged confidential information he had shared in a 1-on-1 to custody staff.* [redacted],

reported similar concerns about seeing mental health staff sharing information with custody staff."

Defendants' Response:
CDCR and LAC do not condone the sharing of confidential healthcare information with custody staff. The exception to the rule is when inmate-patients pose a risk to themselves or others. During these instances, LAC clinical staff only divulge information as necessary to intervene to preserve the safety of the inmate-patients and others. To address any potential misunderstandings, the LAC clinical staff have been reminded to hold any necessary discussions with custody regarding inmate-patients away from the inmate-patients so as to avoid any appearance of staff colluding against the inmate-patients or inappropriately sharing confidential information.

Specific to plaintiffs' mention of [redacted] CDCR has reviewed plaintiffs' concern and finds no evidence of the inappropriate sharing of healthcare information with custody. Ms. [redacted] the clinician involved in Mr. [redacted] care during his participation in CCCMS, was consulted and affirmed she has no recollection of confidential information being shared with custody officers.

Pages 20 – 21 of Plaintiffs' Letter:
Plaintiffs write, "Mr. [redacted] reported that this abuse [alleged abuse by custody] has caused him to become suicidal and repeatedly consider harming himself, and that he repeatedly refused his mental health contacts because he was afraid to leave his cell. Mr. [redacted] records document that he first reported being harassed by officers in the EOP ASU Hub building to his clinician on December 19, 2018. On December 21, 2018, he was urgently seen by his clinician after reporting distress arising from 'negative interactions with custody and torn pictures of his decease[d] mother found in his cell following a cell search.' Mr. [redacted] told his clinician that 'his cell was searched … and two pictures of his mother were ripped.' In the treatment note, Mr. [redacted] clinician documented that he 'was visibly distraught by the idea that [an officer] would tear up pictures of his mother whose birthday had just passed and whose death anniversary is approaching. I/P was tearful and trying to compose himself while relaying what happened.' Mr. [redacted] mental health records document that on December 26, 2018, he boarded up in the LAC D5 Mental Health building bathroom because he was 'afraid for his life' due to custody officers in his unit, and had to be talked down so that controlled force would not be used. Mr. [redacted] records document that he continued to report distressing encounters with staff up until his transfer to CSP – Sacramento on February 20, 2019."

Defendants' Response:
The incidents of alleged staff misconduct by custody staff are being addressed separately from this letter. A review of healthcare records confirm that Mr. [redacted] reported being harassed by officers in the EOP ASU Hub building to a clinician on December 19, 2018, and that he reported being upset about the photos of his mother when he met with a clinician on December 21, 2018. However, there are no mental health records to corroborate Mr. [redacted] statements of the reported incident of boarding up in the LAC D5 Mental Health building bathroom because he was afraid of the custody officers in his unit.

Pages 23 of Plaintiffs' Letter:
Plaintiffs write, "The attack [assault by another prisoner on November 4, 2018] on Mr. [redacted] *[James* [redacted] [redacted] *appears to have had a severe impact on his mental health. His records reflect that on November 14, 2018, Mr.* [redacted] *told his clinician that he feels 'anxious every time he goes to chow since he was attacked coming back from chow.' His clinician noted he 'reports lack of sleep and crying spells as well as 'bad dreams'…. [and] was educated regarding PTSD and his symptoms.' When seen by his clinician on D-Yard recently, it was clear that the assault and [the officer's alleged] role in it continues to weigh heavily on Mr.* [redacted] *During this contact on March 25, 2019, Mr.* [redacted] *'reported anxiety because the officer he feels is behind his assault came into D1 recently.' His clinician noted that he 'continues to talk about the CO on C yard that [he] feels is behind [his] assault and is fixated on that topic. [He] is sometimes difficult to re-direct.'"*

Defendants' Response:
The incidents of alleged staff misconduct by custody staff are being addressed separately from this letter. Defendants have reviewed the healthcare records cited by plaintiffs' counsel. Mr. [redacted] was seen on November 13, 2018, not November 14, 2018. Dr. [redacted] Mr. [redacted] clinician, indicated Mr. [redacted] suffered trauma the previous week after being attacked by another inmate by being punched from the back and fainting. Mr. [redacted] was described as reporting periods of loss of balance. With regard to plaintiffs' quotation that Mr. [redacted] clinician noted he "reports lack of sleep and crying spells as well as 'bad dreams'…. [and] was educated regarding PTSD and his symptoms," this was reported by Mr. [redacted] to his clinician on November 19, 2018. Defendants confirm that Mr. [redacted] reported to his clinician on March 25, 2019, his belief an officer was behind the assault.

Please let me know if you have any questions regarding defendants' responses to the mental health issues in this letter. As previously stated, CDCR is working separately on the various allegations of staff misconduct raised in plaintiffs' letter. CDCR takes these allegations very seriously, and the Office of Legal Affairs is working collaboratively with the Associate Director, the Office of Internal Affairs, and the institution to research these allegations.

Sincerely,

/s/ ***Katie Riley***

KATIE RILEY
Attorney IV

cc: *Coleman* Special Master Team

Exhibit I

ROSEN BIEN GALVAN & GRUNFELD LLP

101 Mission Street, Sixth Floor
San Francisco, California 94105-1738
T: (415) 433-6830 ▪ F: (415) 433-7104
www.rbgg.com

Thomas Nolan
Email: tnolan@rbgg.com

March 19, 2019

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VIA ELECTRONIC MAIL ONLY

Russa Boyd
Tamiya Davis
Non-Medical Class Action Team
CDCR Office of Legal Affairs
Russa.Boyd@cdcr.ca.gov
Tamiya.Davis@cdcr.ca.gov

VIA U.S. MAIL

Debbie Asuncion, Warden
California State Prison Los Angeles County
P.O. Box 8457
Lancaster, CA 93539

Re: *Armstrong v. Newsom*
Plaintiffs' Report re December 2018 Monitoring Tour of California State Prison–Los Angeles County
Our File No. 0581-03

Dear Ms. Boyd, Ms. Davis, and Ms. Asuncion:

Enclosed is Plaintiffs' Monitoring Tour Report on our December 10-13, 2018 tour of California State Prison–Los Angeles County (LAC). We would like to thank the staff at LAC who assisted with this tour for their courtesy and professionalism.

The attached tour report finds a number of areas of non-compliance that have been longstanding at CSP-LAC. We hope to discuss plans to remedy these problems with the local ADA team at LAC during the upcoming tour at LAC in May of 2019. We look forward to working with you to improve the institution's compliance with the *Armstrong* Remedial Plan.

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Please note that the report and the attachments to the report are subject to the protective order in this case and should not be copied or distributed without referring to that order and following the procedures therein.

Sincerely,

ROSEN BIEN
GALVAN & GRUNFELD LLP

/s/ Thomas Nolan

By: Thomas Nolan
Of Counsel

TN:DVC:cg
Enclosure

cc: Ed Swanson
Nicholas Meyer
Patricia Ferguson
Trennie Rios
Erin Anderson
Sharon Garske
Erick Rhoan
Annakarina De La Torre-Fennell
Jay Russell
Adriano Hrvatin
Kelly Mitchell
Teauna Miranda
Georgia Johas-Darnell
Laurie Hoogland
Maria Rocha
Pam Cantelmi
Steven Blum
Bruce Beland
John Dovey
Vincent Cullen
Donald Meier
Judy Burleson
Kelli Abernathy
Laurene Payne
Ceasar Aguila
Desiree Collum
Anastasia Bartle
Lynda Robinson
Ngoc Vo
Samantha Chastain
Dawn Malone-Stevens
Joseph Williams
Cathy Jefferson
Matt Espenshade
Lois Welch
Steven Faris
CCHCS Accountability
OLA *Armstrong* Co-Counsel

California State Prison – Los Angeles County (LAC)
December 10-13, 2018 Monitoring Tour
Armstrong v. Newsom

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were also found during the most recent prior tour reports by the Prison Law Office, and/or during the Joint Monitoring tour at LAC in April of 2018. In addition, following our tour, we sent a letter raising individual-level concerns stemming from our class member interviews during the tour. That letter is enclosed hereto as **Exhibit A.**

Throughout this report, we make recommendations and requests for information. These requests and recommendations are summarized again at the end of the report.

Some of the key issues identified in this report, almost all of which have also been reported as problems in prior reports, include the following:

- *Staff Misconduct:* There were continuing reports of severe staff misconduct against disabled class members in the Armstrong case and Coleman case. Oftentimes this staff misconduct takes place directly on account of the individual's disability, and even when it appears somewhat unconnected from a given individual's disability, it creates a climate of fear of retaliation that makes it hard for disabled individuals to request the accommodations they require.

- *Wheelchair Inspections:* The monitors were repeatedly told by class members that housing unit staff members do not conduct timely wheelchair inspections and that the institution does not make repairs in a timely and appropriate manner. In addition, there were clear problems with incomplete or missing wheelchair inspection logs.

- *Extra Clothing, Showers, and Toileting Supplies:* Numerous class members reported that LAC fails to provide class members who have toileting issues and experience accidents with appropriate access to extra showers and clean clothing, and with appropriate toileting supplies. An incontinence log instituted by the ADA coordinator to document the provision of supplies and extra showers and clothing was not being used, and there were no extra linens in several of the housing units where the most wheelchair users are housed. There were also numerous complaints about not being able to get bags for disposing of diapers and other soiled items, and about inadequate supplies of toilet paper.

- *General Problems with Shower Access for ADA Individuals:* There were widespread complaints from class members that they cannot access the ADA showers because everyone showers in dayroom and the non-disabled individuals get in line before individuals with disabilities.

- *ADA Worker Issues:* There were widely reported problems with ADA workers. Across the institution, class members complained that ADA workers are poorly trained. ADA workers reportedly do not help

G. Disability-Related Staff Misconduct

Several prisoners we interviewed on the tour reported troubling instances of staff misconduct that was targeted at prisoners with disabilities, ranging from verbal harassment to excessive use of force complaints. Disturbingly, many of the complaints of staff misconduct came from prisoners housed in D-yard and in the C5 facility, where many class members with serious disability needs are housed.

1. *Mr.* [redacted] *DNH, D-*[redacted], requested on April 13, 2018 that Officer [redacted] in his unit be trained on how to adequately communicate with inmates with hearing impairments, as he was denied breakfast because the officer called for him to receive his tray but he did not hear the officer. He reported that, after he requested his tray, Officer [redacted] told him he had already traded the food to another inmate in exchange for sacrificing his yard time. Mr. [redacted] complaint was placed on the Non-Compliance Log.

2. *Mr.* [redacted] *B4, DPW*, said that in July 2018 he was not buckled in by Officer [redacted] when he went out to the hospital and flipped over three times in the van. Mr. [redacted] reported that Officer [redacted] drove quickly, and that as a result he flew back and forth in the back of the van. He reported that, soon after the van left, he fell over and hit his head and then saw the two officers laughing at him. He has since experienced neck and back pains. His medical records document that he was seen by a doctor at LAC following his complaints of neck pain and that he informed the provider that he "flipped backwards while being transported in a van July 1, 2018." Shortly after our interview with Mr. [redacted] on December 10, 2018, he was seen by his primary care provider, who noted that he "has a history of chronic neck pain present since early July after his wheelchair flipped backwards off of vehicle lift" and noted that his neck pain was "currently not adequately controlled."

Plaintiffs request that LAC investigate the van incident reported by Mr. [redacted] and take appropriate action with the staff responsible. Furthermore, this incident should be added to the non-compliance log.

3. Mr. [redacted] D5, DPO, reported that Officer [redacted] in the C5 Unit threatened him for a whole month in August 2018. On August 23, 2018 he was at the medical window and Officer [redacted] told him to go back to his cell. He pulled away and then [redacted] claimed he struck him. He was written up with battery on a peace officer and has been in ASU since that time. He said that Officer [redacted] has a history of beating up inmates, especially EOPs, SNYs, and those with disabilities. On August 25, 2018, officers in D5 Unit assaulted him in his cell in retaliation for his alleged assault on Officer [redacted] He does not know the names of these officers, but says they were the first watch ASU staff.

Multiple class members also reported that B-yard Officer "[redacted] or "[redacted] frequently harasses DPW class members on B-yard. *Mr.* [redacted], *B1*, *DPW*, reported that Officer [redacted] does not provide showers to inmates who have accidents when they request them. *Mr.* [redacted] *B1*, *DPW*, reported that Officer [redacted] often refuses to let ADA inmates out of their cells when he works on the weekends.

We also received two particularly concerning use of force reports from *Mr.* [redacted] *DPW*. With respect to the first incident, Mr. [redacted] informed us that on July 25, 2018 he was sent to the EOP-ASU and had his radio taken away for making threats to a custody officer. As he was entering his assigned D5 cell [redacted], control booth officers closed the door on his foot. An officer opened his door and guards yanked him out of the cell, then slammed his face, kicked him in the face, and broke his glasses and radio. He reported that a psychiatric technician who witnessed the incident told staff that he was hurt, so he was taken to the CTC and then to Antelope Valley Hospital, where he stayed for two days. After this assault he was made DPW due to his injuries. He reported that officers repeatedly prevented medical staff at the hospital from taking a statement from him about what happened and refused to take pictures of his injuries.

Officers' reports of the incident claim that while Mr. [redacted] was being transferred to cell D5-[redacted], he "intentionally stuck his leg out causing the cell door from fully closing," refused to remove his foot from the door, and then "forced his way out of the cell lunging towards the escorting officers." **Exhibit D** at 2. Mr. [redacted] was 52 years old at the time of the incident and has been diagnosed with severe tricompartmental arthosis in his right knee and moderate hip arthosis in both of his hips. These diagnoses of severe arthritis were confirmed following x-rays that Mr. [redacted] received on February 22, 2018. Due to his osteoarthritis, Mr. [redacted] was classified DPM and was issued a cane, mobility vest, walker, and knee braces before the July 25, 2018 incident. *See* July 2, 2018 LAC DECS Log. His medical records document that he had used a walker to ambulate for the past three years. Given Mr. [redacted] mobility restrictions, it is unlikely that he had the range of motion to stick his leg into the door and "lunge" at the officers as reported the incident reports.

In appeal number D-[redacted], Mr. [redacted] reported this incident. In his appeal, dated July 28, 2018, he wrote that he lost his walker and cane. He also wrote that he suffered from acute flaccid paralysis to his lower extremities, and reported that he was sent to Antelope Valley Hospital following the incident, but that when he was returned he was not placed into a DPW cell. His medical records confirm that he was sent out to Antelope Valley Hospital following the incident, where he was diagnosed with acute flaccid paralysis and provided with a wheelchair. Mr. [redacted] also reported that, following his return, he was not given wipes, despite his inability to control his bowel movements. The RAP committee did not respond to his reports of excessive force, but

noted that he had not been provided wipes until August 1, 2018 and that he was "inappropriately housed in 7/27/18 when [he] returned from outside medical."

Mr. [redacted] second incident occurred in the D5 ASU Hub building on November 14, 2018. He informed us that an officer came to his cell (D5-[redacted] to take him to his counselor CCI [redacted] on November 14, 2018. The officer opened the food port, placed handcuffs on him in the front (waist-chains), and then told him to "stand up" and "turn around" so he could put chains on Mr. [redacted] Mr. [redacted] told him "I am DPW. I cannot stand," so the Officer said he was not going to open the door to lock the chains and that he would mark Mr. [redacted] down as a refusal. Mr. [redacted] then asked if he could talk to the Sergeant, so the Officer called out for Sergeant [redacted] to come to the door. When the Sergeant came over, the Officer said "he refused to uncuff," so the Sergeant and Officer grabbed the chains, pulling him out of his wheelchair and into the cell door. Mr. [redacted] arms came entirely out of the food-port (there were at least four officers pulling), which ripped the skin off of his hands and wrists. The Officers then took the cuffs off, making Mr. [redacted] fall backwards into his cell, laughing and remarking "you stood up now" along with a racial slur.

Mr. [redacted] reported that he was not written up nor was any use of force report written about the incident. He added that this was "one of many times" he was denied medical, yard, and groups on while housed on D5 because could not get out of his wheelchair and stand up. On Friday, November 23, 2018 he reported that he spoke to EOP ASU Lieutenant [redacted] about the incident and showed him the injuries, leading Lieutenant [redacted] to order that he could only be taken out of his cell by a Sergeant, even though a Sergeant was responsible for the incident. He informed us that the four officers who were party to the incident were Officers [redacted] and [redacted]

We request that the two incidents reported by Mr. [redacted] be investigated and that appropriate actions be taken to address any staff misconduct.

H. Program Assignment Discrimination

Several class members reported difficulty receiving assignments at LAC, or otherwise reported that staff belittled their ability to participate in program assignments. These reports are detailed below.

1. *Mr.* [redacted] *DPM, B-*[redacted], requested a job assignment and wrote that he had been at LAC for almost five years without an assignment. The RAP Response, received March 15, 2018, noted that "an inmate's position on the wait list is determined by several factors the most common being the length of time since being A1A. Additionally when inmates transfer in from other institutions on non-adverse transfers they usually retain their A1A status effective date. Also taken into account is supervisor's request for an inmate, taking into account institutional needs, ethnic

Exhibit J

State of California Department of Corrections and Rehabilitation

Memorandum

Date : August 8, 2019

To : GEORGE JAMIE
Associate Director (A)
High Security Mission

CHRIS PODRATZ
Region III Health Care Executive

Subject: **LAC RESPONSE TO THE *ARMSTRONG* MONITORING TOUR – DECEMBER 10-13, 2018**

Please find the attached information to Rosen, Bien, Galvan & Grunfeld (RBGG) report from the *Armstrong* Monitoring Tour, which took place at California State Prison – Los Angeles County in December 2018. The documentation provided includes a response to the report from the institution, to include Health Care Services Response as well, and the Request for Information and supporting documentation RBGG has asked for in their report.

The response that follows has been organized to follow the format of the RBGG report. The response and "Request for Information" provide information and rebuttal to some points raised in the RBGG report. While it is recognized that there were some areas of concern raised in the report that show room for improvement by the institution, it should be noted that the tour report shows LAC has made marked improvements by all staff to be in compliance with the *Armstrong* Remedial Plan and departmental policy regarding the care and treatment of incarcerated inmate-patients who are identified as *Armstrong* class members.

I. HEADQUARTERS RESPONSIBILITIES

A. Failure to Transfer DME Between Prisons

Under the *Armstrong* Remedial Plan, no person shall be deprived of an assistive device that was properly obtained unless there are documented safety or security reasons or a physician determines the appliances does not constitute a reasonable accommodation. ARP § IV.F.3. We continued to receive reports from LAC class members that their DMEs were not properly transferred with them when they were moved to or from LAC. We also reviewed multiple 1824 requests from the review period that raised similar concerns. These reports are detailed below.

1. *Mr.* [redacted] *DLT, DNH, D-*[redacted], reported on July 15, 2018 that he was transferred from RJD to LAC on July 10, 2018 without his hearing impaired mobility vest, orthotic boots, back brace, wedge pillow, or hearing aids. Following his appeal, his back brace and wedge pillow were found by the DVP to be "not medically indicated" (*see* Section VI.C, *infra*) and were discontinued. He received his remaining DMEs on July 24, 2018, two weeks after his transfer.

Response: LAC's Inmate Appeals Office received [redacted]n's CDCR 1824 on July 20, 2018 relative to the above issue in which the ADAC, forwarded to RJD to be placed on their Allegation of Non-Compliance Log. The IAO and the ADA office should have completed the Interim Accommodation Assessment to determine if there was anything that could be done to temporarily accommodate [redacted] until his DME was received from RJD. The inter-

5. *Mr.* [redacted] *DPW, S-*[redacted] wrote that he was transferred from CMF without his medical mattress. He requested to have his medically-granted mattress returned to him. The DVP form merely noted that there was "no medical indication for specialized mattress" and declined his request. A medical necessity standard should not be used in responding to disability accommodation requests.

Response: [redacted] was transferred to LAC's Administrative Segregation Unit on June 12, 2018, and at the time of transfer, he did not have a DME mattress listed on his inter-facility transfer from CMF and did not have one listed in SOMS or have an order for a mattress. At that time there was no indication of the issuance of a medical mattress in SOMS or DECS while housed at CMF. After filing a 7362 regarding a DME mattress on June 13, 2018, he refused the medical RN line the next day. He refused a PCP appointment on June 22, 2018 and other RN lines on June 26, July 5, July 17, and July 20, 2018. [redacted] submitted a CDCR 602 on July 10, 2018 which was received and processed as a CDCR 1824. Based on [redacted]' allegation, he was referred to Health Care and scheduled for an evaluation. Unfortunately, Mr. [redacted] refused his appointment, suggesting there was no need for a reasonable accommodation. This patient also refused the next PCP encounter on July 25, 2018.

Regarding the medical necessity standard concerns, see the response provided in Section II.A.

G. Disability-Related Staff Misconduct

Several prisoners we interviewed on the tour reported troubling instances of staff misconduct that was targeted at prisoners with disabilities, ranging from verbal harassment to excessive use of force complaints. Disturbingly, many of the complaints of staff misconduct came from prisoners housed in D-yard and in the C5 facility, where many class members with serious disability needs are housed.

1. *Mr.* [redacted], *DNH, D-*[redacted], requested on April 13, 2018 that Officer [redacted] in his unit be trained on how to adequately communicate with inmates with hearing impairments, as he was denied breakfast because the officer called for him to receive his tray but he did not hear the officer. He reported that, after he requested his tray, Officer [redacted] told him he had already traded the food to another inmate in exchange for sacrificing his yard time.

Response: This incident was placed on the Non-Compliance Log. Based on the findings of the inquiry, the allegation was not confirmed. Based on interviews and documentation, [redacted] received his morning meal and lunch as it was documented on CDCR-114A

2. *Mr.* [redacted], *B4, DPW*, said that in July 2018 he was not buckled in by Officer [redacted] when he went out to the hospital and flipped over three times in the van. Mr. [redacted] reported that Officer [redacted] drove quickly, and that as a result he flew back and forth in the back of the van. He reported that, soon after the van left, he fell over and hit his head and then saw the two officers laughing at him. He has since experienced neck and back pains. His medical records document that he was seen by a doctor at LAC following his complaints of neck pain and that he informed the provider that he "flipped backwards while being transported in a van July 1, 2018." Shortly after our interview with Mr. [redacted] on December 10, 2018, he was seen by his primary care provider, who noted that he "has a history of chronic

neck pain present since early July after his wheelchair flipped backwards off of vehicle lift" and noted that his neck pain was "currently not adequately controlled."

Plaintiffs request that LAC investigate the van incident reported by Mr. [redacted] and take appropriate action with the staff responsible. Furthermore, this incident should be added to the non-compliance log.

Response: Mr. [redacted]'s allegations identified above were placed on LAC's Non-Compliance Log. During the inquiry, custody, medical staff, and [redacted] were interviewed, and it was determined the allegations were not confirmed.

3. Mr. [redacted], [redacted], D5, [redacted], reported that Officer [redacted] in the C5 Unit threatened him for a whole month in August 2018. On August 23, 2018 he was at the medical window and Officer [redacted] told him to go back to his cell. He pulled away and then [redacted] claimed he struck him. He was written up with battery on a peace officer and has been in ASU since that time. He said that Officer [redacted] has a history of beating up inmates, especially EOPs, SNYs, and those with disabilities. On August 25, 2018, officers in D5 Unit assaulted him in his cell in retaliation for his alleged assault on Officer [redacted] He does not know the names of these officers, but says they were the first watch ASU staff.

Multiple class members also reported that B-yard Officer "[redacted]" or "[redacted]" frequently harasses DPW class members on B-yard. *Mr.* [redacted], [redacted], *B1, DPW*, reported that Officer [redacted] does not provide showers to inmates who have accidents when they request them. *Mr.* [redacted], [redacted], *B1, DPW*, reported that Officer [redacted] often refuses to let ADA inmates out of their cells when he works on the weekends.

Response: [redacted]'s allegations were placed on the LAC's Non-Compliance Log. Based on the finding of the inquiry, the allegations were not confirmed. The inquiry determined that [redacted] only accepts assistance from black inmates and typically requests the assistance from Mr. [redacted] who provides him assistance Monday through Friday when he is assigned to work. Several staff members and ADA workers were interviewed and state the officer and staff allow [redacted] a shower and out of cell time. However, often times [redacted] declines other ADA workers to assist him.

We also received two particularly concerning use of force reports from:

Mr. [redacted], [redacted], *DPW*. With respect to the first incident, Mr. [redacted] informed us that on July 25, 2018 he was sent to the EOP-ASU and had his radio taken away for making threats to a custody officer. As he was entering his assigned D5 cell ([redacted]), control booth officers closed the door on his foot. An officer opened his door and guards yanked him out of the cell, then slammed his face, kicked him in the face, and broke his glasses and radio. He reported that a psychiatric technician who witnessed the incident told staff that he was hurt, so he was taken to the CTC and then to Antelope Valley Hospital, where he stayed for two days. After this assault he was made DPW due to his injuries. He reported that officers repeatedly prevented medical staff at the hospital from taking a statement from him about what happened and refused to take pictures of his injuries.

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In appeal number D-[redacted], Mr. [redacted] reported this incident. In his appeal, dated July 28, 2018, he wrote that he lost his walker and cane. He also wrote that he suffered from acute flaccid paralysis to his lower extremities, and reported that he was sent to Antelope Valley Hospital following the incident, but that when he was returned he was not placed into a DPW cell. His medical records confirm that he was sent out to Antelope Valley Hospital following the incident, where he was diagnosed with acute flaccid paralysis and provided with a wheelchair. Mr. [redacted] also reported that, following his return, he was not given wipes, despite his inability to control his bowel movements. The RAP committee did not respond to his reports of excessive force, but noted that he had not been provided wipes until August 1, 2018 and that he was "inappropriately housed in 7/27/18 when [he] returned from outside medical."

Response: [redacted] transferred to LAC on June 11, 2018, and refused his initial PCP visit on June 20, 2018, and also the next scheduled appointment on July 19, 2018 prior to his incident. At that time, his DME consisted of a cane, walker, mobility vest, glasses and a knee brace. He was designated at that time as DPM according to SOMS where his 1845/7410 DPP Verification/Accommodation Chrono was done on October 5, 2017. [redacted]'s allegations of "Excessive Use of Force" surrounding Incident Log # LAC-D05[redacted] were addressed through the "Report of Findings" and "Staff Complaint" process, of which there were no findings of staff misconduct. With regard to inappropriately housing [redacted] upon his return from the hospital on July 25, 2018, this issue was placed on the Non-Compliance Log on August 8, 2018 based on the information provided on the CDCR 1824 submitted on July 28, 2018. [redacted] was not inappropriately housed following his return from the hospital as he was still designated as DPM. It was not until two (2) days later when Mr. [redacted]'s DPP designation was changed to DPW, where he was then appropriately re-housed in a DPW cell. LAC staff made an attempt to interview [redacted] on August 12, 2018 through the "Allegation of Non-Compliance Inquiry Process" and [redacted] refused to cooperate. As a result the allegations were not confirmed. Finally, the RAP committee did in fact respond to the excessive force allegations by stating they could not respond due to there being a CDCR 602 (Log # LAC-[redacted]) already filed by [redacted].

For purposes of a longitudinal perspective on his DME and mobility issues a Progress note–Nurse on November 11, 2017 detailed an encounter where [redacted] "jumped out of bed and carried his walker like he wants to hit" and "stood and walked with no issue". It was also noted during this

encounter that a part of the walker leg and screw had been removed. On a February 14, 2018 Outpatient Progress Note, the provider referenced the RN encounter on November 11, 2017, and noted "Patient was able to walk to the exam bed and turn and sit easily on the bed without any difficulties." And also "Patient seen by me walking normally to the transport van".

After the July 25, 2018 incident, [redacted]'s neurosurgery consult on July 26, 2018 post-incident noted that "he has not had any bowel or bladder incontinence and is currently using a urinal" at that encounter. On July 28, 2018, on [redacted]'s return from Antelope Valley Hospital, the P&S at the LAC TTA noted on exam that [redacted] "denies urination or bowel movement incontinence." [redacted] had no orders for incontinence supplies while at LAC. It should also be noted that the most recent medical documentation regarding [redacted]'s mobility prior to these incidents at LAC was on February 21, 2018 at Kern Valley State Prison. The PCP at KVSP noted in his Outpatient Progress note for that date that [redacted] had a "normal gait, moving all extremities easily in a coordinated manner" and also that [redacted] is "observed to walk normally without using a walker or cane etc.", that a "pursuit of secondary gain suspected" in regards to [redacted]'s presentation at that exam.

Mr. [redacted]'s second incident occurred in the D5 ASU Hub building on November 14, 2018. He informed us that an officer came to his cell (D5-[redacted] to take him to his counselor CCI [redacted] on November 14, 2018. The officer opened the food port, placed handcuffs on him in the front (waist-chains), and then told him to "stand up" and "turn around" so he could put chains on Mr. [redacted]. Mr. [redacted] told him "I am DPW. I cannot stand," so the Officer said he was not going to open the door to lock the chains and that he would mark Mr. [redacted] down as a refusal. Mr. [redacted] then asked if he could talk to the Sergeant, so the Officer called out for Sergeant [redacted] to come to the door. When the Sergeant came over, the Officer said "he refused to uncuff," so the Sergeant and Officer grabbed the chains, pulling him out of his wheelchair and into the cell door. Mr. [redacted]'s arms came entirely out of the food- port (there were at least four officers pulling), which ripped the skin off of his hands and wrists. The Officers then took the cuffs off, making Mr. [redacted] fall backwards into his cell, laughing and remarking "you stood up now" along with a racial slur.

Mr. [redacted] reported that he was not written up nor was any use of force report written about the incident. He added that this was "one of many times" he was denied medical, yard, and groups on while housed on D5 because could not get out of his wheelchair and stand up. On Friday, November 23, 2018 he reported that he spoke to EOP ASU Lieutenant [redacted] about the incident and showed him the injuries, leading Lieutenant [redacted] to order that he could only be taken out of his cell by a Sergeant, even though a Sergeant was responsible for the incident. He informed us that the four officers who were party to the incident were Officers [redacted], and [redacted].

We request that the two incidents reported by Mr. [redacted] be investigated and that appropriate actions be taken to address any staff misconduct.

Exhibit K

ROSEN BIEN GALVAN & GRUNFELD LLP

101 Mission Street, Sixth Floor
San Francisco, California 94105-1738
T: (415) 433-6830 ▪ F: (415) 433-7104
www.rbgg.com

Thomas Nolan
Email: tnolan@rbgg.com

July 16, 2019

VIA ELECTRONIC MAIL ONLY

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SUBJECT TO PROTECTIVE ORDERS

Russa Boyd
Non-Medical Class Action Team
CDCR Office of Legal Affairs
Russa.Boyd@cdcr.ca.gov

RC Johnson, Warden
California State Prison
Los Angeles County
44750 60th Street West
Lancaster, CA 93536

Re: *Armstrong v. Newsom*: Plaintiffs' Report re May 21-24, 2019 Monitoring Tour of California State Prison – Los Angeles County
Our File No. 0581-03

Dear All:

Enclosed is my report on Plaintiffs' May 21-24, 2019 monitoring tour of California State Prison – Los Angeles County ("LAC"). I would like to thank the staff at LAC who assisted with this tour for their courtesy and professionalism.

I look forward to working with you to improve the institution's compliance with the *Armstrong* Remedial Plan.

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Please note that the report and the attachments to the report are subject to the protective order in this case and should not be copied or distributed without referring to that order and following the procedures therein.

Sincerely,

ROSEN BIEN
GALVAN & GRUNFELD LLP

/s/ Thomas Nolan

By: Thomas Nolan
Of Counsel

TN:dvc
Attachment: Plaintiffs' Report and Exhibits

cc: Ed Swanson
Alexander Powell
Nicholas Meyer
Patricia Ferguson
Tamiya Davis
Mark Navarro
Erin Anderson
OLA Armstrong
Sharon Garske
Annakarina De La Torre-Fennell
Robert Henkels
Jay Russell
Adriano Hrvatin
Kelly Mitchell
Teauna Miranda
Georgia Johas-Darnell
Landon Bravo
Joseph Williams
Cathy Jefferson
Vincent Cullen
Desiree Collum
Lynda Robinson
Barb Pires
Ngoc Vo
Samantha Chastain
Olga Dobrynina
Dawn Malone-Stevens
Bryan McCloughan
Aledandrea Tonis
Gently Armedo
Matt Espenshade
Lois Welch
Steven Faris
Prison Law Office
Laurie Hoogland
Steven Blum
Bruce Beland
Jeff Macomber
John Dovey
Donald Meier
Robin Hart
Laurene Payne
Ceasar Aguila
CCHCS
Accountability
Cindy Flores

California State Prison – Los Angeles County (LAC)
May 21-24, 2019 Monitoring Tour
Armstrong v. Newsom

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problems noted in our March 19, 2019 Report regarding our December 2018 Monitoring Tour of LAC ("December 2018 Report") continue to be significant barriers to LAC's compliance with the ARP, *Armstrong* court orders, and the ADA. Following our tour, we sent a letter, attached hereto as **Exhibit A**, in which we requested LAC to follow up on individual accommodation needs of 41 of the 60 class members we interviewed during our tour. Please let us know what was done to evaluate the claimed accommodation needs and to actually accommodate these class members in response to our letter.

Throughout this report, we make recommendations and requests for information. These requests and recommendations are summarized again at the end of the report.

Some of the key issues identified in this report, almost all of which have also been reported as problems in prior reports, include the following:

- *Staff Misconduct:* We have serious, ongoing concerns about the use of excessive and unreasonable force on *Coleman* and *Armstrong* class members. We are also troubled by the persistent reports of harassment, retaliation, and custodial indifference to the needs of people with disabilities that we regularly receive from class members at LAC. Class members in the EOP Units at LAC raised these complaints the most persistently, although the complaints also came from class members on other facilities. Along with EOP program participants, class members with serious disabilities appear to be frequent targets of staff abuse and class members' willingness to make 1824 requests is often impeded by a fear of retaliation for making such requests. As we have emphasized in previous reports, staff misconduct – particularly the use of excessive force – creates a climate of fear that in turn produces a chilling effect on the ability of individuals with disabilities to request the accommodations that they need.

- *Transfer of DME Between and Within Institutions:* Our review of documents in connection with the tour showed that LAC still struggles to transfer DME with class members when they move between facilities within LAC and when they transfer to or from another prison. Problems with loss of DME when class members transfer into or out of the ASU building remain the dominant concern.

- *Incontinence Accommodations:* We continue to receive numerous complaints from class members that they are not afforded proper accommodations for their incontinence by either medical or custody staff. There were particular problems with access to adequate amounts of toilet paper and to showers after incontinence accidents.

- *Access to ADA Workers:* Class members continue to report that they have trouble obtaining assistance from ADA workers, particularly on the

F. Staff Misconduct Targeting Prisoners with Disabilities

We continue to receive disturbing allegations of staff misconduct from class members at LAC. In particular, during our tour we received multiple reports from class members that they were subjected to excessive or unnecessary force by officers and that officers show regular indifference or outright disdain for their accommodation needs. These allegations come most persistently from *Armstrong* class members housed in the EOP units at LAC (C5, D-Yard, and the D5 ASU Hub) and from the units on B-Yard and C-Yard that house the largest number of individuals who use wheelchairs. These complaints repeatedly name the same officers, again and again, who class members say target vulnerable prisoners with disabilities in need of assistance. Plaintiffs' Counsel in *Coleman* have also recently reported extensive concerns regarding staff misconduct, particularly the use of excessive force, against EOPs at LAC. *See* **Exhibit D.** Despite these ongoing reports, supervisory staff at LAC have been unable to bring this staff misconduct to an end. In light of the ongoing staff misconduct reports, we have questions about what has been done thus far to combat this problem:

- What has LAC management done thus far in response to the numerous staff misconduct complains covering *Armstrong* and *Coleman* class members at LAC during the last few years?
- How many officers or other staff have been disciplined at LAC for the staff misconduct issues reported in plaintiffs' letter and reports?
- What other steps has LAC considered to combat staff misconduct?
- Has the institution considered expanding the use of video cameras to combat this problem?
- What about using the 30% of positions not covered by post and bid to hand select officers for the EOP buildings and the buildings with large numbers of individuals who use wheelchairs? Has LAC used this approach?
- Has LAC management moved any correctional officers to different yards of housing units due to reports of staff misconduct against them?

LAC's problems with staff misconduct and high rates of use of force have been well-documented by the Office of the Inspector General in recent reports.

In his recent special report regarding staff complaint inquiries at Salinas Valley State Prison, the Inspector General noted that only two institutions (SVSP and CMC) processed more staff misconduct complaints than the 184 complaints processed by LAC staff during the six-month review period. Office of the Inspector General, Special Review of Salinas Valley State Prison's Processing of Inmate Allegations of Staff

Misconduct ["OIG SM Report"] at 20 (Jan. 2019).[3] In that Report, the Inspector General concluded that "the dependability of the staff complaint inquiries [at Salinas Valley State Prison] was significantly marred by inadequate investigative skills that reviewers demonstrated—notably, by their deficiencies in interviewing, collecting evidence, and writing reports." *Id* at 3. The OIG "found at least one significant deficiency in 173 of the 188 staff complaint inquiries (92 percent)." *Id*. The Inspector General noted, in particular, that "[a]lthough [his] special review focused only on Salinas Valley, the process we reviewed is in place at prisons statewide. Therefore, the conditions we found may also exist to some degree at other institutions." *Id* at 89. In a subsequent California State Assembly Budget Subcommittee hearing, Inspector General Roy Wesley bluntly told the state assembly that CDCR's staff complaint inquiry process is "entirely driven by the purpose to exonerate staff." See 3/4/19 Hr'g Audio Recording at 1:53:53.[4]

In his most recent use of force monitoring report, the Inspector General found that only three institutions employed force more often than LAC, which recorded 421 use of force incidents in 2018. Office of the Inspector General, Monitoring the Use of Force ["OIG UOF Report"] at 36 (Jun. 2019). The Report also found that four incidents reviewed by the Inspector General did not comply with departmental policies in their actual use of force, that five out of seven reviewed controlled use of force incidents did not comply with policy, and that fifty incidents were out of compliance outside of the actual use of force. *Id* at 32, 38.

1. Staff Misconduct Allegations From *Armstrong* Class Members in the D5 ASU Hub

We continue to receive numerous alarming accounts of staff misconduct from class members in the D5 ASU Hub. Class members in the D5 ASU Hub have repeatedly told our staff that D5 officers use demeaning racial epithets in conversation with them, subject them to violent and unnecessary force, and ignore their requests for help during mental health crises.

Of note, our December 2018 Report contained three allegations of excessive or unreasonable force involving class members in the D5 Unit. *See* December 2018 Report at 13-15. Likewise, *Coleman* Plaintiffs' April 2019 Letter detailed twenty-six different allegations involving as many as nineteen different officers regarding staff abuse of

[3] *Available* at https://www.oig.ca.gov/wp-content/uploads/2019/05/2019_Special_Review_-_Salinas_Valley_State_Prison_Staff_Complaint_Process.pdf.

[4] *Available* at https://www.assembly.ca.gov/media/assembly-budget-subcommittee-5-public-safety-20190304/audio.

mentally ill prisoners in the D5 Hub. *See* Ex. D at 5-8, 14, 17-21. Additional reports that we received during our May 2019 LAC tour are detailed below.

1. *Mr.* [redacted] *DPM, D5-*[redacted] reported that he experienced bad heartburn on April 17, 2019 and asked Officer [redacted] if he could be taken to the TTA. Officer [redacted] responded curtly "don't waste my time." Around the same time, a nurse practitioner warned him not to go "man down" if he felt chest pains. A few weeks later, Mr. [redacted] felt chest pains and again asked to go to the TTA. Officer [redacted] allegedly told him "shut your mouth you fucking nigger" and told him "I hope you go man down and I can take you there," implying that he would use unnecessary force on Mr. [redacted] if he went "man down."[5] During this same day, Officer [redacted] responded "fuck you" to Mr. [redacted] when he asked for medical attention. Mr. [redacted] also reported that numerous officers in the D5 Unit give wrong-size portions during meal times and often trade meals to prisoners in exchange for their yard time or showers. In particular, Mr. [redacted] reported that Officers [redacted] and [redacted] often gives prisoners extra food to skip a shower. According to Mr. [redacted] reports, Officer [redacted] is often verbally abusive towards prisoners in D5, telling them things like "fuck you go to sleep" in response to requests for assistance.

2. *Mr.* [redacted] *DLT, D5-*[redacted] reported during our interview with him on May 21, 2019 that officers in the D5 Unit continually call him "Coleman Snitch" because of the role he played in testifying in the 2013 Enforcement Hearings in *Coleman v. Newsom*. He said that he was assaulted by Officers [redacted] and Sergeant [redacted] on June 13, 2017 and that these officers – on second watch – regularly abuse and use excessive force against mentally ill prisoners. He also reported that multiple prisoners in the EOP hub are ignored after they engage in self-harm.

3. *Mr.* [redacted] *DPM, D5-*[redacted] reported in a letter following our tour that Officer [redacted] assaulted him on June 17, 2018 after he refused to wear his anti-seizure helmet.[6] He alleged that, after he refused to put on his anti-seizure helmet, Officer [redacted] slammed his head into his top bunk, lifting him out of his wheelchair. *Mr.* [redacted] *DLT, D5-*[redacted] separately reported witnessing this incident. He informed us that he saw Officer [redacted] punch Mr. [redacted] in the face that day from his cell. Mr. [redacted] records document that he told medical staff about the assault that same day: "Patient alleges earlier today he was assaulted regarding his refusal to wear his safety helmet. Patient noted with small superficial scrapes on lower right extremity Lateral aspect of right knee noted with soft tissue swelling… c/o pain to right and left side of his head… [t]his writer reported observed injuries to Dr. [redacted] in the TTA, patient requested to

[5] Other prisoners have alleged that Officer [redacted] used racially demeaning epithets during interactions with them as well. *See* Ex. D at 17.

[6] Other class members have also alleged that Officer [redacted] used excessive or unnecessary force on them. *See* December 2018 Report at 13-15.

be brought up for further evaluation." Another note in Mr. [redacted] medical file repeats Mr. [redacted] allegation: "I/P alleges he was assaulted with his own helmet and the officer slammed his helmet on his head in an aggressive manner and was told he has to wear his helmet due to a history of seizures." Following the incident, Mr. [redacted] told mental health staff that he felt unsafe in the D5 Hub and requested to be discharged to the CCCMS level of care, presumably so that he would not be around Officer [redacted].

4. *Mr.* [redacted] *D-*[redacted], reported that he was severely beaten by first watch officers in the D5 Unit on August 25, 2018 while he was asleep in his cell. Due to his injuries, he requested a wheelchair, a permanent cane, neck brace, knee brace, elbow brace, seizure helmet, dentures, and ankle brace. In response to his request, he was provided with dentures and a helmet was ordered for his seizures. Dr. [redacted] found that he had "no medical ind for: neck brace, elbow brace, wheelchair, or stockings." His appeal was also treated as a staff misconduct complaint, but was not placed on the non-compliance log because the RAP claimed "there is not nexus [sic] to your disability."

If they have not already been investigated, by outside investigators, we request that the staff misconduct incidents described in this section be investigated by staff from outside LAC.

2. **Staff Misconduct Allegations Against Facility-C Officer** [redacted]

During our tour, we interviewed C-Yard Building 1 3rd Watch Officer [redacted] who until recently worked in the C5 EOP Unit on 3rd Watch. Officer [redacted] was the subject of one allegation of excessive force in the December 2018 Report and eight allegations in Plaintiffs' April 2019 Letter in the *Coleman* case. *See* December 2018 Report at 13, Ex. D at 10-11, 15-16, 21-24. Of note, at least sixty-five EOP prisoners signed a petition to the C-Yard Captain in September 2018 requesting that Officer [redacted] be moved out of the C5 Unit due to his alleged practice of assaulting prisoners with mental illnesses at whim. Ex. D at 27-28. As we interviewed him using the routine questions for housing unit officers, Officer [redacted] joked about using force on prisoners ("What do you do if a prisoner breaks his cane to use it as a weapon?" "Then we spray them.") and evinced clear disdain for the needs of prisoners with disabilities ("Can you keep the shower hose in the ADA shower for class members to use?" "No, we can't put [the hose] in there, they'll fucking break it and it'll need to be replaced.").

We also received two more allegations of staff misconduct regarding Officer [redacted] These allegations are detailed below.

1. *Mr.* [redacted] *DPV, C5-*[redacted] reported that he accidentally got lotion in his one functioning eye on April 25, 2019. He asked Psychiatric Technicians [redacted] and [redacted] for medical attention, but they ignored him, only responding "leave us alone." No officers let him out of his cell for three hours after the accident. After he was let out of his cell, he went to talk to Sergeant [redacted] who would not talk to him and

motioned him away. Officer [redacted] (a different custody staff member) then came over and said "Lock it Up!", to which Mr. [redacted] responded "I'm trying to talk to the Sergeant." Officer [redacted] then came over, said "I'm tired of this," and grabbed Mr. [redacted] by the shoulders, leading him back to his cell. Mr. [redacted] who is well aware of the danger of resisting Officer [redacted] let himself be led back to his cell, but looked back once at Officer [redacted] Officer [redacted] immediately barked "if you look around again I'll drop you right here", to which Mr. [redacted] turned his head back quickly. The next day, Mr. [redacted] was able to go and see medical staff After he was evaluated by medical staff in the D/C-Yard medical building, he was sent to a hospital emergency room, because staff told him he had a corneal ulcer and could lose his eye, which would render him completely blind. His medical records confirm that he was diagnosed with a corneal ulceration on April 26, 2019 by his primary care provider, who then sent him to the Palmdale Regional Medical Center, where he was diagnosed and treated for a left corneal abrasion.

2. *Mr.* [redacted] *DLT, DNH, C5-*[redacted] reported a staff misconduct incident involving Officer [redacted] on March 22, 2019. That evening, Mr. [redacted] returned from dinner during 3rd Watch to find his assigned cell has been searched, with all of his personal belongings spilled onto the floor. Mr. [redacted] was told by Officer [redacted] that Officer [redacted] had searched his cell. Mr. [redacted] could not find Officer [redacted] so he returned to his cell and began to clean up his belongings. While he was cleaning his cell, Officer [redacted] came over to him and told him again that Officer [redacted] had conducted the cell search. A few hours later, during evening dayroom, Mr. [redacted] went over to Officer [redacted] and asked why his property had been thrown around his cell; in response, Officer [redacted] allegedly told Mr. [redacted] that he would "search his cell anyway he wants to."

During the cell search, Officer [redacted] took six apples from Mr. [redacted] which he had as an approved snack for his diabetes. Officer [redacted] also claimed he had one and a half gallons of alcohol in his cell, but other inmates who witnessed the cell search reported that this is not accurate. For instance, *Mr.* [redacted] *EOP, C5*, reported that he was in the C5 Unit during the search and heard Officer [redacted] going through Mr. [redacted] property; soon after, Mr. [redacted] reported seeing Officer [redacted] exit Mr. [redacted] cell with a small bag of apples. Later that day, another officer in the unit, Officer [redacted] gave Mr. [redacted] a cell search receipt with his name on it claiming that alcohol was found in his cell, even though Officer [redacted] was reportedly doing the diabetic line at the time. Mr. [redacted] was later written up for possession of contraband alcohol.

3. Other Allegations of Staff Misconduct

We have also received additional reports of staff misconduct against other prisoners with disabilities, including the following.

1. *Mr.* [redacted] *DPO, B-1-*[redacted] We have received reports of a concerning excessive use of force incident involving class member Mr. [redacted] and an Officer [redacted] on December 9, 2018. As is the case with Officer [redacted] Officer [redacted] has been the subject of previous excessive force complaints involving *Coleman* class members at LAC. *Id* at 8-9. According to class members' recent reports, Officer [redacted] was recently reassigned to the mail room and no longer interacts with class members on a daily basis.

The incident on December 9, 2018 began when Mr. [redacted] asked his neighbor for a glove so that he could clean his toilet. After his neighbor handed him the glove, Officer [redacted] formerly B1 3rd Watch, thought that the pair had exchanged contraband, so he directed Tower Officer [redacted] to open Mr. [redacted] cell door. Rather than ask Mr. [redacted] to cuff up, Officer [redacted] immediately slammed Mr. [redacted] into the ground, severely injuring Mr. [redacted] spine. Mr. [redacted] was then strip-searched and had his cell searched, both with negative findings.

Mr. [redacted] cellmate, *Mr.* [redacted] reported that he witnessed the entire incident. While Mr. [redacted] sat on his bunk, he witnessed Officers [redacted] and [redacted] arrive at his cell-front. After the door had opened, Mr. [redacted] reported that he witnessed Officer [redacted] grab Mr. [redacted] by the shoulder without any warning, pull him towards the cell door, and then yank him to the ground. According to Mr. [redacted] report, Mr. [redacted] fell hard on his back. Officer [redacted] then flipped Mr. [redacted] over and brought him out of the cell. While this was in process, Mr. [redacted] attempted to tell Officer [redacted] that Mr. [redacted] had serious back problems, but Officer [redacted] ignored him. Mr. [redacted] then walked over to his cell-front and witnessed Officer [redacted] press his knee into Mr. [redacted] back and then cuff Mr. [redacted] up. While on the ground, Mr. [redacted] allegedly told Officer [redacted] that he was a DPP prisoner and, after he struggled to stand on his own accord, brought a wheelchair for him to be wheeled to the program office. A few minutes later, a number of officers arrived at Mr. [redacted] cell-front, cuffed him up, and took him to the lower-A shower, where he was strip searched and then returned to his cell approximately twenty minutes later. A few minutes after that, Mr. [redacted] was returned his the cell; Mr. [redacted] had to help him get to the lower bunk bed due to his evident discomfort from the incident.

Mr. [redacted] filed an 1824 request soon after the incident (*B-*[redacted], in which he reported that Officer [redacted] used excessive force to slam him to the ground during third watch in the B1 building. In his 1824, he requested a back brace and a mobility walker – which he had previously been prescribed by his doctor – to deal with the pain from the assault. Inappropriately, the IAP instructed Mr. [redacted] to "fill out a 1824 requesting medical to reevaluate his medical treatment plan" in response to his request on December 12, 2018.

While Mr. [redacted] was ordered a back brace and provided with a walker on that day, the RAP incorrectly claimed that his requests were denied and directed him to file a

602 about his issue rather than an 1824. His allegations about excessive force were not placed on the non-compliance log.

Mr. [redacted] medical records document he also filed a 7362 request the day after the incident, writing "I'm in extreme [*sic*] pain due to inmate officer involved incident I need immediate [*sic*] medical help." **Exhibit E at 1.** On December 11, 2018, two days after he was assaulted, Mr. [redacted] went "man down" and was taken to the clinic for an evaluation. At the clinic, he told Dr. [redacted] that "on Sunday he was slammed down by custody officers and has since been complaining of progressively worsening acute on chronic lower back pain radiating down left leg..." *Id.* at 2. According to his medical records, he also informed RN [redacted] that "custody slammed me down last Sunday and now it hurts back, I cannot sit up or walk." *Id.* at 3. At the clinic, Mr. [redacted] was given a wheelchair to help him ambulate and was sent out for an MRI.

The MRI results, received a month later, resulted in Mr. [redacted] being diagnosed with multilevel degenerative spondylosis with a left asymmetric disc extrusion. Due to his injuries, Mr. [redacted] was made DPO, which remains his designation today.

Incredibly, Officer [redacted] claimed that no force was used during the incident. In his description of the incident, Officer [redacted] wrote "I approached cell [redacted] and instructed the Control Booth Officer to open the cell door. As the cell door opened, [redacted] stood in the doorway facing my position. I gave [redacted] a direct order to exit the cell; [redacted] stated, "No" and quickly turned his body towards his right side, losing his balance causing his momentum to bring him stumbling towards my position and falling on the ground… I asked [redacted] if he needed medical attention, [redacted] refused medical attention by stating, "No, I'm good." **Exhibit F.** No incident report was produced to Plaintiffs' Counsel regarding the incident.

Following the assault, Mr. [redacted] filed a staff misconduct complaint against Officer [redacted] and was accordingly interviewed by ISU Officers. Mr. [redacted] expressed serious reservations about the credibility and thoroughness of this investigation, as many of the LAC ISU officers are reportedly friends with Officer [redacted]

2. *Mr.* [redacted] *DNH, D5-*[redacted] likewise alleged that he was a victim of excessive force at the hands of custody staff. He reported that he was assaulted by Officer [redacted] on April 15, 2019.[7] The day of the assault, he had not been let out of his cell to take the medications he is prescribed to prevent seizures and had suffered a seizure that morning as a result. His medical records document that Mr. [redacted] did indeed have a seizure that morning. Mr. [redacted] informed our staff that, because he had not been let out of his cell to take his medications that morning, he complained to

[7]Officer [redacted] was also the subject of one complaint in *Coleman* Plaintiffs' April 2019 Letter. *See* Ex. D at 15.

staff about the issue. Later that day, Officer [redacted] approached him in front of the chow hall, twisted his arm, knocked his seizure-prevention helmet off of his head, and said "who's a bitch now?" According to Mr. [redacted] Mr. [redacted] left hearing aid was broken during the assault. As of the date of our interview, his hearing aid had not been repaired.

As in the case of Mr. [redacted] Mr. [redacted] custody records claim that no force was used by Officer [redacted] during the incident. In his write-up of the incident for a Rules Violation Report for "Threatening Staff" from the incident, Officer [redacted] claims that he originally approached Mr. [redacted] to order him "to tuck in his shirt before entering the dining hall." **Exhibit G**. Mr. [redacted] then allegedly became very tense and cursed at Officer [redacted] who directed him to cuff up; according to the report, Mr. [redacted] at first refused and then peaceably cuffed up without resistance. Mr. [redacted] was then taken to the D-Yard Gym and placed into a holding cell. Officer [redacted] report does not state that he used force on Mr. [redacted] nor does it articulate an imminent threat to justify the use of force, as required by policy.

3. *Mr.* [redacted] *DPO, C4-*[redacted] also reported a disturbing use of force incident that occurred in early April 2019. When he arrived to LAC from RJD on April 10, 2019, he was placed into the ASU building without any of his property. He told one of the officers in the building that he needed his testosterone shot and his morphine, but was told that they did not have the testosterone shot and that his morphine had been discontinued. He began to suffer withdrawals from morphine and broke the windows in his cell, so staff took him out of his cell and placed him in a holding cage. After he was placed in the cage, he continued to inform officers of his withdrawals, to which the 3rd Watch Sergeant told him "fuck you man." He grew frustrated and began to kick the door of his holding cell, so the Sergeant opened the cell door, put a lock around his fist to form makeshift brass knuckles, stepped on Mr. [redacted] bad foot, and said challengingly "kick me, motherfucker, kick me." During this altercation, the Lieutenant walked around the corner, saw what was happening, and spun on his heel to leave the vicinity without intervening. The Sergeant then shut and locked the cage, leaving Mr. [redacted] there for the next three hours. Then two officers came, retrieved Mr. [redacted] and placed him in Z1-[redacted], which was covered in feces. He was left in that cell for five days and did not receive any cleaning supplies the whole time. He filed a staff misconduct appeal about these events, but as of the time of his interview on May 23, 2019 had yet to receive a response or a log number.

Is there a record of Mr. [redacted] appeal? If so, please provide a copy to Plaintiffs' Counsel.

4. *Mr.* [redacted] *DLT, DNH, D-*[redacted], reported on August 27, 2018 that Officers in the D4 EOP Unit, including Officers [redacted] and [redacted] refused to provide him with assistance when he was experiencing severe chest pains. He requested to be moved from the D4 Unit to a different unit where he could receive

medical assistance when needed. In response to his request, CCI Soto moved him to the D1 Unit, and the RAP treated his allegations as a staff misconduct complaint.

5. *Mr.* [redacted] *DLT, B-*[redacted], reported that on September 18, 2018 he left the chow hall with his walker, which has a bag on it to help him carry his possessions, as he cannot hold items while pushing his walker. He alleged that three officers stopped him, put him up against the wall, took his walker, and then took the bag from the walker and threw it out. He requested to have his bag returned to him, which he needs to carry his legal materials and other supplies. His allegation was placed on the non-compliance log for further inquiry. In response to his appeal, the RAP informed Mr. [redacted] that he could request assistance from ADA workers with carrying items and did not return his bag to him.

6. *Mr.* [redacted], *DNM, S-*[redacted], reported that he was jumped by an officer on April 29, 2018, who then stole his eyeglasses. His appeal was not stamped received by staff until almost six months later on October 19, 2018. On October 23, 2018 his PCP submitted a request for a new pair of glasses for him and the RAP referred his allegation to the Inmate Appeals office to process as a staff complaint. His allegation was not placed on the non-compliance log.

7. *Mr.* [redacted] *DPM, B-*[redacted], reported that on July 31, 2018 Officer [redacted] searched his cell (B3-[redacted] and removed his mattress. Officer [redacted] did not return Mr. [redacted] mattress to him or replace it with another mattress, leaving Mr. [redacted] to sleep on his hard metal bed. Mr. [redacted] requested to have his mattress returned to him. According to staff, Mr. [redacted] was offered a different mattress later that day, but refused. He was not provided another mattress until August 7, 2018. His allegation was also placed onto the non-compliance log for further inquiry.

8. *Mr.* [redacted] *DPM, S-*[redacted], reported on December 18, 2018 that Officer [redacted] in the D4 Unit took all of his DMEs from him on December 1, 2018, including his TENS unit, nasal inhaler, therapeutic boots, and braces. According to Mr. [redacted] allegations, he was then assaulted by multiple officers, who hit him in the back, knees, and chest. The assault exacerbated Mr. [redacted] chronic pain. Mr. [redacted] requested replacement of all of his DMEs. He also requested a walker to help him ambulate around his unit.

Despite the fact that Mr. [redacted] DME were verified through the appeal process, he was not provided with the DME. Instead, Dr. [redacted] found he had "no medical indication" for any of his lost DMEs and refused to return them to him. Mr. [redacted] allegations were processed as a staff complaint, but were not placed on the non-compliance log.

Why was a new medical opinion sought regarding Mr. [redacted] DME? We strongly object to this punitive approach to prisoners who file 1824 requests seeking

to have missing DME returned. Mr. [redacted] existing entitlement to these DME should have been enough basis to return them to him or order new replacement DME. This appeal raises serious concerns about retaliation in the 1824 process.

9. *Mr. [redacted] DPW, A-[redacted]*, reported that Tower Officer [redacted] refused to let him out of his cell on January 19, 2019 when other inmates were allowed out, and that this was done in retaliation for Mr. [redacted] frequent grievances and requests. The RAP screened out Mr. [redacted] appeal and did not place his allegations on the non-compliance log. In another appeal (*A-[redacted]*), Mr. [redacted] reported on February 11, 2019 that it was twenty-four degrees Fahrenheit in his unit and yet officers refused to turn on the heat. According to Mr. [redacted] allegations, officers instead taunted inmates for being cold and belittled their need for a livable temperature. He requested that officers be rotated from his unit so that he and other prisoners did not have to face harassment from officers. His request was screened out as non-ADA related and he was directed to file a 602 about his concerns.

In still another complaint filed on December 7, 2018 (*A-[redacted]*), Mr. [redacted] reported that staff often place his property on his upper bunk after cell searches, which he cannot reach due to his DPW status, without risking a serious fall or injury. In response to his appeal, the RAP informed him that "custody staff assigned to the housing units have been informed to be mindful when searching the cells of inmates with disabilities to ensure when items are moved they are not placed in an area such as on the top of the bunk or other areas within the cell, which may make it difficult for the inmate to reach." Mr. [redacted]'s allegation was not placed on the non-compliance log.

10. *Mr. [redacted] DPO, D-[redacted]*, reported that he was told by an officer in his unit that he would be written up if he took his wheelchair into his cell. He requested to be moved into an ADA cell. The RAP declined to move him, and failed to respond to his complaint about the threat to write Mr. [redacted] up for taking his own DME into his cell.

11. *Mr. [redacted] EOP, D-[redacted]*, reported that he attempted suicide on July 18, 2018 and was beaten up by guards on C-Yard as a result. He reported that this incident severely impacted his mental health and that he was severely depressed as a result. Rather than treat his appeal as a staff misconduct problem or convert it to a 602-SM, the RAP merely told him to file a new 602-SM about the incident.

12. *Mr. [redacted] DLT, DNH, B-[redacted]*, reported that his mobility vest was taken from him and thrown away by staff during a mass search on July 30, 2018. He requested a new mobility vest. The IAP Reviewer (CCI [redacted] attempted – but was unable – to find out which staff threw away Mr. [redacted] vest. The RAP provided him with a new vest on August 13, 2018 and placed his allegations on the non-compliance log. In another 1824 request, (*B-[redacted]*), Mr. [redacted] reported that he was placed in flex-cuffs behind his back on July 30, 2018 for five hours, despite his

permanent waist-chains chrono. This cuffing caused Mr. [redacted] to reinjure his right shoulder. During the IAP, Mr. [redacted] informed CCI [redacted] that he was not sure the name of the staff member who cuffed him in contravention of his waist-chains chrono. According to the RAP, his complaint was reviewed by the Warden, who determined it should be addressed via the staff complaint process. Mr. [redacted] complaint was not placed on the non-compliance log.

13. *Mr.* [redacted] *DNH, C-*[redacted], reported that on August 9, 2018 he went out to the hospital following an overdose and, upon his return the next day, all of his property including his DMEs were gone. Mr. [redacted] finally received his property back and was given a hearing impaired vest nearly three weeks later on August 28, 2018. He also had hearing aids reordered the same day. However, he did not receive his orthotics, as Dr. [redacted] found he had "no medical indication" for them. His allegation was placed onto the non-compliance log.

As was the case with Mr. [redacted] above, we do not understand why was a new medical opinion was sought regarding Mr. [redacted] DME as part of the 1824 process. We strongly object to this punitive approach to prisoners who file 1824 requests seeking to have missing DME returned. Mr. [redacted] existing entitlement to these DME should have been enough basis to return them to him or order new replacement DME. This appeal raises serious concerns about retaliation in the 1824 process.

Dr. [redacted] also used the wrong standard in resolving whether Mr. [redacted] should have his orthotics. The standard is reasonable accommodation – basically, are the orthotics helpful.

Plaintiffs request an update regarding the investigations into the allegations of staff misconduct in our December 2018 Report. We also ask that all of the allegations detailed above be investigated by non-LAC ISU staff. We ask that this section of the report not be shared with line staff at LAC, and that any investigation into our class members' allegations be conducted by non-LAC staff. Like Mr. [redacted] we are concerned that any investigation by LAC ISU staff will merely paper over our class members' complaints and obstruct any attempts to bring about badly needed changes to LAC.

We furthermore request that headquarters and institutional leadership develop a corrective action plan to address our class members' repeated and consistent allegations of staff misconduct at LAC.

Exhibit L

OFFICE OF LEGAL AFFAIRS
Jennifer Neill
General Counsel
P.O. Box 942883
Sacramento, CA 94283-0001

July 23, 2019

VIA EMAIL ONLY

Mr. Thomas Nolan
Rosen Bien Galvan & Grunfeld LLP
tnolan@rbgg.com

Re: California State Prison, Los Angeles County: Non Class Action Allegations

Dear Mr. Nolan:

This letter is to acknowledge receipt of the correspondence received from your office on July 16, 2019, concerning allegations at California State Prison, Los Angeles County (LAC).

The allegations mentioned below, that were presented in your correspondence, were routed to the appropriate personnel at CDCR. The Legal Liaison for the High Security Mission, Alan Sobel, will provide you with information when it becomes available.

- Page 21 – All six bullet points.
- Page 23 , number 1 regarding Mr. [redacted]
- Page 23, number 2 regarding Mr. [redacted]
- Page 24, number 4 regarding Mr. [redacted] The first sentence in this paragraph will be responded to by Mr. Sobel. This allegation was also previously reported on page 13 of Plaintiff's LAC Dec 2018 AMT report dated 3/19/19, and has already been assigned to Mr. Sobel. The rest of the paragraph will be responded to through *Armstrong*.
- Page 24, number 1 regarding Mr. [redacted]
- Page 25, number 2 regarding Mr. [redacted]
- Page 26, number 1 regarding Mr. [redacted]
- Page 28, number 3 regarding Mr. [redacted]
- Page 28, number 4 regarding Mr. [redacted]
- Page 29, number 6 regarding Mr. [redacted]
- Page 29, number 7 regarding Mr. [redacted]
- Page 29, number 8 regarding Mr. [redacted] The second and third sentences will be responded to by Mr. Sobel. The remainder will be responded to through *Armstrong*.

- Page 30, number 9 regarding Mr. [redacted] The second half of the first paragraph beginning with "In another appeal (A-[redacted])" and ending with "file a 602 about his concerns.", will be responded to by Mr. Sobel. Everything else in number 9 will be responded to through *Armstrong*.
- Page 30, number 11 regarding Mr. [redacted] has been assigned to OLA's *Coleman* team.

If we need any additional information in order to address these matters, we will contact your office.

Sincerely,

/s/ Erin D. Anderson

ERIN D. ANDERSON
Appeals and Compliance Coordinator
Office of Legal Affairs

cc: Russa Boyd, Attorney IV
Alan Sobel, Attorney IV
Tamiya Davis, Attorney III

Exhibit M

State of California

Department of Corrections and Rehabilitation

Memorandum

Date : April 8, 2020

To : JARED LOZANO
Associate Director
High Security Mission

CHRIS PODRATZ
Region II Health Care Executive

Subject: **LAC RESPONSE TO THE *ARMSTRONG* MONITORING TOUR –MAY 21-24, 2019**

Please find the attached information to Rosen, Bien, Galvan & Grunfeld (RBGG) report from the *Armstrong* Monitoring Tour, which took place at California State Prison-Los Angeles County (LAC) in May 2019. The documentation provided includes a response to the report from the institution, to include Health Care Services Response as well, and the Request for Information and supporting documentation RBGG has requested in their report.

The response that follows has been organized to follow the format of the RBGG report. The response and "Request for Information" provide information and rebuttal to some points raised in the RBGG report. While it is recognized that there were some areas of concern raised in the report that show room for improvement by the institution, it should be noted that the tour report shows LAC has made marked improvements by all staff to be in compliance with the *Armstrong* Remedial Plan and departmental policy regarding the care and treatment of incarcerated inmate-patients who are identified as *Armstrong* class members.

I. INTRODUCTION AND EXECUTIVE SUMMARY

On May 21-24, 2019 representatives from Plaintiffs' Counsel, including attorneys Thomas Nolan and Hugo Cabrera, and Paralegal Dylan Verner-Crist conducted an *Armstrong* monitoring tour at California State Prison – Los Angeles County (LAC) to monitor the prison's compliance with the *Armstrong* Remedial Plan (ARP), *Armstrong* court orders, and the Americans with Disabilities Act (ADA). We would like to thank Warden RC Johnson, CAMU CCI [redacted], ADA Coordinator Michelle Wofford, *Armstrong* CCI [redacted], *Clark* CCI [redacted], and OLA Attorney Tamiya Davis for their assistance facilitating our tour.

As of midnight, May 22, 2019, LAC had the capacity to house 2,300 people, but actually housed 3,223 individuals, which brought the prison to 140.1% of capacity. According to Defendants' records, 382 identified and tracked *Armstrong* class members lived at the prison at the time of our visit. The following number of impacting placement class members were housed at the prison according to the June 3, 2019 DECS Report:

F. Staff Misconduct Targeting Prisoners with Disabilities

We continue to receive disturbing allegations of staff misconduct from class members at LAC. In particular, during our tour we received multiple reports from class members that they were subjected to excessive or unnecessary force by officers and that officers show regular indifference or outright disdain for their accommodation needs. These allegations come most persistently from *Armstrong* class members housed in the EOP units at LAC (C5, D-Yard, and the D5 ASU Hub) and from the units on B-Yard and C-Yard that house the largest number of individuals who use wheelchairs. These complaints repeatedly name the same officers, again and again, who class members say target vulnerable prisoners with disabilities in need of assistance. Plaintiffs' Counsel in *Coleman* have also recently reported extensive concerns regarding staff misconduct, particularly the use of excessive force, against EOPs at LAC. *See* **Exhibit D.** Despite these ongoing reports, supervisory staff at LAC have been unable to bring this staff misconduct to an end. In light of the ongoing staff misconduct reports, we have questions about what has been done thus far to combat this problem:

- What has LAC management done thus far in response to the numerous staff misconduct complains covering *Armstrong* and *Coleman* class members at LAC during the last few years?
- How many officers or other staff have been disciplined at LAC for the staff misconduct issues reported in plaintiffs' letter and reports?
- What other steps has LAC considered to combat staff misconduct?
- Has the institution considered expanding the use of video cameras to combat this problem?
- What about using the 30% of positions not covered by post and bid to hand select officers for the EOP buildings and the buildings with large numbers of individuals who use wheelchairs? Has LAC used this approach?
- Has LAC management moved any correctional officers to different yards of housing units due to reports of staff misconduct against them?

LAC's problems with staff misconduct and high rates of use of force have been well-documented by the Office of the Inspector General in recent reports.

In his recent special report regarding staff complaint inquiries at Salinas Valley State Prison, the Inspector General noted that only two institutions (SVSP and CMC) processed more staff misconduct complaints than the 184 complaints processed by LAC staff during the six-month review period. Office of the Inspector General, Special Review of Salinas Valley State Prison's Processing of Inmate Allegations of Staff Misconduct ["OIG SM Report"] at 20 (Jan.

2019).[3] In that Report, the Inspector General concluded that "the dependability of the staff complaint inquiries [at Salinas Valley State Prison] was significantly marred by inadequate investigative skills that reviewers demonstrated—notably, by their deficiencies in interviewing, collecting evidence, and writing reports." *Id* at 3. The OIG "found at least one significant deficiency in 173 of the 188 staff complaint inquiries (92 percent)." *Id*. The Inspector General noted, in particular, that "[a]lthough [his] special review focused only on Salinas Valley, the process we reviewed is in place at prisons statewide. Therefore, the conditions we found may also exist to some degree at other institutions." *Id* at 89. In a subsequent California State Assembly Budget Subcommittee hearing, Inspector General Roy Wesley bluntly told the state assembly that CDCR's staff complaint inquiry process is "entirely driven by the purpose to exonerate staff." See 3/4/19 Hr'g Audio Recording at 1:53:53.[4]

In his most recent use of force monitoring report, the Inspector General found that only three institutions employed force more often than LAC, which recorded 421 use of force incidents in 2018. Office of the Inspector General, Monitoring the Use of Force ["OIG UOF Report"] at 36 (Jun. 2019). The Report also found that four incidents reviewed by the Inspector General did not comply with departmental policies in their actual use of force, that five out of seven reviewed controlled use of force incidents did not comply with policy, and that fifty incidents were out of compliance outside of the actual use of force. *Id* at 32, 38.

1. Staff Misconduct Allegations From *Armstrong* Class Members in the D5 ASU Hub

We continue to receive numerous alarming accounts of staff misconduct from class members in the D5 ASU Hub. Class members in the D5 ASU Hub have repeatedly told our staff that D5 officers use demeaning racial epithets in conversation with them, subject them to violent and unnecessary force, and ignore their requests for help during mental health crises.

Of note, our December 2018 Report contained three allegations of excessive or unreasonable force involving class members in the D5 Unit. *See* December 2018 Report at 13-15. Likewise, *Coleman* Plaintiffs' April 2019 Letter detailed twenty-six different allegations involving as many as nineteen different officers regarding staff abuse of mentally ill prisoners in the D5 Hub. *See* Ex. D at 5-8, 14, 17-21. Additional reports that we received during our May 2019 LAC tour are detailed below.

1. **Mr. [redacted] DPM**, D5-[redacted], reported that he experienced bad heartburn on April 17, 2019 and asked Officer [redacted] if he could be taken to the TTA. Officer [redacted] responded curtly "don't waste my time." Around the same time, a nurse practitioner warned him not to go "man down" if he felt chest pains. A few weeks later, Mr [redacted] felt chest pains and again asked to go to the TTA. Officer [redacted] allegedly told him "shut your mouth you fucking nigger" and told him "I hope you go man down and I can take you there," implying

[3] *Available* at https://www.oig.ca.gov/wp- content/uploads/2019/05/2019_Special_Review_-_Salinas_Valley_State_Prison_Staff_Complaint_Process.pdf.

[4] *Available* at https://www.assembly.ca.gov/media/assembly-budget-subcommittee-5- public-safety-20190304/audio.

that he would use unnecessary force on Mr. [redacted] if he went "man down."[5] During this same day, Officer [redacted] responded "fuck you" to Mr. [redacted] when he asked for medical attention. Mr. [redacted] also reported that numerous officers in the D5 Unit give wrong-size portions during meal times and often trade meals to prisoners in exchange for their yard time or showers. In particular, Mr. [redacted] reported that Officers [redacted] and [redacted] often gives prisoners extra food to skip a shower. According to Mr. [redacted] reports, Officer [redacted] is often verbally abusive towards prisoners in D5, telling them things like "fuck you go to sleep" in response to requests for assistance.

2. **Mr. [redacted] DLT**, D5 [redacted], reported during our interview with him on May 21, 2019 that officers in the D5 Unit continually call him "Coleman Snitch" because of the role he played in testifying in the 2013 Enforcement Hearings in *Coleman v. Newsom*. He said that he was assaulted by Officers [redacted] and Sergeant [redacted] on June 13, 2017 and that these officers – on second watch – regularly abuse and use excessive force against mentally ill prisoners. He also reported that multiple prisoners in the EOP hub are ignored after they engage in self-harm.

3. **Mr. [redacted] DPM**, D5-[redacted], reported in a letter following our tour that Officer [redacted] assaulted him on June 17, 2018 after he refused to wear his anti- seizure helmet.[6] He alleged that, after he refused to put on his anti-seizure helmet, Officer [redacted] slammed his head into his top bunk, lifting him out of his wheelchair. Mr. [redacted] DLT, D5-[redacted] separately reported witnessing this incident. He informed us that he saw Officer [redacted] punch Mr. [redacted] in the face that day from his cell. Mr [redacted] records document that he told medical staff about the assault that same day: "Patient alleges earlier today he was assaulted regarding his refusal to wear his safety helmet. Patient noted with small superficial scrapes on lower right extremity Lateral aspect of right knee noted with soft tissue swelling... c/o pain to right and left side of his head... [t]his writer reported observed injuries to Dr [redacted] in the TTA, patient requested to be brought up for further evaluation." Another note in Mr. [redacted] medical file repeats Mr. [redacted] allegation: "I/P alleges he was assaulted with his own helmet and the officer slammed his helmet on his head in an aggressive manner and was told he has to wear his helmet due to a history of seizures." Following the incident, Mr. [redacted] told mental health staff that he felt unsafe in the D5 Hub and requested to be discharged to the CCCMS level of care, presumably so that he would not be around Officer [redacted]

Response: On June 17, 2018, [redacted] was at SVSP. A review of his SOMS disciplinary report indicates that on June 17, 2019, while at LAC he received an RVR for Willfully Resisting a Peace Officer in the Performance of Duties. The RVR is still pending adjudication process. A 602 staff complaint was submitted to the appeals office regarding the above incident and is being reviewed.

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[5] Other prisoners have alleged that Officer [redacted] used racially demeaning epithets during interactions with them as well. *See* Ex. D at 17.

[6] Other class members have also alleged that Officer [redacted] used excessive or unnecessary force on them. *See* December 2018 Report at 13-15.

4. **Mr.** *D-* , reported that he was severely beaten by first watch officers in the D5 Unit on August 25, 2018 while he was asleep in his cell. Due to his injuries, he requested a wheelchair, a permanent cane, neck brace, knee brace, elbow brace, seizure helmet, dentures, and ankle brace. In response to his request, he was provided with dentures and a helmet was ordered for his seizures. Dr. found that he had "no medical ind for: neck brace, elbow brace, wheelchair, or stockings." His appeal was also treated as a staff misconduct complaint, but was not placed on the non- compliance log because the RAP claimed "there is not nexus [sic] to your disability."

Response: was not a class member at the time of the alleged incident. Therefore, the allegation was not placed on the non-compliance log. On a July 25, 2018 Outpatient Progress note, was seen for seizure activity. He received a Temporary cane the next day to assist with any mobility or balance issues following the incident per a signed 7536 on July 26, 2018. was seen by the PCP as noted on a September 10, 2018 Outpatient Progress Note, where a physical exam was conducted and his requests were considered along with his overall ambulatory needs. Based on this exam, his 1845/7410 was updated to reflect a DLT code with corresponding restrictions. DME requests, including a neck brace, wheelchair, compression stockings, and diapers, were considered at this visit, but not provided. A knee brace, ankle brace or elbow brace were not brought to the attention of the PCP at this time. He transferred to SVSP on December 22, 2018 before any other DME requests were able to be addressed at LAC.

If they have not already been investigated, by outside investigators, we request that the staff misconduct incidents described in this section be investigated by staff from outside LAC.

2. **Staff Misconduct Allegations Against Facility-C Officer**

During our tour, we interviewed C-Yard Building 1 3rd Watch Officer who until recently worked in the C5 EOP Unit on 3rd Watch. Officer was the subject of one allegation of excessive force in the December 2018 Report and eight allegations in Plaintiffs' April 2019 Letter in the *Coleman* case. *See* December 2018 Report at 13, Ex. D at 10-11, 15-16, 21-24. Of note, at least sixty-five EOP prisoners signed a petition to the C-Yard Captain in September 2018 requesting that Officer be moved out of the C5 Unit due to his alleged practice of assaulting prisoners with mental illnesses at whim. Ex. D at 27-28. As we interviewed him using the routine questions for housing unit officers, Officer joked about using force on prisoners ("What do you do if a prisoner breaks his cane to use it as a weapon?" "Then we spray them.") and evinced clear disdain for the needs of prisoners with disabilities ("Can you keep the shower hose in the ADA shower for class members to use?" "No, we can't put [the hose] in there, they'll fucking break it and it'll need to be replaced.").

Response: Officer's response when asked "what do you do if a prisoner breaks his cane to use it as a weapon" was an appropriate response, in that, pepper spray is a use of force option to utilized to prevent the risk of serious injury to inmates or staff if necessary. C5 shower hose in lower section shower is now connected to the shower and is being utilized by ADA inmates. Informal OJT training was provided to all custody staff on facility C regarding inmates with disabilities and the shower hose being left in the ADA shower in October 2019.

We also received two more allegations of staff misconduct regarding Officer [redacted] These allegations are detailed below.

1. **Mr.** [redacted], DPV, C5-[redacted], reported that he accidentally got lotion in his one functioning eye on April 25, 2019. He asked Psychiatric Technicians [redacted] and [redacted] for medical attention, but they ignored him, only responding "leave us alone." No officers let him out of his cell for three hours after the accident. After he was let out of his cell, he went to talk to Sergeant [redacted], who would not talk to him and motioned him away. Officer [redacted] (a different custody staff member) then came over and said "Lock it Up!", to which Mr. [redacted] responded "I'm trying to talk to the Sergeant." Officer [redacted] then came over, said "I'm tired of this," and grabbed Mr. [redacted] by the shoulders, leading him back to his cell. Mr. [redacted], who is well aware of the danger of resisting Officer [redacted] let himself be led back to his cell, but looked back once at Officer [redacted]. Officer [redacted] immediately barked "if you look around again I'll drop you right here", to which Mr. [redacted] turned his head back quickly. The next day, Mr. [redacted] was able to go and see medical staff. After he was evaluated by medical staff in the D/C-Yard medical building, he was sent to a hospital emergency room, because staff told him he had a corneal ulcer and could lose his eye, which would render him completely blind. His medical records confirm that he was diagnosed with a corneal ulceration on April 26, 2019 by his primary care provider, who then sent him to the Palmdale Regional Medical Center, where he was diagnosed and treated for a left corneal abrasion.

2. **Mr.** [redacted] DLT, DNH, C5-[redacted], reported a staff misconduct incident involving Officer [redacted] on March 22, 2019. That evening, Mr. [redacted] returned from dinner during 3rd Watch to find his assigned cell has been searched, with all of his personal belongings spilled onto the floor. Mr. [redacted] was told by Officer [redacted] that Officer [redacted] had searched his cell. Mr. [redacted] could not find Officer [redacted] so he returned to his cell and began to clean up his belongings. While he was cleaning his cell, Officer [redacted] came over to him and told him again that Officer [redacted] had conducted the cell search. A few hours later, during evening dayroom, Mr. [redacted] went over to Officer [redacted] and asked why his property had been thrown around his cell; in response, Officer [redacted] allegedly told Mr. [redacted] that he would "search his cell anyway he wants to."

During the cell search, Officer [redacted] took six apples from Mr. [redacted] which he had as an approved snack for his diabetes. Officer [redacted] also claimed he had one and a half gallons of alcohol in his cell, but other inmates who witnessed the cell search reported that this is not accurate. For instance, Mr. [redacted], EOP, C5, reported that he was in the C5 Unit during the search and heard Officer [redacted] going through Mr. [redacted] property; soon after, Mr. [redacted] reported seeing Officer [redacted] exit Mr. [redacted] cell with a small bag of apples. Later that day, another officer in the unit, Officer [redacted] gave Mr. [redacted] a cell search receipt with his name on it claiming that alcohol was found in his cell, even though Officer [redacted] was reportedly doing the diabetic line at the time. Mr. [redacted] was later written up for possession of contraband alcohol.

3. Other Allegations of Staff Misconduct

We have also received additional reports of staff misconduct against other prisoners with disabilities, including the following.

1. **Mr.** [redacted] DPO, B-1-[redacted] We have received reports of a concerning excessive use of force incident involving class member Mr. [redacted] and an Officer [redacted] on December 9, 2018. As is the case with Officer [redacted] Officer [redacted] has been the subject of previous excessive force complaints involving *Coleman* class members at LAC. *Id* at 8-9.

According to class members' recent reports, Officer [redacted] was recently reassigned to the mail room and no longer interacts with class members on a daily basis.

The incident on December 9, 2018 began when Mr. [redacted] asked his neighbor for a glove so that he could clean his toilet. After his neighbor handed him the glove, Officer [redacted] formerly B1 3rd Watch, thought that the pair had exchanged contraband, so he directed Tower Officer [redacted] to open Mr. [redacted] cell door. Rather than ask Mr. [redacted] to cuff up, Officer [redacted] immediately slammed Mr. [redacted] into the ground, severely injuring Mr. [redacted] spine. Mr. [redacted] was then strip-searched and had his cell searched, both with negative findings.

Mr. [redacted] cellmate, [redacted] reported that he witnessed the entire incident. While Mr. [redacted] sat on his bunk, he witnessed Officers [redacted] and [redacted] arrive at his cell-front. After the door had opened, Mr. [redacted] reported that he witnessed Officer [redacted] grab Mr. [redacted] by the shoulder without any warning, pull him towards the cell door, and then yank him to the ground. According to Mr [redacted] report, Mr. [redacted] fell hard on his back. Officer [redacted] then flipped Mr. [redacted] over and brought him out of the cell. While this was in process, Mr. [redacted] attempted to tell Officer [redacted] that Mr. [redacted] had serious back problems, but Officer [redacted] ignored him. Mr. [redacted] then walked over to his cell-front and witnessed Officer [redacted] press his knee into Mr. [redacted] back and then cuff Mr. [redacted] up. While on the ground, Mr. [redacted] allegedly told Officer [redacted] that he was a DPP prisoner and, after he struggled to stand on his own accord, brought a wheelchair for him to be wheeled to the program office. A few minutes later, a number of officers arrived at Mr. [redacted] cell-front, cuffed him up, and took him to the lower-A shower, where he was strip searched and then returned to his cell approximately twenty minutes later. A few minutes after that, Mr. [redacted] was returned his the cell; Mr. [redacted] had to help him get to the lower bunk bed due to his evident discomfort from the incident.

Mr. [redacted] filed an 1824 request soon after the incident (*B-[redacted]*), in which he reported that Officer [redacted] used excessive force to slam him to the ground during third watch in the B1 building. In his 1824, he requested a back brace and a mobility walker -- which he had previously been prescribed by his doctor – to deal with the pain from the assault. Inappropriately, the IAP instructed Mr. [redacted] to "fill out a 1824 requesting medical to reevaluate his medical treatment plan" in response to his request on December 12, 2018.

While Mr. [redacted] was ordered a back brace and provided with a walker on that day, the RAP incorrectly claimed that his requests were denied and directed him to file a 602 about his issue rather than an 1824. His allegations about excessive force were not placed on the non-compliance log.

Response: [redacted] was not an Armstrong class member at the time of the incident. Therefore, was not placed on the non-compliance log. [redacted]'s allegation of excessive force was reviewed through the 602 staff complaint process.

Mr. [redacted] medical records document he also filed a 7362 request the day after the incident, writing "I'm in extreme [*sic*] pain due to inmate officer involved incident I need immediate [*sic*] medical help." **Exhibit E at 1.** On December 11, 2018, two days after he was assaulted, Mr. [redacted] went "man down" and was taken to the clinic for an evaluation. At the clinic, he told Dr. [redacted] that "on Sunday he was slammed down by custody officers and has since been complaining of progressively worsening acute on chronic lower back pain radiating down left leg..." *Id.* at 2. According to his medical records, he also informed RN [redacted] that "custody slammed me down last Sunday and now it hurts back, I cannot sit up or walk." *Id.* at 3. At the clinic, Mr. [redacted] was given a wheelchair to help him ambulate and was sent out for an MRI.

The MRI results, received a month later, resulted in Mr. [redacted] being diagnosed with multilevel degenerative spondylosis with a left asymmetric disc extrusion. Due to his injuries, Mr. [redacted] was made DPO, which remains his designation today.

Incredibly, Officer [redacted] claimed that no force was used during the incident. In his description of the incident, Officer [redacted] wrote "I approached cell 119 and instructed the Control Booth Officer to open the cell door. As the cell door opened [redacted] stood in the doorway facing my position. I gave [redacted] a direct order to exit the cell; [redacted] stated, "No" and quickly turned his body towards his right side, losing his balance causing his momentum to bring him stumbling towards my position and falling on the ground.... I asked [redacted] if he needed medical attention, [redacted] refused medical attention by stating, "No, I'm good." **Exhibit F.** No incident report was produced to Plaintiffs' Counsel regarding the incident.

Following the assault, Mr [redacted] filed a staff misconduct complaint against Officer [redacted] and was accordingly interviewed by ISU Officers. Mr. [redacted] expressed serious reservations about the credibility and thoroughness of this investigation, as many of the LAC ISU officers are reportedly friends with Officer [redacted]

2. **Mr.** [redacted] DNH, D5 [redacted] likewise alleged that he was a victim of excessive force at the hands of custody staff. He reported that he was assaulted by Officer [redacted] on April 15, 2019.[7] The day of the assault, he had not been let out of his cell to take the medications he is prescribed to prevent seizures and had suffered a seizure that morning as a result. His medical records document that Mr. [redacted] did indeed have a seizure that morning. Mr. [redacted] nformed our staff that, because he had not been let out of his cell to take his medications that morning, he complained to staff about the issue. Later that day, Officer [redacted] approached him in front of the chow hall, twisted his arm, knocked his seizure-prevention helmet off of his head, and said "who's a bitch now?" According to Mr. [redacted] Mr. [redacted] left hearing aid was broken during the assault. As of the date of our interview, his hearing aid had not been repaired.

As in the case of Mr. [redacted], Mr. [redacted] custody records claim that no force was used by Officer [redacted] during the incident. In his write-up of the incident for a Rules Violation Report for "Threatening Staff" from the incident, Officer [redacted] claims that he originally approached Mr. [redacted] to order him "to tuck in his shirt before entering the dining hall." **Exhibit G.** Mr. [redacted] then allegedly became very tense and cursed at Officer [redacted] who directed him to cuff up; according to the report, Mr. [redacted] at first refused and then peaceably cuffed up without resistance. Mr. [redacted] was then taken to the D-Yard Gym and placed into a holding cell. Officer [redacted] report does not state that he used force on Mr. [redacted] nor does it articulate an imminent threat to justify the use of force, as required by policy.

Response: A review of [redacted] SOMS indicates that he received a similar RVR dated April 13, 2019, for Threatening to Kill a Public Official. A review of the RVR dated April 15, 2019, for Threatening Staff indicates that [redacted] was ordered to tuck in his shirt and became angry and started to yell at staff. [redacted] was extremely tense with his hands balled into fists. He was ordered to submit to handcuffs but did not comply and continued to yell at staff. [redacted] was ordered again to submit to handcuffs and this time complied with the orders. There was no force

[7]Officer [redacted] was also the subject of one complaint in *Coleman* Plaintiffs' April 2019 Letter. *See* Ex. D at 15.

utilized. A review of the 7219 located in the RVR package indicates three old injuries and no new injuries. A review of the hearing results indicates [redacted] told the senior hearing officer that "I was supposed to be locked up (ASU) when that happened," referring to the April 13, 2019 incident. At a September 25, 2019 Audiology Consultation, [redacted] received a replacement left side hearing aid and had his right hearing aid cleaned.

3. **Mr.** [redacted] DPO, C4-[redacted] also reported a disturbing use of force incident that occurred in early April 2019. When he arrived to LAC from RJD on April 10, 2019, he was placed into the ASU building without any of his property. He told one of the officers in the building that he needed his testosterone shot and his morphine, but was told that they did not have the testosterone shot and that his morphine had been discontinued. He began to suffer withdrawals from morphine and broke the windows in his cell, so staff took him out of his cell and placed him in a holding cage. After he was placed in the cage, he continued to inform officers of his withdrawals, to which the 3rd Watch Sergeant told him "fuck you man." He grew frustrated and began to kick the door of his holding cell, so the Sergeant opened the cell door, put a lock around his fist to form makeshift brass knuckles, stepped on Mr. [redacted] bad foot, and said challengingly "kick me, motherfucker, kick me." During this altercation, the Lieutenant walked around the corner, saw what was happening, and spun on his heel to leave the vicinity without intervening. The Sergeant then shut and locked the cage, leaving Mr. [redacted] there for the next three hours. Then two officers came, retrieved Mr. [redacted] and placed him in Z1- [redacted], which was covered in feces. He was left in that cell for five days and did not receive any cleaning supplies the whole time. He filed a staff misconduct appeal about these events, but as of the time of his interview on May 23, 2019 had yet to receive a response or a log number.

Is there a record of Mr. [redacted] appeal? If so, please provide a copy to Plaintiffs' Counsel.

4. **Mr.** [redacted] DLT, DNH, D-[redacted] reported on August 27, 2018 that Officers in the D4 EOP Unit, including Officers [redacted] refused to provide him with assistance when he was experiencing severe chest pains. He requested to be moved from the D4 Unit to a different unit where he could receive medical assistance when needed. In response to his request, CCI [redacted] moved him to the D1 Unit, and the RAP treated his allegations as a staff misconduct complaint.

5. **Mr.** [redacted] DLT, B-[redacted] reported that on September 18, 2018 he left the chow hall with his walker, which has a bag on it to help him carry his possessions, as he cannot hold items while pushing his walker. He alleged that three officers stopped him, put him up against the wall, took his walker, and then took the bag from the walker and threw it out. He requested to have his bag returned to him, which he needs to carry his legal materials and other supplies. His allegation was placed on the non-compliance log for further inquiry. In response to his appeal, the RAP informed Mr. [redacted] that he could request assistance from ADA workers with carrying items and did not return his bag to him.

Response: Patient expired on February 25, 2019. Corrections Services reached out to the Deputy Medical Executive for Utilization Management. Walker bags are considered a non-formulary item in the DME formulary. Providers can still order bags for walkers; however, they must pursue the non-formulary process. As stated in the RAP response, patients with walkers can request assistance from the ADA workers.

6. **Mr.** [redacted] DNM, *S*-[redacted] reported that he was jumped by an officer on April 29, 2018, who then stole his eyeglasses. His appeal was not stamped received by

staff until almost six months later on October 19, 2018. On October 23, 2018 his PCP submitted a request for a new pair of glasses for him and the RAP referred his allegation to the Inmate Appeals office to process as a staff complaint. His allegation was not placed on the non-compliance log.

7. **Mr.** [redacted] DPM, *B-*[redacted] reported that on July 31, 2018 Officer [redacted] searched his cell (B3-[redacted]) and removed his mattress. Officer [redacted] did not return Mr. [redacted] mattress to him or replace it with another mattress, leaving Mr. [redacted] to sleep on his hard metal bed. Mr. [redacted] requested to have his mattress returned to him. According to staff, Mr. [redacted] was offered a different mattress later that day, but refused. He was not provided another mattress until August 7, 2018. His allegation was also placed onto the non-compliance log for further inquiry.

8. **Mr.** [redacted] **DPM**, *S-*[redacted] reported on December 18, 2018 that Officer [redacted] in the D4 Unit took all of his DMEs from him on December 1, 2018, including his TENS unit, nasal inhaler, therapeutic boots, and braces. According to Mr. [redacted] allegations, he was then assaulted by multiple officers, who hit him in the back, knees, and chest. The assault exacerbated Mr. [redacted] chronic pain. Mr. [redacted] requested replacement of all of his DMEs. He also requested a walker to help him ambulate around his unit.

Despite the fact that Mr. [redacted] DME were verified through the appeal process, he was not provided with the DME. Instead, Dr. [redacted] found he had "no medical indication" for any of his lost DMEs and refused to return them to him. Mr. [redacted] allegations were processed as a staff complaint, but were not placed on the non- compliance log.

Why was a new medical opinion sought regarding Mr. [redacted] DME? We strongly object to this punitive approach to prisoners who file 1824 requests seeking to have missing DME returned. Mr. [redacted] existing entitlement to these DME should have been enough basis to return them to him or order new replacement DME. This appeal raises serious concerns about retaliation in the 1824 process.

Response: This incident was placed on the non-compliance log in July 2019 and was found to be not confirmed. Upon arriving to LAC on November 26, 2018 per an Initial Health Screen Male-Text, [redacted] had a list of DME items in his possession at that time in R&R that included knee braces, ankle braces, wrist braces, mobility vest, therapeutic shoes (not boots), cane, and glasses. [redacted] did not arrive with a TENS unit, nor was there an order for one. Nasal inhalers are not DME. However, when he was transferred to Ad-Seg on December 1, 2018, it appears that his DME may have been packaged up in his personal property. [redacted] was seen in an Outpatient Progress Note for a new arrival on December 18, 2018. During this encounter, the PCP assessed [redacted] request for DME wrist, ankle, and knee braces. When the PCP interviewed him regarding RAP & DME in a December 24, 2018 Outpatient Progress Note, he did a medical assessment of [redacted] The PCP found certain DME items were not needed for [redacted] conditions and discontinued them based on that exam. However, since he was a new arrival, his DME orders were not active because they were not reconciled at the time, so there were not any orders to "discontinue." Instead, the PCP documented the encounter and findings on the progress note and did not re-order those items. He placed an order for shoe inserts only. He addressed each item in his Outpatient Progress Note on the December 24, 2018. He also ordered medications and a physical therapy consult. Custom fit orthotics were discussed and the PCP determined during this exam that [redacted] did not fit the qualifications for them at the time, and as an accommodation, ordered therapeutic insoles. For the walker request, the PCP determined a cane was the proper accommodation at the time citing "observation of the patient walking greater than 100 yards

without difficulty or pause." Patients' DME should be given to them upon transferring per policy, however it doesn't appear to have been done in this case. Training is being done to ensure DME stays with patients when moving. Also, training on chart reconciliation processes is ongoing with providers at LAC to ensure policy is being followed appropriately which takes place during our monthly Medical Accommodation Committee meetings.

9. **Mr.** [redacted] DPW, *A-*[redacted] reported that Tower Officer [redacted] refused to let him out of his cell on January 19, 2019 when other inmates were allowed out, and that this was done in retaliation for Mr. [redacted] frequent grievances and requests. The RAP screened out Mr. [redacted] appeal and did not place his allegations on the non-compliance log. In another appeal (*A-*[redacted]), Mr. [redacted] reported on February 11, 2019 that it was twenty-four degrees Fahrenheit in his unit and yet officers refused to turn on the heat. According to Mr. [redacted] allegations, officers instead taunted inmates for being cold and belittled their need for a livable temperature. He requested that officers be rotated from his unit so that he and other prisoners did not have to face harassment from officers. His request was screened out as non-ADA related and he was directed to file a 602 about his concerns.

In still another complaint filed on December 7, 2018 (*A-*[redacted]), Mr. [redacted] reported that staff often place his property on his upper bunk after cell searches, which he cannot reach due to his DPW status, without risking a serious fall or injury. In response to his appeal, the RAP informed him that "custody staff assigned to the housing units have been informed to be mindful when searching the cells of inmates with disabilities to ensure when items are moved they are not placed in an area such as on the top of the bunk or other areas within the cell, which may make it difficult for the inmate to reach." Mr. [redacted] allegation was not placed on the non-compliance log.

10. **Mr.** [redacted] DPO, *D-*[redacted] reported that he was told by an officer in his unit that he would be written up if he took his wheelchair into his cell. He requested to be moved into an ADA cell. The RAP declined to move him, and failed to respond to his complaint about the threat to write Mr. [redacted] up for taking his own DME into his cell.

Response: A review of the 1824 dated February 2, 2019, indicates that [redacted] was designated DPO, which does not require a wheelchair accessible cell. DPO inmates are intermittent wheelchair users prescribed for outside the cell and wheelchair does not require being inside the cell. Therefore, staff was appropriate in advising [redacted] not take the wheelchair inside the cell. A review of SOMS disciplinary section does not indicate that a RVR was issued for the above allegation. [redacted] expired on May 22, 2019.

11. **Mr.** [redacted] EOP, *D-*[redacted] reported that he attempted suicide on July 18, 2018 and was beaten up by guards on C-Yard as a result. He reported that this incident severely impacted his mental health and that he was severely depressed as a result. Rather than treat his appeal as a staff misconduct problem or convert it to a 602- SM, the RAP merely told him to file a new 602-SM about the incident.

12. **Mr.** [redacted] DLT, DNH, *B-*[redacted] reported that his mobility vest was taken from him and thrown away by staff during a mass search on July 30, 2018. He requested a new mobility vest. The IAP Reviewer (CCI [redacted] attempted – but was unable – to find out which staff threw away Mr. [redacted] vest. The RAP provided him with a new vest on August 13, 2018 and placed his allegations on the non- compliance log. In another 1824 request, (*B-*[redacted]), Mr. [redacted] reported that he was placed in flex-cuffs behind his back on July 30, 2018 for five hours, despite his permanent waist-chains chrono. This cuffing caused Mr. [redacted] to reinjure his

right shoulder. During the IAP, Mr. [redacted] informed CCI [redacted] that he was not sure the name of the staff member who cuffed him in contravention of his waist-chains chrono. According to the RAP, his complaint was reviewed by the Warden, who determined it should be addressed via the complaint process. Mr. [redacted] complaint was not placed on the non-compliance log.

Response: [redacted] was seen on August 13, 2018 by his PCP per an Outpatient Progress Note for the RAP request. [redacted] was medically evaluated and given a new mobility vest, which was signed for by [redacted] on the same day per a 7536. The allegation of being placed in flex cuffs for approximately five hours has been reviewed by the hiring authority and determined that it be addressed via the staff complaint process.

13. [redacted] DNH, C-[redacted] eported that on August 9, 2018 he went out to the hospital following an overdose and, upon his return the next day, all of his property including his DMEs were gone. Mr. [redacted] finally received his property back and was given a hearing impaired vest nearly three weeks later on August 28, 2018. He also had hearing aids reordered the same day. However, he did not receive his orthotics, as Dr [redacted] found he had "no medical indication" for them. His allegation was placed onto the non-compliance log.

As was the case with Mr. [redacted] above, we do not understand why was a new medical opinion sought regarding Mr. [redacted] DME as part of the 1824 process. We strongly object to this punitive approach to prisoners who file 1824 requests seeking to have missing DME returned. Mr. [redacted] existing entitlement to these DME should have been enough basis to return them to him or order new replacement DME. This appeal raises serious concerns about retaliation in the 1824 process.

Dr. [redacted] also used the wrong standard in resolving whether Mr. [redacted] should have his orthotics. The standard is reasonable accommodation – basically, are the orthotics helpful.

Response: [redacted] last had a receipt for shoes on July 11, 2017. The provider who saw him, per an August 15, 2018 Outpatient Progress Note, ordered [redacted] a pair of inserts based on this exam, as a reasonable accommodation, which was 5 days after he returned from the hospital. [redacted] did not have an order for therapeutic shoes while at LAC, and it should be noted that [redacted] does not have an order for Therapeutic Orthotics from any of the five institutions he has been to in the last 12 months. LAC takes the opportunity to review patients with existing orders and re-evaluate the need for the DME, in this case orthotic shoes, anytime the patient requests a replacement. This type of practice ensures that DME is being replaced per CCHCS HCDOM 3.6.1e (13) (B) policy.

Plaintiffs request an update regarding the investigations into the allegations of staff misconduct in our December 2018 Report. We also ask that all of the allegations detailed above be investigated by non-LAC ISU staff. We ask that this section of the report not be shared with line staff at LAC, and that any investigation into our class members' allegations be conducted by non-LAC staff. Like Mr. [redacted] we are concerned that any investigation by LAC ISU staff will merely paper over our class members' complaints and obstruct any attempts to bring about badly needed changes to LAC.

We furthermore request that headquarters and institutional leadership develop a corrective action plan to address our class members' repeated and consistent allegations of staff misconduct at LAC.

Response: Defendants take staff complaints seriously and acknowledge the need for staff to foster an environment conducive to meeting the needs of inmates with disabilities. Defendants are in the process of developing regulations that will change CDCR's appeals and grievance

process. Defendants have kept Plaintiffs' counsel advised of the status and progress of the new regulations and Defendants will continue to do so.

G. Failure to Properly Accommodate Prisoners with Serious Hearing Impairments

According to the *Armstrong* Remedial Plan, CDCR and CCHCS must ensure sign language interpreters are provided for all required encounters when sign language is the prisoner's primary means of communication. ARP § II.E.1. We received a complaint from a class member, [redacted] DPH, B1[redacted] who reported that it is difficult for him to get the LAC SLI to assist him and show up for his programming classes (he is in a GED class), even though he is one of only two SLI users housed at LAC. He also reported that he did not have access to an SLI during his recent RVR 115 hearing, at which he was found guilty.

Response: LAC has an assigned SLI that participates in [redacted] GED class. [redacted] was interviewed via SLI and stated that the SLI is attending his GED classes. If SLI is not available, which is rare, the teacher is able to utilize the VRI and [redacted] is able to get assistance during class time. A review of RVR dated December 27, 2018, for Constructive Possession of a Cellular Telephone indicates that a SLI was utilized for effective communication during the hearing process of the RVR.

Please send us all of Mr. [redacted] recent disciplinary records, including all 115 hearing results. If he was not provided with an SLI at his RVR hearing, the RVR should be dismissed.

The DAI Non-Compliance Logs for January 2019, February 2019, and March 2019 list 51 allegations that an SLI was not provided to either [redacted], *DPH, DLT, DNV, DPS,* or **Mr.** [redacted] DPH, for various mental health and medical contacts. Twelve of these allegations were confirmed following an investigation.

Response: A review of LAC Non-Compliance Logs from January through March 2019 indicates that LAC only had four Non-compliance SLI inquiries. Based on the findings of the inquires, three are not confirmed and one was confirmed The four inquiries were all in March 2019 for [redacted] regarding the same classification issue. The Institutional Classification Committee on January 31, 2019, did not indicate that effective communication was utilized via the SLI. However, committee members and the SLI were interviewed and stated that the SLI was present and did provide SLI communication during the committee. Additionally, the SLI was utilized during the staff assistance review prior to committee. LAC has hired an additional SLI staff member effective August 5, 2019.

Given these reports, we are concerned that DPH class members are not provided with adequate accommodations during required encounters.

What is LAC doing to address this problem and ensure that deaf and hard of hearing class members who use sign language are provided with appropriate services in the future?

Response: On August 5, 2019, LAC hired an additional Sign Language Interpreter (SLI) to assist with DPH inmates that require SLI assistance.

Exhibit N

ROSEN BIEN GALVAN & GRUNFELD LLP

101 Mission Street, Sixth Floor
San Francisco, California 94105-1738
T: (415) 433-6830 ▪ F: (415) 433-7104
www.rbgg.com

Thomas Nolan
Email: tnolan@rbgg.com

February 7, 2020

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SUBJECT TO PROTECTIVE ORDERS

Russa Boyd
Non-Medical Class Action Team
CDCR Office of Legal Affairs
Russa.Boyd@cdcr.ca.gov

RC Johnson, Warden
California State Prison - Los Angeles County
44750 60th Street West
Lancaster, CA 93536

Re: *Armstrong v. Newsom*: Plaintiffs' Report re November 18-21, 2019 Monitoring Tour of California State Prison – Los Angeles County
Our File No. 0581-03

Dear All:

Enclosed is my report on Plaintiffs' November 18-21, 2019 monitoring tour of California State Prison – Los Angeles ("LAC"). I would like to thank the staff at LAC who assisted with this tour for their courtesy and professionalism.

I look forward to working with you to improve the institution's compliance with the *Armstrong* Remedial Plan.

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Please note that the report and the enclosures to the report are subject to the protective order in this case and should not be copied or distributed without referring to that order and following the procedures therein.

Sincerely,

ROSEN BIEN
GALVAN & GRUNFELD LLP

/s/ Thomas Nolan

Thomas Nolan
By: Of Counsel

TN:DVC
Attachment: Plaintiffs' Report and Exhibits

cc: Co-Counsel
Ed Swanson
Alexander Powell
Nicholas Meyer
Patricia Ferguson
Tamiya Davis
Amber Lopez
Erin Anderson
Robin Stringer
Annakarina De La Torre-Fennell
Damon McClain
Sean Lodholz
Gently Armedo
Lois Welch
Adam Fouch
Teauna Miranda
Landon Bravo
Laurie Hoogland
Bruce Beland
Robert Gaultney
Saundra Alvarez
Tabitha Bradford
John Dovey
Donald Meier
Robin Hart
Ceasar Aguila
Steven Faris
Alexandrea Tonis
CCHCS Accountability
Cindy Flores
Joseph Williams
Cathy Jefferson
Vincent Cullen
Desiree Collum
Lynda Robinson
Barb Pires
Ngoc Vo
Samantha Chastain
Olga Dobrynina
Dawn Malone-Stevens
Bryan McCloughan

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members were assigned to positions blatantly inaccessible to them – such as a DPO class member assigned as an ADA worker – or were subjected to discriminatory comments or profiling by work supervisors. There were also some individuals who said they were technically assigned to jobs but that they have never been required to report for the position. There were also some reports of pay irregularities with respect to ADA worker positions.

- *Problems with LAC's Grievance Process*: Multiple class members reported that they had filed 1824 reasonable accommodation requests or 602 administrative appeals in recent months but had never received a response to their appeals. We also interviewed one class member who handed our staff an appeal response he had recently been given that belonged to another class member. This response falsely documented that it had been given to the appropriate class member twenty-two days earlier.

- *Lack of Proper Supervision of ADA Workers:* Class members on C-Yard reported serious concerns regarding the ADA assistance program on their yard. In particular, class members reported that some ADA workers on C-Yard engage in drug dealing or other illicit activity while working, that some of the workers refuse to wait after escorting class members to particular areas, and that some of the ADA workers endanger class members through their negligence. Class members on other yards reported that they are unable to get ADA workers to assist with basic tasks such as cell cleaning.

- *Problems with LAC's Physical Plant:* We raised numerous concerns regarding the physical plant at LAC in our last tour report. *See* July 2019 Report at 66-76. We are now working at with CDCR Headquarters through the Master Planning Process to address class members' concerns about various aspects of the physical plant at LAC, including the lack of accessible showers and inaccessible emergency exits. Some of these issues are covered by the Master Planning process managed out of headquarters. However, other issues, like the cracks and gaps in the path of travel, are now the responsibility of LAC to repair because these features of the Master Plan were fully CASP certified as completed and accessible.

- *Accuracy of DME and DECS Tracking:* Despite some improvement, LAC continues to have a significant number of discernable errors in its SOMS DPP tracking, including some individuals who appear to have missing codes. These errors continue despite LAC medical leadership's insistence that they have engaged in concerted efforts in recent months to correct

G. Staff Misconduct Targeting Prisoners with Disabilities

Plaintiffs exhaustively documented our extensive, ongoing concerns about the pervasive culture of staff misconduct at LAC in our last monitoring report. *See* July 2019 Report at 21-31. In 2019 alone, our office shared thirty-three complaints of excessive or unreasonable use of force from *Coleman* or *Armstrong* class members at LAC and requested that Defendants investigate our class members' reports. We have also shared five complaints from class members that officers ignored requests for emergency mental health care from them or others at LAC, five complaints from class members that LAC officers use or have used racist epithets when talking to them, and eighteen complaints by class members of retaliation for speaking out about abuses or requesting ADA accommodations. We have included a list of these allegations with this report as **Exhibit B.**

In our July 2019 Report, we asked Defendants to answer numerous questions about what they have done to tackle the problems with staff abuse and misconduct at LAC. *See* July 2019 at 21. We also requested that Defendants develop a corrective action plan to remedy the persistent problems with staff misconduct at LAC. *Id* at 78.

To date, we have only received a substantive response from Defendants to a small minority of these allegations. Defendants have yet to respond to any of our requests. In fact, our conversations with investigatory staff at LAC during the November 2019 tour revealed that the current misconduct processes still consists largely of document reviews of the reports by the very officers who were accused of misconduct.

During our tour, we spoke to the appeals coordinator at LAC, who informed us that there are no video-cameras at LAC except in the visiting units, so staff misconduct inquiries are conducted by interviewing involved staff, the complainant, and possible witnesses, along with all custodial documentation of the incident. The appeals coordinator also informed us that investigatory staff only review the 7219 and 837 forms as part of staff misconduct inquiries into use of force complaints, even if the complainant alleged significant injuries that may not have been diagnosed or fully evaluated at the time the 7219 medical evaluation was conducted in their complaint. We were very concerned to hear this. We were also concerned to hear that investigatory staff do not review videotaped use of force interviews as part of their staff misconduct inquiry process, even if doing so could sustain allegations of serious injuries.

We also spoke with Associate Warden Eric Jordan, who – as the C/D-Yard Associate Warden – is tasked with reviewing 837 incident reports as part of the use of force review process. Because LAC does not have video-cameras in any of its units or yards, AW Jordan's reviews consist solely of reviewing officers' justifications for their uses of force. This process provides no meaningful oversight of the use of force on incarcerated individuals at LAC, because officers merely have to provide a justification for their use of force – no matter how misleading – for their actions to be rubber-stamped.

We are gravely concerned that these current investigatory practices merely rubber-stamp the actions of officers who may be repeatedly abusing the *Armstrong* class members under their supervision. As we have repeatedly emphasized, such abuse creates a culture of fear that officers are actively hostile to the needs of the people under their supervision and care. This, in turn, serves to prevent people with disabilities from actively seeking assistance with their disability-related needs and as such prevents CDCR from coming into compliance with the Americans with Disabilities Act.

As we wrote in our July 2019 Report, the Inspector General has found that CDCR's current staff misconduct investigation process functions is "entirely driven by the purpose to exonerate staff." *See* March 4, 2019 Assembly Hearing Audio Recording at 1:53:53 (available at https://www.assembly.ca.gov/media/assembly-budget-subcommittee-5-public-safety-20190304/audio). In addition to this condemnation, the Office of the Inspector General recently issued a sentinel report that damningly underscored that the department will not sustain misconduct allegations against officers based on the testimony of incarcerated individuals alone. In his report, the Inspector General emphasized that

> the OIG is concerned that the department attorneys' actions suggest an apparent bias and hostility against inmate testimony and evidence provided by inmates, and set a dangerous precedent in which widespread officer misconduct, which in some cases cannot be proven by any means other than evidence or testimony provided by inmates, will go undiscovered and unpunished… **simply because an individual is incarcerated does not mean he or she can never provide credible and reliable information**.

Office of the Inspector General Sentinel Case No. 20-01, January 10, 2020 (available at https://www.oig.ca.gov/wp-content/uploads/2020/01/OIG-Sentinel-Case-No.-20-01.pdf.) [emphasis added]. Given the Department's apparent disregard for the testimony of incarcerated individuals, it seems obvious that the conditions at LAC will not resolve without the installation of video-cameras in yards and facilities across the prison. Indeed, as Governor Gavin Newsom recently stated in his budget for FY 2020-21, "video evidence has been a critical tool for investigating inmate violence and staff misconduct allegations." *See* Governor's Budget Summary 2020-21 at 139, available at http://www.ebudget.ca.gov/FullBudgetSummary.pdf. We recommend that headquarters and institutional leadership request funding to install cameras throughout LAC to address class members' repeated and ongoing concerns regarding the institution's staff culture.

We would also like to emphasize that we continue to receive frequent complaints from LAC class members that officers regularly subject them to serious staff misconduct, ranging from excessive or unreasonable force to constant, biting verbal harassment. These reports were unabated during our most recent tour, and also surfaced during our review of 1824s filed during the review period:

1. *Mr. [redacted], *D5, DNH, DNV*, reported that he was assaulted by Officer [redacted] on October 14, 2019. At approximately 6:00am that morning, he had a seizure and was placed into a gurney. *See* October 10, 2019 6:10 a.m. Progress Note (documenting the seizure). Officer [redacted] then cuffed him up, searched his cell, and then approached him and briefly choked Mr. [redacted] with his hands. Later, when Mr. [redacted] returned to his cell, some of his property – including photos of his family – was missing. In the following days, Mr. [redacted] filed a 602 about his property and Officer [redacted] s use of unreasonable force. A week after the incident, on October 21, 2019, Officer [redacted] and Officer [redacted] allegedly came up to his cell front and told him "the photos of your wife were nice." Mr. [redacted] told us in November that he was continuing to face repeated harassment from officers because of the October 14, 2019 incident.

2. *Mr. [redacted], *Z1, DPM*, reported serious staff misconduct problems on C-Yard. In March 2019, while housed in the C3 Unit, Mr. [redacted] overheard Officer [redacted] inform other incarcerated people in the unit (who were allegedly part of the 25ers) that Mr. [redacted] is incarcerated for a sex offense. Mr. Carrasco also reported that he heard Officer [redacted] tell the gang members "When you stab him, stab towards the heart." Fearing for his life, Mr. [redacted] told Sergeant [redacted] later that day that he felt suicidal, but that the sergeant ignored his request for help. He reports that he then told other officers that he had safety concerns and asked to be placed in segregation, but that they also refused to help him. He reported that, in his panic, he decided his only way to get to safety was to attack a random incarcerated person on the yard, so that he would be placed into segregation. He reported that he then assaulted another individual on the yard; while this assault successfully moved him to safety, he is now facing serious charges of assault with a deadly weapon. Neither his assault nor the pending charges would have occurred without officers' assistance and indifference to his safety concerns.

3. *Mr. [redacted], *DPO, B2,* reported serious problems with Officer [redacted] in his unit. A few days after he complained to Sergeant [redacted] that she was forcing him to strip out every day before he went to yard, she deliberately closed the cell door on his foot while he was leaving for yard. He filed a Form 22 about this incident to the Warden, but has not received a response. When we were interviewing Officer [redacted] during the tour of the B2 housing unit, and we asked to see him, she told us that "he has a wheelchair, but it's just for show."

4. *Mr. [redacted], *B2, DPW*, also reported experiencing problems with Officer [redacted], who he explained will selectively strips out *Armstrong* class members before and after yard. Mr. [redacted] also reported recently witnessing Officer [redacted] close a cell door on another *Armstrong* class member's foot.

5. *Mr. [redacted], *D3, DPV*, reported that in August 2019 he was feeding some birds on D-Yard when multiple officers came up to him and grabbed him

by the arms without warning. The officers, including Officer [redacted], twisted his arms tightly and then walked him to the gym, where a sergeant came and asked him "What do you have to say for yourself?" Because Officer [redacted] was vigorously twisting his arm, he reported that he squeezed out of the Officer's grasp and they told him he was resisting and that he "gave up all of his rights" when he was sentenced. Fortunately, the sergeant then told him he would be let off with "a warning" and sent him go back to his cell without further incident.

6. *Mr. [redacted], *B1, DPW,* reported that officers who work on 2nd Watch in the B1 Unit refuse to let him out after incontinence accidents to shower. He suffers from incontinence accidents roughly one to two times a day. He also reported that Officer [redacted] refuses to let him out and often calls him the n-word when he asks to be let out. On the weekends, when Officer [redacted] works as the control tower officer, he is never let out to shower because Officer [redacted] refuses to open the door.

7. *Mr. [redacted], *B1, DPM, DNV, LD*, reported that Officer [redacted], who works in the tower on the weekends in his unit, will not let people shower or out onto the dayroom during the weekends. Because incarcerated people with disabilities tend to need more assistance and shower at higher rates, Officer [redacted]'s misconduct disproportionately affects *Armstrong* class members. Mr. [redacted] also reported that Officer [redacted] frequently uses foul language, such as the n-word and "faggot" to demean incarcerated people who ask for assistance.

8. *Mr. [redacted], *B1, DPO,* reported a concerning incident with Officer [redacted] on June 1, 2019. At approximately 11:00 a.m. that morning, Mr. [redacted] had just returned from the yard and asked Officer [redacted] for a shower. Officer [redacted] told him "No, no, you can't come out" and told him that he did not believe he needed a shower. Mr. [redacted] reported that he needed a shower at that time because of an incontinence accident that morning. Almost every morning, Mr. [redacted] wakes up with urine and sometimes feces from incontinence while he was sleeping. Because he reports that he can never get first watch officers to let him out to shower, he often goes to yard and then returns and asks for a shower. That day, Officer [redacted] refused him a shower, so he went back to his cell and, after shift change, asked Officer [redacted] for a shower. He reported that Officer [redacted] did then let him out to shower. However, as he was waiting outside the shower for his turn, Officer [redacted] returned – even though the shifts had changed at that point – and asked him "How did you get out of your cell?" When Mr. [redacted] told him that another officer had let him out to shower, Officer [redacted] then told him "No, you have to take it in [to your cell.]" Officer [redacted] then repeated his direction, to which Mr. [redacted] replied "It's not even your watch." Officer [redacted] then took out his cuffs and told him to cuff up, but after other incarcerated people objected, Officer [redacted] left him alone.

9. *Mr. [redacted], *B1, DPO*, reported that Officer [redacted] does not let him or incarcerated people with disabilities out to shower or out for dayroom.

10. *Mr. [redacted], [redacted], *C1, DPW*, reported that he has been unable to get a single change of laundry in the 15 weeks he has been at LAC. Because he is DPW, he struggles to wash his own laundry and has been unable to wash anything other than his underclothes. He has had the same laundry issue, including the same sheets, for 15 weeks now. He reported to us that the laundry officer on C-Yard refuses to exchange his clothes and has repeatedly told him "You're in a wheelchair, you don't have any special privileges. I'll treat you the same as every inmate who walks and runs and everything." Every two to three weeks, Mr. [redacted] reports that he gives a laundry slip in to the laundry workers, but nothing has happened. He reports that he filed an 1824 about this issue two weeks ago and was later interviewed by LAC ADA staff, who told him that they would talk to the laundry worker. Since then, however, nothing has changed. Following our interview with him, we heard officers approach Mr. [redacted] and tell him that they would provide him with fresh laundry. It should not take a visit from Plaintiffs' Counsel for *Armstrong* class members to obtain fresh laundry.

11. *Mr. [redacted], [redacted], A4, DPO*, reported a troubling altercation with an officer on A-Yard on October 1, 2019. That day, he was on his way to his assignment and went through gate change. The gate change officer, Officer [redacted], aggressively patted him down, pushing him hard out of his wheelchair. Mr. [redacted] objected "Hey man you almost pushed me out of the chair", to which Officer [redacted] responded "Yeah, I know." Mr. [redacted] reports that he replied "What you mean?", to which Officer [redacted] responded "I know I almost pushed you out of the chair. I'd do it again. Next time I see you I'll push you out of the chair." Following the incident, Mr. [redacted] filed a 602 and 1824 about this misconduct. On October 9, 2019, Officer [redacted] came up to his cell-front, pounded on the front of his cell, and told him "you're a crybaby. I'm going to get you extra tissues because you're a crybaby." On October 10, 2019, he was interviewed by two sergeants about the incident. He reports he has yet to receive a formal response to his complaint.

12. *Mr. [redacted], [redacted], *B1, DPW*, reported experiencing problems with Officer [redacted] in his unit, who often makes it difficult for ADA workers to assist incarcerated people with disabilities in the B1 Unit. Mr. [redacted] reported that Officer [redacted] refuses to let ADA workers into the B1 Unit to help people with disabilities. Instead, Officer [redacted] forces people with disabilities to go out to the yard to get assistance. Even if the ADA workers live in the B1 Unit, Officer [redacted] refuses to let them out to help class members. Mr. [redacted] also reported that Officer [redacted] refuses to let class members shower, even when they have recent had an incontinence accident.

13. *Mr. [redacted], [redacted], *B1, DPM*, reported experiencing problems with Officer [redacted]. He reported that he leaves his wheelchair outside of his cell, because he is DPM, and in response she calls medical staff and falsely claims that other incarcerated people use his wheelchair. He also reported that Officer [redacted] often refuses to let him shower and yells at him to move faster across the unit despite his mobility impairment.

14. *Mr.* [redacted], *D1, DPO, DNH, D-19*[redacted], *D-19-*[redacted], filed two 1824s in April 2019 claiming that Officer [redacted], the second watch tower officer in D1, refused to let him out for ADA showers and used racial discriminatory language directed at him. One appeal was screened out as duplicative with the other and the other appeal was screened out because Mr. [redacted] had also filed a 602, although his allegation was also placed on the non-compliance log and the RAP asserted that the D1 Unit officers denied his allegations. According to the non-compliance logs, LAC have not yet made findings in their investigation (*ALTS*[redacted]) into Mr. [redacted]'s complaint, despite the fact that nearly eight months have passed since his allegation. We request an explanation for the delay in completing the investigation.

15. *Mr.* [redacted], *A5, DLT, A-19*[redacted], filed an 1824 on July 11, 2019 reporting that on June 25, 2019 he was harassed and falsely written up by Officer [redacted] in the A/B Medical Building, and that as a result he refused his most recent physical therapy appointment because he is scared to interact with Officer [redacted]. He requested that Officer [redacted]'s behavior be investigated. His allegation was placed onto the non-compliance log. According to the July 2019 Non-Compliance Logs, although an investigation was opened into Mr. [redacted]'s allegations (*ALTS*[redacted]), the investigation has not yet been completed, even though numerous months have passed since the incident.

16. **Mr.* [redacted], *DPW, A-19*[redacted], submitted an 1824 on June 27, 2019. In his appeal, he wrote that he has ongoing difficulties getting let out of his cell by staff despite his "knocking, yelling and even asking many inmates to tell tower officers to let [him] out." He also wrote that he has missed dayroom and pill call due to not being let out of his cell when requested. The RAP placed his allegation on the employee non-compliance logs. Mr. [redacted] also reported on June 29, 2019 (*A-19*[redacted]) that staff on first watch will not let him out of his cell and that people housed in cells 128 and 130 are constantly in their cells as well. He requested his cell door be popped open. Mr. [redacted] filed another 1824 on June 28, 2019 (*A-19*[redacted]) alleging that the tower officer in his unit refused to let him out for pill call, even though the podium officer has called over to them to let him out. This allegation should be added to LAC's employee non-compliance log and promptly investigated.

As these allegations make clear, class members at LAC are disproportionately concerned about the actions of a relatively small number of officers. In our last report, we shared numerous allegations involved Officer [redacted], who currently works in the C1 Unit. *See* July 2019 Report at 24-25. Officer [redacted] has now been the subject of twelve allegations of serious staff misconduct that Plaintiffs' Counsel have shared with Defendants. Ex. B. We have also raised repeated concerns regarding Officer [redacted], who currently works in the D4 Unit and has been the subject of four complaints; Officer [redacted], who works in the B1 Unit and was the subject of two complaints in the March 2019 Report, ten complaints in the July 2019 Report, and six

additional complaints in this report; and Officer [redacted], who works in the B2 Unit and was the subject of three complaints in the July 2019 Report and two additional complaints in this report. *See* Section (III)(F), *supra*, Ex. B, March 2019 Report at 13-15, and July 2019 Report at 21-31. As Exhibit B makes clear, we also have repeated concerns about a number of other officers at LAC.

Our conversations with supervisory staff during our tour have led us to understand that institutional leadership are aware of the frequency of complaints against these officers. Despite this, due to the current investigatory practices at LAC, no adverse action has been taken against any of these officers as far as we are aware. LAC must remedy this by installing video-cameras to more effectively monitor staff misconduct across its yards, units, and gyms.

H. Program Assignment Discrimination

Under the *Armstrong* Remedial Plan, designated DPP facilities must offer class members a range of programming equivalent to that available to nondisabled inmates. *See* ARP § II.I. In our last report, we extensively detailed the numerous troubling disparities in the assignment rates between class members and nondisabled individuals across every yard at LAC. *See* July 2019 Report at 32-35.

1. Possible Problems with the Program Assignment Waitlist System Used at LAC

During our November 2019 tour, we focused on why the disparities highlighted in our last tour report may exist and whether LAC follow the appropriate program assignment waitlist priority codes. A copy of the most recent priority codes are enclosed hereto as **Exhibit C.** During our class member interviews, numerous class members reported that, despite favorable case factors, they had been waiting for months if not years for an assignment to no avail. These reports raise concerns that LAC is not closely following the waitlist priority system for program assignments:

1. *Mr.* [redacted]*, D4, DPM, DNH,* reported that he has been waiting for a job assignment on the waitlist since he arrived at LAC in September 2019, but that he has not yet received one even though he is A1/A and medium custody.

2. *Mr.* [redacted]*, B1, DPW,* reported that he is A1A but that he has been unassigned since he arrived at LAC in August 2019. Shortly after he arrived at LAC, he was placed onto the waitlist by his ICC, but has not yet received an assignment.

3. *Mr.* [redacted]*, B1, DPO,* reported that he has been at LAC since 2015, is A2B, and has an EPRD of June 23, 2022, but is currently unassigned. He has a TABE score of 12.9 and his GED, but has been unable to get any assignment in his four years at LAC.

Exhibit O

ROSEN BIEN GALVAN & GRUNFELD LLP

101 Mission Street, Sixth Floor
San Francisco, California 94105-1738
T: (415) 433-6830 ▪ F: (415) 433-7104
www.rbgg.com

Thomas Nolan
Email: TNolan@rbgg.com

March 27, 2020

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Nick Weber — Nicholas.Weber@cdcr.ca.gov
Russa Boyd — Russa.Boyd@cdcr.ca.gov
Melissa Bentz — Melissa.Bentz@cdcr.ca.gov
Jerome Hessick — Jerome.Hessick@cdcr.ca.gov
Tamiya Davis — Tamiya.Davis@cdcr.ca.gov
Dillon Hockerson — Dillon.Hockerson@cdcr.ca.gov
CDCR Office of Legal Affairs

Re: *Coleman v. Newsom, Armstrong v. Newsom*: Serious Allegations that Custody Staff at CSP – Los Angeles County Regularly Assault, Abuse, and Retaliate Against Incarcerated People with Disabilities
Our File No. 0489-03, 0581-03

Dear OLA Team:

Enclosed along with this letter are fourteen individual letters on behalf of *Coleman* and *Armstrong* class members at California State Prison – Los Angeles County ("LAC"). These letters describe fourteen horrifying incidents of officer brutality and abuse directed at incarcerated people with physical and mental disabilities at LAC. Most of these incidents were witnessed by other class members at LAC who—despite clear risk of retaliation—agreed to come forward and share their accounts to support efforts to end the pervasive culture of staff misconduct at LAC. Defendants must take prompt action to remedy the conditions at LAC, which we intend to share with the Court in *Armstrong*.

We have now reported eighty-eight discrete incidents of staff misconduct against *Coleman* and *Armstrong* class members at LAC, including forty-nine allegations of unreasonable or excessive force. These incidents show that incarcerated people with disabilities at LAC are at risk of serious injuries at the hands of officers:

- An officer refused to let an elderly man with incontinence problems shower and, when he protested, dumped him from his wheelchair. The elderly man was later falsely charged with battering staff.

- After a man with serious mental illness did not promptly terminate his telephone call, officers trashed his cell and handed his belongings to another incarcerated man. When the class member protested, the officers brutally beat him, breaking one of his ribs and three other bones.

- Officers pepper-sprayed a man with serious mental illness who, upset about the impending death of his terminally ill father, yelled out of his cell at the officers during a lockdown. The officers then severely beat the man, giving him a concussion and a broken clavicle bone.

- An officer dumped a man with cancer from his wheelchair after he asked to move housing units so that he would not have to walk across the yard to get his medications. Other officers then dragged him across the yard to the gym, where they severely assaulted him.

- After an African-American man with serious mental illness filed a staff complaint alleging that officers repeatedly called him racial epithets—including the N-word—officers degraded him still further, subjecting him to daily racist taunts, trashing his cell, and threatening to assault him if he spoke out again.

These reports are serious, horrifying, and point to a systemic failing on the part of LAC and headquarters staff to appropriately investigate staff misconduct allegations and to discipline officers who abuse class members.

1. Class Members' Reports Allege Misconduct by the Same Officers Time and Again

Incarcerated people with mental and physical disabilities at LAC have repeatedly named the same officers time and again in their complaints. It is clear that this misconduct is perpetrated by a distinct and concerted group of officers who—because supervisory staff refuse meaningfully to investigate staff misconduct allegations—know they can abuse incarcerated people under their control with no fear of being held accountable. Numerous officers have been the subject of multiple complaints:

- Officer [redacted], who currently works in the C-Yard, Building 1 housing unit, has been named as the main perpetrator in thirteen incidents of staff misconduct, including seven allegations of unreasonable and excessive force.

- Officer [redacted], who currently works in the D-Yard, Building 3 EOP housing unit, has been named as the main perpetrator in six incidents of staff misconduct, including four allegations of unreasonable and excessive force.

- Officer [redacted], who currently works in the D-Yard, Building 3 EOP housing unit, has been named as the main perpetrator in four allegations of unreasonable and excessive force.

- Officer [redacted], who currently works in the D-Yard, Building 5 EOP ASU housing unit, has been named as the main perpetrator in four incidents of staff misconduct, including two allegations of unreasonable and excessive force.

These are only a few of the officers who class members allege regularly assault and abuse them. Despite repeated warnings about the actions of these officers, Defendants have to the best of our knowledge failed to discipline a single one of these officers for the abuses they continue to perpetrate against incarcerated people with disabilities.

2. Class Members' Reports Describe Persistent Patterns in Instances of Alleged Misconduct

Class member reports also describe repeated patterns of staff misconduct, including that:

- Officers regularly bring incarcerated people into the gym to assault them where there are no witnesses to the misconduct.

- Medical evaluations conducted after use of force incidents often deliberately fail to record serious injuries, often because staff intimidate incarcerated people and nursing staff during the evaluations.

- Class members often receive false write-ups alleging that they battered staff during a use of force incident. When these write-ups are heard, disciplinary

officers refuse to let accused incarcerated people call witnesses and summarily find them guilty of the offenses.

- Investigations into instances of misconduct are not impartial, often calling into question class members' accounts, declining to conduct thorough investigations, and even assaulting class members for speaking out.

These patterns point to an overriding culture of fear and abuse at LAC that must be remedied.

3. Defendants' Own COMPSTAT Reports Show Continued Troubling Disparities in Use of Force Rates

We have repeatedly highlighted that force is used against people with significant disabilities, including those with serious mental illness at LAC at far higher rates than their representation in the LAC population. *See, e.g.*, Nov. 15, 2019 Ltr. from Thomas Nolan re [redacted]'s ([redacted]) Allegation of Unnecessary Force at LAC at 7-9 (documenting that the use of force rate against people with serious mental illness at LAC was five to six times higher than the rate against the Non-MHSDS population). This fact has not changed.

Defendants' most recent released COMPSTAT report, excerpts enclosed hereto as **Exhibit B**, show that approximately 80% of use of force incidents at LAC continue to be against people with serious mental illness. As the data shows, there has been no recent change in the number of use of force incidents against people with serious mental illness, nor has there been any change in the percentage of use of force incidents against people with serious mental illness. (The COMSTAT report does not track use of force incidents against individuals with the disabilities that are verified and tracked in *Armstrong*.)

This data underscores the fact that Defendants are still not adequately deescalating potential use of force situations and are instead needlessly using unreasonable force "without regard to the cause of the [incarcerated person's] behavior, the efficacy of such measures, or the impact of those measures on the inmates' mental illnesses." *Coleman v. Wilson*, 912 F. Supp. 1282, 1320 (1995).

4. Defendants Have Not Responded to the Vast Majority of Plaintiffs' Letters, Nor Have They Undertaken Any Systemic Reforms to Remedy Misconduct

Despite these consistent and troubling reports, Defendants have to date provided a meaningful response to **only two** of the eighty-eight incidents of staff misconduct we have reported at LAC.

Over two months ago, Defendants wrote to inform us that they were "researching the use of force incidents at LAC" and "working… to address the apparent increase in use of force incidents involving *Coleman* class members." *See* Jan. 15, 2020 Ltr. From Katie Riley re Plaintiffs' Renewed Concerns re Excessive Force at LAC at 2. A month later, Defendants wrote again to provide "status updates" regarding their response to five of the twenty-two allegations that we reported ten months earlier in an April 10, 2019 letter (no explanation was given for the lack of an update about the other seventeen allegations detailed in that letter).

In these status updates, Defendants wrote that they had recently "committed additional resources (including assigning staff from other CDCR institutions) to expedite the completion of the outstanding inquiries to allegations of inappropriate custody staff conduct at LAC." *See* Feb. 12, 2020 Ltrs. from Alan Sobel re Outstanding LAC Staff Misconduct Allegations.

It has now been six weeks since these updates and we have heard nothing more. Moreover, Defendants have provided no response whatsoever to nearly fifty of the allegations we have reported—not even an acknowledgment letter.

Defendants also have not, to the best of our knowledge, made any effort to address the serious problems at LAC. No cameras have been installed. No outside investigators or strike forces have been called in to look into problems. And no officers have been disciplined or terminated.

In short, nothing appears to have changed. In April 2019, during a *Coleman* tour of LAC, I spoke to the LAC Warden, RC Johnson, about the serious problems at LAC. I asked him what he planned to do to address misconduct at LAC. He told me, point-blank, that did not believe he could do anything based solely on inmate allegations.

This attitude has pervaded Defendants' entire response to staff misconduct, not just at LAC, but throughout the entire system. It is this same attitude that forced Plaintiffs to file the Motion to Stop Defendants from Assaulting, Abusing and Retaliating Against People with Disabilities at Richard J. Donovan Correctional Facility.

While we will ask the Court to include LAC in the relief ordered in *Armstrong*, the hearing on the Motion is likely to be postponed until June. In the meantime, the costly and horrific incidents at LAC must stop or we will have no choice but to file an emergency motion.

In the meantime, please provide within 15 days all CDCR Form 402 and 403 decisions by an LAC hiring authority relating to the specific incidents listed in the

enclosed letters, my prior letters and monitoring reports since January 2019, and/or any alleged staff misconduct at LAC that occurred from January 1, 2018 to the present, in which the alleged victim of the staff misconduct was a *Coleman* or *Armstrong* class member. (A chart showing all outstanding letters and reports from Plaintiffs alleging staff misconduct at LAC is attached hereto as **Exhibit C**.)

For each of these alleged incidents, please produce the following for documents since January 1, 2018:

- All documents and communications relating to the findings of investigations into allegations of staff misconduct at LAC;
- All documents and communications relating to any corrective action or disciplinary action in cases where an investigation confirmed allegations of staff misconduct at LAC;
- All CDCR Form 402s, 403s, 989s from the period at LAC;
- All investigation reports and related documents relating to investigations of staff misconduct at LAC;
- All 602's, HC-602s and 1824s filed by incarcerated people and related to staff misconduct at LAC;
- All documents including written documents and audio and video recording relating to interviewed conducted as part of investigations into staff misconduct at LAC; and
- For any documents within 35 days after the 402/403 decision, the investigation reports and related materials once the time period has passed.

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We anticipate your prompt response regarding this important issue.

Sincerely,

ROSEN BIEN
GALVAN & GRUNFELD LLP

/s/ Thomas Nolan

By: Thomas Nolan

TN:DVC:cg
Encl.: **Exhibit A**, Fourteen Letters re Unreasonable, Excessive Force at LAC
Exhibit B, Excerpted COMPSTAT Report Data
Exhibit C, Chart Showing Outstanding LAC Staff Misconduct Letter and Reports
cc: *Coleman* Special Master Team
Co-Counsel
Coleman & *Armstrong* DAG Team
Roy Wesley
Coleman HQ Team
Ed Swanson
OLA team

See Enclosed Spreadsheet

Last Name	First Name	CDCR #	Date Sent to CDCR	Author of Letter to CDCR	Case Reported In	Date of Incident	Type of Alleged Misconduct	Officers Involved in Alleged Misconduct	Location of Incident	Level of Care	DPP Code	Response from CDCR?	Date of CDCR Response
[redacted]	[redacted]	[redacted]	3/27/2020	Thomas Nolan	Coleman	6/13/2019	Unreasonable Force	[redacted]	C-Yard	CCCMS	None	No	N/A
[redacted]	[redacted]	[redacted]	10/9/2019	Thomas Nolan	Coleman	7/19/2019	Unreasonable Force	Lt. [redacted]	C-Yard Gym	CCCMS	None	No	N/A
[redacted]	[redacted]	F04632	7/16/2019	Thomas Nolan	Armstrong	9/18/2018	Retaliation for ADA Requests/Needs	Three Unnamed Officers	B-Yard	CCCMS	DLT	No	N/A
[redacted]	[redacted]	[redacted]	4/10/2019	Thomas Nolan	Coleman	10/12/2018	Ignored Suicidal Ideation, Ignored Self-Harm	[redacted] First Watch C5 Staff	C5 Unit	EOP	None	No	N/A
[redacted]	[redacted]	[redacted]	4/10/2019	Thomas Nolan	Coleman	11/4/2018	Retaliation, Arranged Assault	[redacted]	C-Yard	EOP	None	No	N/A
[redacted]	[redacted]	[redacted]	8/8/2019	Cara Trapani	Coleman	6/27/2019	Unreasonable Force	[redacted] Sgt.	C-Yard Gym, C-Yard	CCCMS	None	Non-Class Action Acknowledgement Letter	8/26/2019
[redacted]	[redacted]	[redacted]	7/16/2019	Thomas Nolan	Armstrong	3/22/2019	Retaliation	[redacted]	C5 Unit	EOP	DLT, DNH	Non-Class Action Acknowledgement Letter	7/23/2019
[redacted]	[redacted]	[redacted]	3/19/2019	Thomas Nolan	Armstrong	July 2018	Retaliation for ADA Requests/Needs	[redacted]	Transport Van	CCCMS	DPW	Yes	8/12/2019
[redacted]	[redacted]	[redacted]	7/16/2019	Thomas Nolan	Armstrong	6/13/17, Ongoing	Retaliation, Unreasonable Force	[redacted] Sgt. [redacted]	D5 Unit	EOP	DLT	Non-Class Action Acknowledgement Letter	7/23/2019
[redacted]	[redacted]	[redacted]	2/7/2020	Thomas Nolan	Armstrong	Mar-19	Disclosure of Confidential Information, Indifference to Safety Concerns, Officer-Directed Assault	[redacted] Sgt. [redacted]	C3 Unit	CCCMS	DPM	Non-Class Action Acknowledgement Letter	2/14/2020
[redacted]	[redacted]	[redacted]	4/10/2019	Thomas Nolan	Coleman	10/13/2018	Unreasonable Force	[redacted]	B-Yard	CCCMS	None	No	N/A
[redacted]	[redacted]	[redacted]	7/16/2019	Thomas Nolan	Armstrong	Unknown	Retaliation for ADA Requests/Needs	Not Named	D2 Unit	EOP	DPO	No	N/A
[redacted]	[redacted]	[redacted]	7/16/2019	Thomas Nolan	Armstrong	4/15/2019	Verbal Harassment, Unreasonable Force	[redacted]	D-Yard Chow Hall	EOP	DNH	No	N/A
[redacted]	[redacted]	[redacted]	2/7/2020	Thomas Nolan	Armstrong	10/14/2019	Verbal Harassment, Unreasonable Force	[redacted]	D5 Unit	EOP	DNH, DNV	Non-Class Action Acknowledgement Letter	2/14/2020
[redacted]	[redacted]	[redacted]	3/27/2020	Thomas Nolan	Both	8/7/2019	Unreasonable Force	[redacted]	D4 Unit	EOP	DPM	No	N/A
[redacted]	[redacted]	[redacted]	7/16/2019	Thomas Nolan	Armstrong	4/25/2019	Indifference to Medical Needs	Sgt. [redacted]	C5 Unit	EOP	DPV	Non-Class Action Acknowledgement Letter	7/23/2019
[redacted]	[redacted]	[redacted]	3/27/2020	Cara Trapani	Coleman	10/1/2019	Unreasonable Force	[redacted]	D3 Unit	EOP	None	No	N/A
[redacted]	[redacted]	[redacted]	3/27/2020	Thomas Nolan	Both	7/8/2019	Unreasonable Force	[redacted]	D1 Unit	EOP	DPH, DPS, DPV	No	N/A
[redacted]	[redacted]	[redacted]	7/16/2019	Thomas Nolan	Armstrong	12/18/2018	Retaliation for ADA Requests/Needs, Unreasonable Force	[redacted]	D4 Unit	EOP	DPM	Non-Class Action Acknowledgement Letter	7/23/2019

[redacted]	[redacted]	[redacted]	2/7/2020	Thomas Nolan	Armstrong	6/25/2019	Retaliatory Write-ups	[redacted]	A/B Medical Building	GP	DLT	No	N/A
[redacted]	[redacted]	[redacted]	4/10/2019	Thomas Nolan	Coleman	12/4/2018	Unreasonable Force	Sgt. [redacted] Other Unidentified Officers	D-Yard Gym	EOP	None	No	N/A
[redacted]	[redacted]	[redacted]	7/16/2019	Thomas Nolan	Armstrong	4/10/2019	Verbal Harassment, Unreasonable Force	3rd Watch ASU Sergeant	Standalone ASU	CCCMS	DPO	Non-Class Action Acknowledgement Letter	7/23/2019
[redacted]	[redacted]	[redacted]	1/17/2020	Thomas Nolan	Both	11/9/2019	Unreasonable Force	[redacted]	B1 Unit	CCCMS	DLT	Non-Class Action Acknowledgement Letter	1/31/2020
[redacted]	[redacted]	[redacted]	7/16/2019	Thomas Nolan	Armstrong	8/25/2018	Unreasonable Force	Not Named	D5 Unit	EOP	DPM	Non-Class Action Acknowledgement Letter	7/23/2019
[redacted]	[redacted]	[redacted]	3/19/2019	Thomas Nolan	Armstrong	8/23/18, 8/25/18	Unreasonable Force	[redacted] D5 Unit Officers	C-Yard, D5 Unit	EOP	DPO	No	N/A
[redacted]	[redacted]	[redacted]	4/10/2019	Thomas Nolan	Coleman	12/7/18 - 1/26/19	Threats of Harm, Retaliation, Racist Language, Unreasonable Force	Sgt. [redacted] Lt. [redacted]	D5 Unit	EOP	None	Status Update Letter	2/13/2020
[redacted]	[redacted]	[redacted]	2/7/2020	Thomas Nolan	Armstrong	10/1/2019	Retaliation for ADA Requests/Needs	[redacted]	A-Yard Workchange	GP	DPO	No	N/A
[redacted]	[redacted]	[redacted]	2/7/2020	Thomas Nolan	Armstrong	Ongoing	Retaliation for ADA Requests/Needs	[redacted]	B1 Unit	GP	DPW	No	N/A
[redacted]	[redacted]	[redacted]	3/27/2020	Thomas Nolan	Coleman	9/10/2019	Unreasonable Force	[redacted]	D-Yard	EOP	None	No	N/A
[redacted]	[redacted]	[redacted]	7/16/2019	Thomas Nolan	Armstrong	7/30/2018	Retaliation for ADA Requests/Needs	Not Named	B-Yard	GP	DLT, DNH	No	N/A
[redacted]	[redacted]	[redacted]	4/10/2019	Thomas Nolan	Coleman	10/20/2018	Retaliation	[redacted]	C5 Unit	EOP	None	Status Update Letter	2/13/2020
[redacted]	[redacted]	[redacted]	2/7/2020	Thomas Nolan	Armstrong	Unknown	Cell Door Closure, Verbal Harassment	[redacted]	B2 Unit	CCCMS	DPO	No	N/A
[redacted]	[redacted]	[redacted]	8/28/2019	Thomas Nolan	Both	5/18/2019	Unreasonable Force	Sgt. [redacted]	D3 Unit	EOP	DLT	No	N/A
[redacted]	[redacted]	[redacted]	8/28/2019	Thomas Nolan	Both	7/18/2019	Unreasonable Force	Two Unidentified Officers	D5 Unit	EOP	DLT	No	N/A
[redacted]	[redacted]	[redacted]	4/10/2019	Thomas Nolan	Coleman	6/3/2018	Unreasonable Force	[redacted]	D5 Unit	EOP	None	No	N/A
[redacted]	[redacted]	[redacted]	2/7/2020	Thomas Nolan	Armstrong	Ongoing	Retaliation for ADA Requests/Needs, Racist Language	[redacted]	B1 Unit	CCCMS	DPM, DPV, LD	No	N/A
[redacted]	[redacted]	[redacted]	3/19/2019	Thomas Nolan	Armstrong	Ongoing	Retaliation for ADA Requests/Needs	[redacted]	B1 Unit	CCCMS	DPW	No	N/A

[redacted]	[redacted]	[redacted]	7/16/2019	Thomas Nolan	Armstrong	4/17/2019	Indifference to Medical Needs, Racist Language, Verbal Abuse	[redacted]	D5 Unit	EOP	DPM	Non-Class Action Acknowledgement Letter	7/23/2019
[redacted]	[redacted]	[redacted]	3/27/2020	Thomas Nolan	Coleman	1/31/2020	Unreasonable Force	[redacted]	D-Yard Gym	EOP	None	No	N/A
[redacted]	[redacted]	[redacted]	3/27/2020	Thomas Nolan	Coleman	12/11/2019	Unreasonable Force	[redacted] Sgt [redacted] Sgt [redacted] Lt	D-Yard Gym	EOP	None	No	N/A
[redacted]	[redacted]	[redacted]	7/16/2019	Thomas Nolan	Armstrong	6/17/2018	Unreasonable Force	[redacted]	D5 Unit	EOP	DPM	No	N/A
[redacted]	[redacted]	[redacted]	7/16/2019	Thomas Nolan	Armstrong	8/27/2018	Indifference to Medical Needs	[redacted]	D4 Unit	EOP	DLT, DNH	Non-Class Action Acknowledgement Letter	7/23/2019
[redacted]	[redacted]	[redacted]	2/7/2020	Thomas Nolan	Armstrong	Apr-19	Retaliation for ADA Requests/Needs, Racist Language	[redacted]	D1 Unit	CCCMS	DPO, DNH	No	N/A
[redacted]	[redacted]	[redacted]	11/15/2019	Thomas Nolan	Coleman	9/9/2019	Unreasonable Force	[redacted]	D4 Unit	EOP	None	No	N/A
[redacted]	[redacted]	[redacted]	11/15/2019	Thomas Nolan	Coleman	8/1/2019	Unreasonable Force	[redacted] Other Unidentified Officers	D-Yard	EOP	None	Non-Class Action Acknowledgement Letter	11/21/2019
[redacted]	[redacted]	[redacted]	4/10/2019	Thomas Nolan	Coleman	11/30/2018	Threats of Harm	Sgt. [redacted], Lt. [redacted]	R&R	EOP	None	No	N/A
[redacted]	[redacted]	[redacted]	3/27/2020	Thomas Nolan	Coleman	11/8/2019	Unreasonable Force	[redacted]	D-Yard	EOP	None	No	N/A
[redacted]	[redacted]	[redacted]	3/27/2020	Thomas Nolan	Coleman	9/8/2019	Unreasonable Force	[redacted]	D3 Unit, D-Yard Gym	EOP	None	No	N/A
[redacted]	[redacted]	[redacted]	7/16/2019	Thomas Nolan	Armstrong	4/29/2018	Unreasonable Force	Not Named	Standalone ASU	GP	DNM	Non-Class Action Acknowledgement Letter	7/23/2019
[redacted]	[redacted]	[redacted]	3/27/2020	Thomas Nolan	Coleman	11/3/2019	Unreasonable Force	[redacted]	D4 Unit	EOP	None	No	N/A
[redacted]	[redacted]	[redacted]	2/7/2020	Thomas Nolan	Armstrong	Ongoing	Retaliation for ADA Requests/Needs	[redacted]	B1 Unit	GP	DPM	No	N/A
[redacted]	[redacted]	[redacted]	2/7/2020	Thomas Nolan	Armstrong	Fall 2019	Retaliation for ADA Requests/Needs	Laundry Staff	C1 Unit	CCCMS	DPW	No	N/A
[redacted]	[redacted]	[redacted]	11/5/2019	Thomas Nolan	Coleman	4/12/2019	Unreasonable Force	[redacted]	D-Yard, D-Yard Gym	EOP	None	No	N/A
[redacted]	[redacted]	[redacted]	4/10/2019	Thomas Nolan	Coleman	12/7/2018	Unreasonable Force	Sgt. [redacted] Sgt. [redacted]	B-Yard	CCCMS	None	No	N/A
[redacted]	[redacted]	[redacted]	7/16/2019	Thomas Nolan	Armstrong	1/19/19, 2/11/19	Retaliation, Verbal Harassment	[redacted] Other Unnamed Officers	A1 Unit	GP	DPW	Non-Class Action Acknowledgement Letter	7/23/2019
[redacted]	[redacted]	[redacted]	2/7/2020	Thomas Nolan	Armstrong	6/27/2019	Retaliation for ADA Requests/Needs	Unknown	A4 Unit	GP	DPW	No	N/A
[redacted]	[redacted]	[redacted]	2/7/2020	Thomas Nolan	Armstrong	Ongoing	Targeting of Armstrong Class Members	[redacted]	B2 Unit	CCCMS	DPW	No	N/A
[redacted]	[redacted]	[redacted]	4/10/2019	Thomas Nolan	Coleman	Unknown	Racist Targeting	Unknown	C-Yard	CCCMS	None	No	N/A
[redacted]	[redacted]	[redacted]	4/10/2019	Thomas Nolan	Coleman	Early March 2019	Ignored Suicidal Ideation, Threats of Harm	D5 First Watch Officers	D5 Unit	EOP	None	No	N/A

[redacted]	[redacted]	[redacted]	7/16/2019	Thomas Nolan	Armstrong	7/18/2018	Ignored Suicidal Ideation, Unreasonable Force	Not Named	Unknown C-Yard Unit	EOP	None	Non-Class Action Acknowledgement Letter	7/23/2019
[redacted]	[redacted]	[redacted]	2/7/2020	Thomas Nolan	Armstrong	Ongoing	Retaliation for ADA Requests/Needs, Racist Language	[redacted]	B1 Unit	GP	DPW	No	N/A
[redacted]	[redacted]	[redacted]	3/27/2020	Thomas Nolan	Coleman	12/20/2019	Unreasonable Force	[redacted]	D3 Unit	EOP	None	No	N/A
[redacted]	[redacted]	[redacted]	2/7/2020	Thomas Nolan	Armstrong	6/1/2019	Retaliation for ADA Requests/Needs	[redacted]	B1 Unit	GP	DPO	No	N/A
[redacted]	[redacted]	[redacted]	2/7/2020	Thomas Nolan	Armstrong	Ongoing	Retaliation for ADA Requests/Needs	[redacted]	B1 Unit	GP	DPO	No	N/A
[redacted]	[redacted]	[redacted]	1/31/2020	Thomas Nolan	Coleman	7/12/2019	Unreasonable Force	Sgt. [redacted] Unknown Officers	C-Yard, C-Yard Gym	CCCMS	None	No	N/A
[redacted]	[redacted]	[redacted]	7/16/2019	Thomas Nolan	Armstrong	7/16/2018	Unreasonable Force	[redacted]	B1 Unit	GP	DPO	Non-Class Action Acknowledgement Letter	7/23/2019
[redacted]	[redacted]	[redacted]	3/19/2019	Thomas Nolan	Armstrong	Ongoing	Retaliation for ADA Requests/Needs	[redacted]	B1 Unit	GP	DPW	No	N/A
[redacted]	[redacted]	[redacted]	3/27/2020	Thomas Nolan	Coleman	11/23/2018	Unreasonable Force	[redacted]	C/D Medical Building	EOP	None	No	N/A
[redacted]	[redacted]	[redacted]	2/7/2020	Thomas Nolan	Armstrong	Aug-19	Threats of Harm, Unreasonable Force	[redacted] other unnamed officers	D-Yard	EOP	DPV	Non-Class Action Acknowledgement Letter	2/14/2020
[redacted]	[redacted]	[redacted]	4/10/2019	Thomas Nolan	Coleman	8/24/2018	Unreasonable Force	[redacted]	C5 Unit, C-Yard	EOP	None	No	N/A
[redacted]	[redacted]	[redacted]	4/10/2019	Thomas Nolan	Coleman	Late October 2018	Threats of Harm for Suicidal Behavior	[redacted]	D4 Unit	EOP	None	Status Update Letter	2/13/2020
[redacted]	[redacted]	T93746	4/10/2019	Thomas Nolan	Coleman	10/5/2018	Unreasonable Force	[redacted]	D-Yard Medical Building	EOP	None	No	N/A
[redacted]	[redacted]	[redacted]	4/10/2019	Thomas Nolan	Coleman	9/19/2018	Threats of Harm, Sexual Assault, Racist Language, Unreasonable Force	[redacted]	Standalone ASU	CCCMS	None	No	N/A
[redacted]	[redacted]	[redacted]	4/10/2019	Thomas Nolan	Coleman	7/18/18, 7/20/18	Retaliation, Arranged Assault	[redacted]	C-Yard	EOP	None	No	N/A
[redacted]	[redacted]	[redacted]	4/10/2019	Thomas Nolan	Coleman	10/14/2018	Ignored Suicidal Ideation	[redacted]	C5 Unit	EOP	None	No	N/A
[redacted]	[redacted]	[redacted]	4/10/2019	Thomas Nolan	Coleman	Ongoing	Disclosure of Confidential Information	Not Named	C5 Unit	EOP	None	No	N/A
[redacted]	[redacted]	[redacted]	4/10/2019	Thomas Nolan	Coleman	9/16/2018	Retaliation	[redacted]	C5 Unit	EOP	None	No	N/A
Unknown	Unknown	Unknown	4/10/2019	Thomas Nolan	Coleman	6/7/2018	Unreasonable Force	[redacted]	C5 Unit	EOP	None	Status Update Letter	2/13/2020
Unknown	Unknown	Unknown	4/10/2019	Thomas Nolan	Coleman	9/12/2018	Ignored Suicide Attempt, Unreasonable Force	[redacted]	C5 Unit	EOP	None	Status Update Letter	2/13/2020
[redacted]	[redacted]	[redacted]	7/16/2019	Thomas Nolan	Armstrong	8/9/2018	Loss of Property	Not Named	C5 Unit	EOP	DNH	No	N/A
[redacted]	[redacted]	[redacted]	3/19/2019	Thomas Nolan	Armstrong	7/25/2018	Unreasonable Force	Two D5 Unit Officers	D5 Unit	EOP	DPW	Yes	8/12/2019
[redacted]	[redacted]	[redacted]	3/19/2019	Thomas Nolan	Armstrong	11/14/2018	Racist Language, Unreasonable Force	Unidentified D5 Unit Officer, Sgt. [redacted]	D5 Unit	EOP	DPW	No	N/A
[redacted]	[redacted]	[redacted]	11/4/2019	Thomas Nolan	Both	6/13/2019	Unreasonable Force	[redacted]	D4 Unit	EOP	DLT	No	N/A
[redacted]	[redacted]	[redacted]	3/19/2019	Thomas Nolan	Armstrong	4/13/2018	Retaliation for ADA Requests/Needs	[redacted]	D5 Unit	GP	DNH	Yes	8/12/2019

[redacted]	[redacted]	[redacted]	3/27/2020	Thomas Nolan	Both	11/20/2019	Unreasonable Force	ISU Sgt. [redacted]	C-Yard Program Office	CCCMS	DNH	No	N/A
[redacted]	[redacted]	[redacted]	7/16/2019	Thomas Nolan	Armstrong	7/31/2018	Retaliation for ADA Requests/Needs	[redacted]	B3 Unit	GP	DPM	Non-Class Action Acknowledgement Letter	7/23/2019
[redacted]	[redacted]	[redacted]	4/10/2019	Thomas Nolan	Coleman	6/29/2018	Unreasonable Force	[redacted] Sgt. [redacted]	D5 Unit	EOP	None	No	N/A
[redacted]	[redacted]	[redacted]	3/27/2020	Thomas Nolan	Both	8/27/2019	Unreasonable Force	[redacted]	D4 Unit, D-Yard Gym	EOP	None	No	N/A

Exhibit P

OFFICE OF LEGAL AFFAIRS
Jennifer Neill
General Counsel
P.O. Box 942883
Sacramento, CA 94283-0001

May 18, 2020

Thomas Nolan
ROSEN BIEN
GALVAN & GRUNFELD LLP
tnolan@rbgg.com

Dear Mr. Nolan:

This letter is for the purpose of responding to your April 10, 2019 letter regarding "Coleman v. Newsom: Plaintiff's Renewed Concerns about Excessive Use of Force and Staff Misconduct incidents at LAC."

Specifically, this letter addresses the following allegation from your letter:

> [redacted] reported that on October 12, 2018, he told staff on first watch in his unit (C5) that he was suicidal, but they refused to help him or contact mental health staff. He was EOP at the time. Later that night, Mr. [redacted] told multiple officers on first watch, including Officer [redacted], that he was suicidal and showed them his arm, which was bleeding profusely from a cut he made. He was refused help again. Mr. [redacted] was kept in his cell until second watch, when he was taken to see mental health staff. Following this experience, Mr. [redacted] filed a 602 appeal, which found that staff had not violated policy..

An inquiry was opened by California State Prison, Los Angeles County (LAC) regarding this allegation.[1] Two inmates who were housed in close proximity to Mr. [redacted] on October 12, 2018 were interviewed as part of the fact-finding inquiry.

The first inmate witness interviewed indicated that he remembered the incident in question. This inmate witness stated that he did hear Mr. [redacted] talking to himself in his cell a few times during the night, and that Mr. [redacted] may have told a staff member that he was going "man down." The inmate witness indicated that he was not certain that Mr. [redacted] had told a staff member

[1] LAC conducted the fact finding inquiry into the allegations identified in this letter in accordance with the Department's Operations Manual, Article 22. The Department is currently in the process of revising that policy and, once approved and adopted, future fact finding inquiries will comply with the new policy.

about his suicidal ideations. The witness also stated that to his knowledge the staff on Facility C follow suicide prevention procedures and that typically when an inmate claims he is suicidal in Facility C, the staff remove him from his cell and place him in a holding cell until he can be seen by mental health.

The second inmate witness conveyed that on the date in question, he did not hear Mr. [redacted] yelling for help from staff, or see Mr. [redacted] talk to staff at the cell door. However, this witness did remember that in the morning, between 5:00 and 6:00 a.m., staff removed [redacted] from his cell, and that Mr. [redacted] was bleeding from his arms. This inmate witness had never experienced suicidal ideations, or seen any other inmate ask staff for help due to suicidal ideations, therefore he had no observations regarding how staff generally handle inmates who have suicidal ideations.

Mr. [redacted]'s 602 appeal, the incident log, the 7219 (medical report of injury) and the C-3 Officer log books were reviewed as part of the inquiry.

In the 602 appeal, Mr. [redacted] alleges that an officer witnessed him cut his left arm in his cell and failed to report that he was suicidal. An inquiry was performed based on the 602 appeal, and ultimately the 602 appeal was denied because no violation of policy was found.

The incident log indicated that on the morning of October 13, at about 6:15 a.m., an officer observed Mr. [redacted] in his cell with blood on him, and what appeared to be cuts on his left arm. The incident log further provides that Mr. [redacted] told staff he was hearing voices all night long, and the voices told him to cut himself. The officer removed [redacted] from his cell and escorted him to medical for a 7219 medical evaluation. The 7219 indicated that [redacted] required sutures, and that [redacted] stated he was suicidal. The incident log indicates that while at medical, [redacted] was assessed by a psychologist.

The C-3 log books note that security checks were conducted at 0030, 0200, and 0400 hours, and that count was conducted at 2330, 0100, 0300, and 0500. Nothing in the log books indicates that [redacted] was yelling from his cell, or that he was suicidal.

The evidence obtained during the inquiry does not indicate that staff failed to follow policy and procedure. The information revealed during the inquiry was insufficient to warrant a referral to the Office of Internal Affairs, and we now consider this matter closed.

Sincerely,

/s/ Kori Salas

Kori Salas
Attorney III
Office of Legal Affairs

Exhibit Q

OFFICE OF LEGAL AFFAIRS
Jennifer Neill
General Counsel
P.O. Box 942883
Sacramento, CA 94283-0001

May 11, 2020

Thomas Nolan
ROSEN BIEN
GALVAN & GRUNFELD LLP
tnolan@rbgg.com

Dear Mr. Nolan:

This letter is for the purpose of responding to your April 10, 2019 letter regarding "*Coleman v. Newsom*: Plaintiff's Renewed Concerns About Excessive Use of Force and Staff Misconduct incidents at LAC."

Specifically, this letter addresses the following allegation from your letter:

> C5 custody staff's failure to assist class members in the throes of suicidal ideation likely contributed to the recent suicide death of EOP class member [redacted], [redacted], in C5 on October 14, 2018. Two class members, neither of whom gave permission for us to share their names due to fears of retaliation, reported that second watch officers in C5 ignored Mr. [redacted]'s requests for assistance that afternoon. One class member reported that Mr. [redacted] told Officer [redacted] on second watch that he was feeling suicidal, to which the officer responded "wait until third watch." Another class member similarly reported that Officer [redacted] ignored Mr. [redacted]'s requests for assistance. Mr. [redacted] was found hanging in his cell later that day by third watch.

An inquiry was opened by the institution regarding this allegation.[1] The incident report was reviewed as part of the inquiry. In addition, three inmates who housed in cells in close proximity to [redacted] were interviewed in order to determine the credibility of the allegations.

During the inmate interviews, one of the inmates provided information even before being informed of the allegation. This inmate relayed that although he and [redacted] knew each other

[1] LAC conducted the fact finding inquiry into the allegations identified in this letter in accordance with the Department's Operations Manual, Article 22. The Department is currently in the process of revising that policy and, once approved and adopted, future fact finding inquiries will comply with the new policy.

well, he did not suspect that [redacted] was contemplating suicide, and if he had suspected it, he would have told his own clinician.

All inmates were asked during the interview whether they observed Mr. [redacted] tell any member of staff of his suicidal ideations. All three inmates indicated that they did not observe Mr. [redacted] tell a staff member that he had suicidal ideations. The interviewed inmates were also asked whether they themselves had ever informed staff of their suicidal ideations while housed in C5, or seen other inmates do so. In response to the question, one inmate indicated that he had never seen officers "say no or ignore" an inmate who informed staff about having suicidal ideations. Another inmate said that when informed an inmate has suicidal ideations, the officers put you in the shower, call mental health, and then mental health does an assessment. The third inmate indicated that when he informed staff that he was suicidal, the officers put him in a holding cell where staff conducted an unclothed body search, and then he was evaluated by mental health staff and placed on suicide watch.

There was also information obtained during the inquiry that indicates inmates may have presented false information when making the allegation.

The evidence obtained during the inquiry was insufficient to warrant a referral to the Office of Internal Affairs, and we now consider this matter closed.

Sincerely,

/s/ Kori Salas

KORI SALAS
Attorney III
Office of Legal Affairs

Exhibit R

OFFICE OF LEGAL AFFAIRS
Jennifer Neill
General Counsel
P.O. Box 942883
Sacramento, CA 94283-0001

May 8, 2020

Thomas Nolan
Rosen Bien Galvan Grunfeld
tnolan@rbgg.com
VIA EMAIL ONLY

Re: Coleman LAC Report (April 29, 2019):

Dear Mr. Nolan:

This letter is in response to the allegations in your office's letter regarding alleged misconduct by received from your office on April 29, 2019 regarding Mr. [redacted]'s allegations that he was repeatedly by racial epithets by two officers while housed in D5 ASU EOP.

California State Prison-Los Angeles County ("LAC") conducted an inquiry[1] into the allegations raised in your office's letter, as follows:

> [redacted], [redacted] reported that Officers [redacted] and [redacted] repeatedly demeaned him with racial epithets while he was housed in the D5 ASU EOP Hub and refused his requests for urgent mental health care.

CDCR takes every allegation made against the Department seriously, and as such, please be advised that LAC conducted an inquiry into these allegations by referencing various documents, databases, and records to procure all useful information regarding the allegations.

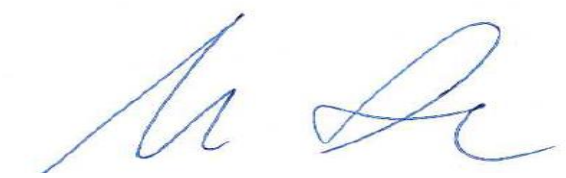
Staff conducting the inquiry interviewed two inmates who were housed in the D5 ASU EOP during a similar time period to Mr. [redacted] Neither of these inmates reported correctional officers [redacted] and [redacted] used racial epithets against any inmate in D5 ASU EOP. Mr. [redacted] refused to participate in the inquiry and did not provide any additional documentation or witnesses to support this allegation. In fact, when attempting to interview Mr. [redacted], he informed custody that he didn't know about issue with either correctional officers [redacted] or [redacted].

[1] LAC conducted the fact finding inquiries into the allegations identified in this Tour Report in accordance with the Department's Operations Manual, Article 22. The Department is currently in the process of revising that policy and, once approved and adopted, future fact finding inquiries will comply with the new policy.

Based upon the documentary review, and the information derived from the interviews attempted and conducted, LAC will be closing the inquiries into the allegation(s) presented in the Report as presented on behalf of Mr. [redacted].

Should you have any questions, please contact the undersigned at [redacted].

Thank you,



MICHAEL A. STONE
Attorney III Legal Liaison, Female Offenders and Program Services
Office of Legal Affairs

cc: Raybon Johnson, Warden (A)

Exhibit S

OFFICE OF LEGAL AFFAIRS
Jennifer Neill
General Counsel
P.O. Box 942883
Sacramento, CA 94283-0001

May 7, 2020

Thomas Nolan, Esq.
Rosen Bien Galvan & Grunfeld
101 Mission Street, Sixth Floor
San Francisco, CA 94105
tnolan@rbgg.com

Re: *Coleman* Report (April 10, 2019)

Dear Mr. Nolan:

This letter is in response to the April 10, 2019 *Coleman* Monitoring Tour Staff Misconduct Report from your office regarding alleged issues occurring at the California State Prison-Los Angeles County ("LAC").

LAC has conducted an inquiry[1] into the numerous allegations, and this correspondence will specifically address that allegations raised in the first page of your office's letter, which is as follows:

- Reports from anonymous Coleman class members primarily in Facility 'D', Building 5, Administrative Segregation (Ad-Seg) about Racially Targeted Abuse.

The California Department of Corrections and Rehabilitation takes every allegation made against the Department seriously, and attempts to look into each and every allegation to determine the efficacy of such allegation. Unfortunately, this section of the April 10, 2019 report does not contain the specificity needed to determine the exact allegations presented from your report.

Despite the absence of sufficient specificity, LAC conducted an inquiry into these allegations by referencing various documents, databases, and records, including the Inmate Appeals Tracking System (IATS) to determine that there were no inmate appeals in regards to the allegations of this inquiry during the above noted time frame. Further LAC also confirmed that there were no

[1] LAC conducted the fact finding inquiries into the allegations identified in this Tour Report in accordance with the Department's Operations Manual, Article 22. The Department is in the process of revising that policy and, once approved and adopted, future fact finding inquiries will comply with the new policy.

Health Care Grievances received and any appeals in regards to the allegations of this inquiry during the identified time frame.

LAC then conducted interviews of six inmates who were incarcerated within D-5 through different time frames. All of the inmates stated that correctional staff treated the inmate population in D-5 fairly and equally. One inmate referenced that the allegation of racial discrimination by staff was untrue. The only inmate who referenced hearing a racial slur one time did not provide any specific facts, nor did such file a complaint at the time.

Based upon the documentary review and the interview, LAC determined that the allegations presented of racially targeted abuse was not supported by evidence gathered and is not sustained. LAC has closed the inquiry into such allegation.

Should you have any questions, please contact the undersigned at [redacted].

Sincerely,

ALAN L. SOBEL
Attorney IV Legal Liaison, High Security Mission
Office of Legal Affairs

cc: Raybon Johnson, Warden

Exhibit T

OFFICE OF LEGAL AFFAIRS
Jennifer Neill
General Counsel
P.O. Box 942883
Sacramento, CA 94283-0001

May 6, 2020

Thomas Nolan, Esq.
Rosen Bien Galvan & Grunfeld
101 Mission Street, Sixth Floor
San Francisco, CA 94105
tnolan@rbgg.com

Re: Coleman Report (April 10, 2019)

Dear Mr. Nolan:

This letter is in response to the April 10, 2019 *Coleman* Monitoring Tour Staff Misconduct Report from your office regarding alleged issues occurring at the California State Prison-Los Angeles County ("LAC").

LAC has conducted an inquiry[1] into the numerous allegations, and this correspondence will specifically address that allegations raised in your office's letter, which is as follows:

- Multiple reports from class members about the extensive retaliation class members experience when they file staff misconduct complaints.

CDCR takes every allegation made against the Department seriously, and attempts to look into each and every allegation to determine the efficacy of such allegation. Unfortunately, this reference contained in your April 10, 2019 report does not contain the specificity needed to determine the exact allegations presented from in your report.

Despite the absence of sufficient specificity, LAC conducted an inquiry into these allegations by referencing various documents, databases, and records, including the Inmate Appeals Tracking System (IATS) to determine that thirteen staff complaints were submitted from Facility C. In addition, it was noted that inmates submitted thirty-three staff complaints from Facility D.

LAC also interviewed six inmates as to their experience or observation of alleged staff retaliation for filing a staff complaint. With the exception of one inmate, all five other inmates reported that they had either retaliated against, threatened or discouraged from filing appeals while housed at LAC. Further, even though one inmate had indicated that he had not filed an appeal while housed in D-5, he had not been threatened, discouraged or told he would be retaliated against for utilizing the appeals process.

[1] LAC conducted the fact finding inquiries into the allegations identified in this Tour Report in accordance with the Department's Operations Manual, Article 22. The Department is in the process of revising that policy and, once approved and adopted, future fact finding inquiries will comply with the new policy.

As to the inmate who reported that he was warned not to file an appeal, also stated that he feared his cell would be searched if he filed appeals. However, based upon inconsistencies within his interview, his allegation regarding the retaliation was determined not to be credible.

Based upon the absence of specific allegations presented in the April 10, 2019 report, the documentary review and the interviews of the inmates, LAC determined that the allegations presented of extensive retaliation was not supported by evidence gathered, and as such, was not sustained. LAC has closed the inquiry into such allegation.

Should you have any questions, please contact the undersigned at [redacted].

Sincerely,

Alan L. Sobel
Attorney IV Legal Liaison, High Security Mission
Office of Legal Affairs

cc: Raybon Johnson, Warden

Exhibit U

OFFICE OF LEGAL AFFAIRS
Jennifer Neill
General Counsel
P.O. Box 942883
Sacramento, CA 94283-0001

March 26, 2020

Thomas Nolan
Rosen Bien Galvan Grunfeld
tnolan@rbgg.com
VIA EMAIL ONLY

RE: COLEMAN LAC REPORT (APRIL 29, 2019):

Dear Mr. Nolan:

This letter is in response to the allegations in your office's letter regarding alleged misconduct by Correctional Officer [redacted] (Office [redacted]) against Coleman class members received from your office on April 29, 2019 regarding inmate [redacted] and others.

California State Prison-Los Angeles County ("LAC") conducted an inquiry[1] into the allegations raised in your office's letter, as follows:

> "[redacted], [redacted], likewise reported that when he was at the EOP level of care and housed in C5, third watch Officers [redacted], [redacted] and [redacted] actively discourage EOP patients from reporting suicidality, as they do not want to have to complete the paperwork associated with suicide watch."
>
> "[redacted], [redacted], reported that when he was housed in C5 at the EOP level of care, he saw another EOP class member in that housing unit get assaulted by custody officers after reporting safety concerns. … [redacted], [redacted], who were housed in C5 at the EOP level of care at the time, also reported witnessing this incident."
>
> "Another EOP class member who signed the petition complaining about Officer [redacted]'s harassment, [redacted], [redacted], reported that the day after

[1] LAC conducted the fact finding inquiries into the allegations identified in this Tour Report in accordance with the Department's Operations Manual, Article 22. The Department is currently in the process of revising that policy and, once approved and adopted, future fact finding inquiries will comply with the new policy.

> he signed the petition, his cell was searched by officers. Over the next few weeks, Officer [redacted] repeatedly refused to let Mr. [redacted] out for yard and pod time, and made snide remarks to the effect that Mr. [redacted] had "gone against him." Mr. [redacted] also reported that multiple other prisoners were retaliated against for signing the petition against Officer [redacted]."

There were a series of allegations of improper conduct directed against Officer [redacted]. The California Department of Corrections and Rehabilitation (CDCR or the Department) takes every allegation made against the Department seriously, and as such, LAC conducted an inquiry into these allegations by referencing various documents, databases, and records, as well as by conducting interviews, where appropriate, to procure information regarding the allegations. It was determined that there was a concerted effort by a number of inmate(s) within the housing unit to present unfounded and false allegations against Officer [redacted] either directly or through other inmates. These efforts were apparently pursued in the attempt to manipulate CDCR into transferring Officer [redacted] to another post within the institution.

On February 1, 2020 LAC ISU conducted an audio-recorded interview with inmate [redacted], [redacted]. The specific allegations raised on behalf of inmate [redacted] in the April 29, 2019 Coleman LAC report were read to the inmate.

After discussing the specific allegations that officers [redacted], [redacted], and [redacted] actively discouraged EOP patients from reporting suicidality, inmate [redacted] stated that staff were not discouraging EOP patients from reporting suicidality.

According to the inmate, he did not make any allegations relevant to [redacted] "harassing" him. He further stated that he did not sign the petition bearing his name (alleging that his signature had been forged). When asked about whether staff ever harassed him by searching his cell or ever refused to let him out to yard or to day room he stated that he had never experienced that kind of behavior at LAC. He suggested that the reason some inmates may be claiming that they were being harassed by cell searches is that there is an erroneous belief prevalent among some inmates in the C5 EOP program that cell searches are limited to once a month (and that any searches that occur more frequently may be viewed as unfairly targeting them). The interviewer asked inmate [redacted] why Officer [redacted] might be targeted by inmates for false or exaggerated reporting and [redacted] explained that [redacted] is a "by the book" officer who holds inmates accountable for violating the rules, which upsets some inmates who expect more leeway.

Based upon the documentary review, and the information derived from the interview, LAC will be closing the inquiries into the allegation(s) presented in the Report as presented on behalf of inmate [redacted].

Should you have any questions, please contact the undersigned at [redacted].

Thank you,

ERIC DUESDIEKER
Attorney III Legal Liaison, High Security Mission
Office of Legal Affairs

cc: Raybon Johnson, Warden (A)

Exhibit V

OFFICE OF LEGAL AFFAIRS
Jennifer Neill
General Counsel
P.O. Box 942883
Sacramento, CA 94283-0001

March 26, 2020

Thomas Nolan
Rosen Bien Galvan Grunfeld
tnolan@rbgg.com
VIA EMAIL ONLY

RE: COLEMAN LAC REPORT (APRIL 29, 2019):

Dear Mr. Nolan:

This letter is in response to the allegations in your office's letter regarding alleged misconduct by Correctional Officer [redacted] (Office [redacted]) against Coleman class members received from your office on April 29, 2019 regarding inmate [redacted] and others.

California State Prison-Los Angeles County ("LAC") conducted an inquiry[1] into the allegations raised in your office's letter, as follows:

> "[redacted], [redacted], (an EOP patient housed in C5 at the time of this incident), reported witnessing an unidentified prisoner attempt suicide on September 12, 2018 by jumping off of the second tier in C5. The prisoner was housed in C5[redacted] at the time; Mr. [redacted] was housed in C5-[redacted]. Mr. [redacted] reported that he was in his cell, and witnessed the prisoner walk up the stairs and jump off the tier. He reported that officers [redacted], [redacted], and [redacted] then walked over to the suicidal prisoner. Officer [redacted] told the prisoner to lay down, but Officer [redacted] told him to get up, and then picked him up. Officer [redacted] was also reportedly saying things like "get your bitch ass up, you wanna die, well we'll kill your fucken ass, get your fucking ass up."
>
> Mr. [redacted] saw that Officer [redacted] was holding the prisoner by the throat and that he pushed him backwards into a holding cage. After he placed the prisoner

[1] LAC conducted the fact finding inquiries into the allegations identified in this Tour Report in accordance with the Department's Operations Manual, Article 22. The Department is currently in the process of revising that policy and, once approved and adopted, future fact finding inquiries will comply with the new policy.

> into the cage, Officer [redacted] started joking about the suicide attempt, saying things like "this motherfucker thought he could fly." Twenty minutes later, nursing staff arrived and attended to the prisoner, and then returned him to the holding cage. Shortly afterwards, the unidentified prisoner asked Officer [redacted] for his dinner tray, to which Officer [redacted] reportedly replied "I thought you wanted to kill yourself, now you wanna eat, no, you can't have shit." Mr. [redacted] estimated that the prisoner stayed in the holding cage for another twenty minutes before being taken out to a crisis bed. Mr. [redacted] reported that this incident was investigated by an outside office, who interviewed him and the unidentified prisoner. He added that the prisoner was sent something to sign for this investigation.
>
> Mr. [redacted] reported that when the unidentified prisoner showed the document to the officers, they threatened him if he pursued it, so the prisoner decided not to pursue the complaint. Unlike the unidentified prisoner, Mr. [redacted] decided to report the incident. But since then, Mr. [redacted] has had his cell searched multiple times by officers in what appears to be retaliation. Another prisoner, who did not want his name to be used in this letter out of fear of retaliation, reported to us that he had also witnessed this incident, and told us that "[t]he 3rd watch C/Os ruffed him up Bad, as if he was resisting. But the inmate wasn't combative, or anything. He wanted to die."

There were a series of allegations of improper conduct directed against Officer [redacted]. The California Department of Correction and Rehabilitation (CDCR or the Department) takes every allegation made against the Department seriously, and as such, LAC conducted an inquiry into these allegations by referencing various documents, databases, and records, as well as by conducting interviews, where appropriate, to procure information regarding the allegations. It was determined that there was a concerted effort by a number of inmate(s) within the housing unit to present unfounded and false allegations against Officer [redacted] either directly or through other inmates. These efforts were apparently pursued in the attempt to manipulate CDCR into transferring Office [redacted] to another post within the institution.

Though Mr. [redacted] did not provide a name for the inmate involved in the September 12, 2018 event, the date provided coupled with housing unit information allowed CDCR to identify the inmate in question through a "Notice of Unusual Occurrence" (NOU) from the date in question. It is noted that the affected inmate did not file any appeals nor was there any record that the inmate ever filed any allegations of staff misconduct in relation to the September 12, 2018 incident.

On June 3, 2019 LAC ISU conducted an audio-recorded interview with the affected inmate. The inmate expressly refuted the claim that he was assaulted by staff during the incident, similarly he refuted the notion that he had been mistreated by staff during the incident.

Regarding the allegation of retaliatory cell searches, LAC ISU was informed by another class

member of a prevalent belief in Mr. [redacted]'s housing unit that cell searches were limited to once a month. This false belief may have contributed to the belief that any searches more frequent than once a month was retaliatory. However, the Office of Legal Affairs is informed that officers assigned to each housing unit are tasked with conducting three cell searches per shift on second and third watch, or six cell searches daily in each housing unit. These searches occur seven days a week for a total of 42 cell searches per week or roughly 168 cell searches per month. LAC is designed with 100 cells per housing unit, so on average a cell would be searched more than once a month. This excludes additional searches based upon reasonable suspicion that an inmate is involved in misconduct.

Based upon the documentary review, and the information derived from the interview, LAC will be closing the inquiries into the allegation(s) presented in the Report as presented on behalf of Mr. [redacted].

Should you have any questions, please contact the undersigned at [redacted].

Thank you,

ERIC DUESDIEKER
Attorney III Legal Liaison, High Security Mission
Office of Legal Affairs

cc: Raybon Johnson, Warden (A)

Exhibit W

OFFICE OF LEGAL AFFAIRS
Jennifer Neill
General Counsel
P.O. Box 942883
Sacramento, CA 94283-0001

January 17, 2020

Mr. Thomas Nolan, Esq. (Of Counsel)
Rosen Bien Galvan & Grunfeld LLP
101 Mission Street, Sixth Floor
San Francisco, CA 94105

RE: CALIFORNIA DEPARTMENT OF CORRECTIONS AND REHABILITATION RESPONSE TO ADVOCACY LETTER ON BEHALF OF INMATE [redacted]

Dear Mr. Nolan:

This letter is in response to the allegation(s) presented in your August 28, 2019 correspondence regarding claims presented on behalf of Inmate [redacted] concerning his incarceration at California State Prison-Los Angeles County (LAC).

Please be advised that LAC conducted an inquiry[1] into the allegations raised in your correspondence, which were as follows:

- May 18, 2019: Inmate [redacted] alleges that he was told he was being moved from D-Yard Building three to C-Yard Building five due to enemy concerns. Inmate [redacted] argued that he did not want to move and claimed that he became stressed and suicidal and began boarding up in his cell. A third watch Sergeant (Sgt.) came to talk to him and Inmate [redacted] allegedly swallowed two razors. The Sgt. had the Tower Officer open the door and Inmate [redacted] alleges that the Sgt. and other Correctional Officers (CO) dragged him out of his cell head first, punched, kicked and stomped him in the middle of the unit. He claims there were a dozen CO's involved and his right knee and ankle were injured.

- July 18, 2019: The second allegation concerns an incident in which Inmate [redacted] claims that he was forced to go to committee by being cuffed and placed in waist chains and a wheelchair. At committee, Inmate [redacted] was informed he could not go back to the D-Yard and was upset with that news. Inmate [redacted] claims that two officers took him out of committee and to the holding cages in the unit. After some arguing, Inmate [redacted]

[1] LAC conducted the fact finding inquiry into the allegations identified in this letter in accordance with the Department's Operations Manual, Article 22. The Department is currently in the process of revising that policy and, once approved and adopted, future fact finding inquiries will comply with the new policy.

stood up out of the wheelchair and one of the officers allegedly slammed him to the ground and Inmate [redacted] landed on his face causing his teeth to cut the inside of his lip.

California Department of Corrections and Rehabilitation (CDCR) takes every allegation made against the Department seriously, and in order to procure further information regarding these allegations, CDCR referenced various documents, databases, and records to procure all useful documentary information regarding the allegations. Further, CDCR interviewed a number of inmates, including Inmate [redacted] in order to secure additional information regarding the allegations as presented, including any potential additional witnesses, or any other evidence that Inmate [redacted] may have regarding the presented allegations.

All interviews were conducted in a confidential manner, and LAC inquired of Inmate [redacted], if he had any information to add that was not provided in the advocacy report. Further, LAC also inquired as to whether Inmate [redacted] had any additional witnesses that may have witnessed either of the incidents that are alleged to have occurred. LAC also reviewed all documentary materials created as a result of the May 18, 2019 and July 18, 2019 incidents. LAC also reviewed other documentary databases in the attempt to secure additional information regarding the allegations presented.

Based upon the information produced from the inquiry into these allegations, it appears that Inmate [redacted] was upset that he was being moved from LAC Facility "D" to LAC Facility "C", due to an enemy concern. According to the interviews with Inmate [redacted], on May 18, 2019, as he did not believe that he should be transferred, he covered up the cell door and window at the beginning of third watch. He further wedged his cane in the cell door to prevent entry. At that time, Inmate [redacted] also communicated that he had swallowed several razor blades.

Based upon Inmate [redacted] communication that he had swallowed several razor blades, and his covering up of his cell door and window, and out of concern for the safety of the inmate, CDCR conducted a cell extraction. This was done in accordance with CDCR policy. As such, based upon the information presented, and the information derived from the inquiry interviews and review of documentation, the allegations of misconduct occurring on the part of LAC correctional staff on May 18, 2019 is unfounded.

The July 18, 2019 incident also stemmed from Inmate [redacted]' anger at the transfer of his housing unit. It appears that as Inmate [redacted] was being moved from Administrative Segregation to Facility "C", he refused to proceed any further, and attempted to apply the brakes of his wheelchair. [redacted] then attempted to stand up and exit his wheelchair and move towards the escorting CO's, and that was when correctional staff employed reasonable force on Inmate [redacted].

During the multiple interviews with Inmate [redacted] regarding this incident, he also raised issues involving inappropriate conduct of correctional staff propositioning inmates to fight other inmates, and also alleged that correctional staff in some manner convinced other inmates to bang on his cell to keep him up at night. When questioned regarding these allegations, Inmate [redacted] was unable and unwilling to provide any witnesses to the alleged

inappropriate staff conduct, and then recanted such allegation. Based upon the wide variety of allegations presented by Inmate [redacted], and the information derived from additional inmate interviews, LAC was able to establish that Inmate [redacted]' allegations were not credible. Rather, the evidence collected reflected that Inmate [redacted]' allegations were apparently presented as a result of Inmate [redacted]' attempt to avoid a District Attorney referral as a result of the Rules Violation Report he received for the assault of a CO.

Based upon finding Inmate [redacted] allegations as unfounded, and securing contrary information to the allegations raised, LAC has closed the inquiry into the issues raised in your August 28, 2019 correspondence.

Thank you for your attention to this correspondence. Should you have any further questions, please contact the undersigned at [redacted].

Thank you,

/s/ Alan L. Sobel

ALAN L. SOBEL
Attorney IV Legal Liaison, High Security Mission
Office of Legal Affairs

cc: R. Johnson, Warden, LAC

Exhibit X

OFFICE OF LEGAL AFFAIRS
Jennifer Neill
General Counsel
P.O. Box 942883
Sacramento, CA 94283-0001

February 13, 2020

Mr. Thomas Nolan, Esq. (Of Counsel)
Rosen Bien Galvan & Grunfeld LLP
101 Mission Street, Sixth Floor
San Francisco, CA 94105

CDCR RESPONSE TO ADVOCACY LETTER ON BEHALF OF INMATE [redacted] (CDCR NO.[redacted])

Dear Mr. Nolan:

Please accept this correspondence from the California Department of Corrections & Rehabilitations (CDCR) as a status update to the allegation(s) presented on behalf of Inmate [redacted] (CDCR No.: [redacted]) concerning his incarceration at California State Prison – Los Angeles County (LAC).

CDCR acknowledges that our response to the allegation(s) on behalf of Inmate [redacted] (CDCR No.: [redacted]) has been pending for some time. Nevertheless, CDCR takes every allegation we receive seriously. Recently, CDCR has committed additional resources (including assigning staff from other CDCR institutions) to expedite the completion of the outstanding inquiries to allegations of inappropriate custody staff conduct at LAC. Specifically, CDCR is still in the process of completing the inquiry into the allegations raised on behalf of Inmate [redacted] (CDCR No.: [redacted]), and we will provide an updated status once it is completed.

Should you have any questions, or need further assistance, please do not hesitate to contact the undersigned.

Thank you,

/s/ Alan L. Sobel

ALAN L. SOBEL
Attorney IV Legal Liaison, High Security Mission
Office of Legal Affairs

cc: R. Johnson, Warden

Exhibit Y

OFFICE OF LEGAL AFFAIRS
Jennifer Neill
General Counsel
P.O. Box 942883
Sacramento, CA 94283-0001

February 13, 2020

Mr. Thomas Nolan, Esq. (Of Counsel)
Rosen Bien Galvan & Grunfeld LLP
101 Mission Street, Sixth Floor
San Francisco, CA 94105

CDCR RESPONSE TO ADVOCACY LETTER ON BEHALF OF INMATE [redacted] (CDCR NO. [redacted])

Dear Mr. Nolan:

Please accept this correspondence from the California Department of Corrections & Rehabilitations (CDCR) as a status update to the allegation(s) presented on behalf of Inmate [redacted] (CDCR No.: [redacted]) concerning his incarceration at the California State Prison–Los Angeles County (LAC).

CDCR acknowledges that our response to the allegation(s) on behalf of Inmate [redacted] (CDCR No.: [redacted]) has been pending for some time. Nevertheless, CDCR takes every allegation we receive seriously. Recently, CDCR has committed additional resources (including assigning staff from other CDCR institutions) to expedite the completion of the outstanding inquiries to allegations of inappropriate custody staff conduct at LAC. Specifically, CDCR is still in the process of completing the inquiry into the allegations raised on behalf of Inmate [redacted] (CDCR No.: [redacted]), and we will provide an updated status once it is completed.

Should you have any questions, or need further assistance, please do not hesitate to contact the undersigned.

Thank you,

/s/ Alan L. Sobel

ALAN L. SOBEL
Attorney IV Legal Liaison, High Security Mission
Office of Legal Affairs

cc: R. Johnson, Warden

Exhibit Z

OFFICE OF LEGAL AFFAIRS
Jennifer Neill
General Counsel
P.O. Box 942883
Sacramento, CA 94283-0001

February 13, 2020

Mr. Thomas Nolan, Esq. (Of Counsel)
Rosen Bien Galvan & Grunfeld LLP
101 Mission Street, Sixth Floor
San Francisco, CA 94105

CDCR RESPONSE TO ADVOCACY LETTER ON BEHALF OF INMATE [redacted] (CDCR NO. [redacted])

Dear Mr. Nolan:

Please accept this correspondence from the California Department of Corrections & Rehabilitations (CDCR) as a status update to the allegation(s) presented on behalf of Inmate [redacted] (CDCR No.: [redacted]) concerning his incarceration at the California State Prison–Los Angeles County (LAC).

CDCR acknowledges that our response to the allegation(s) on behalf of Inmate [redacted] (CDCR No.: [redacted]) has been pending for some time. Nevertheless, CDCR takes every allegation we receive seriously. Recently, CDCR has committed additional resources (including assigning staff from other CDCR institutions) to expedite the completion of the outstanding inquiries to allegations of inappropriate custody staff conduct at LAC. Specifically, CDCR is still in the process of completing the inquiry into the allegations raised on behalf of Inmate [redacted] (CDCR No.: [redacted]), and we will provide an updated status once it is completed.

Should you have any questions, or need further assistance, please do not hesitate to contact the undersigned.

Thank you,

/s/ Alan L. Sobel

ALAN L. SOBEL
Attorney IV Legal Liaison, High Security Mission
Office of Legal Affairs

cc: R. Johnson, Warden

Exhibit AA

OFFICE OF LEGAL AFFAIRS
Jennifer Neill
General Counsel
P.O. Box 942883
Sacramento, CA 94283-0001

February 13, 2020

Mr. Thomas Nolan, Esq. (Of Counsel)
Rosen Bien Galvan & Grunfeld LLP
101 Mission Street, Sixth Floor
San Francisco, CA 94105

CDCR RESPONSE TO ADVOCACY LETTER ON BEHALF OF ANONYMOUS INMATE AS TO ISSUES(S) IN C5

Dear Mr. Nolan:

Please accept this correspondence from the California Department of Corrections & Rehabilitations (CDCR) as a status update to the allegation(s) presented on behalf of Anonymous Inmate as to issue(s) in C5 concerning his incarceration at the California State Prison–Los Angeles County (LAC).

CDCR acknowledges that our response to the allegation(s) on behalf of Anonymous Inmate as to issue(s) in C5, has been pending for some time. Nevertheless, CDCR takes every allegation we receive seriously. Recently, CDCR has committed additional resources (including assigning staff from other CDCR institutions) to expedite the completion of the outstanding inquiries to allegations of inappropriate custody staff conduct at LAC. Specifically, CDCR is still in the process of completing the inquiry into the allegations raised on behalf of Anonymous Inmate as to issue(s) in C5, and we will provide an updated status once it is completed.

Should you have any questions, or need further assistance, please do not hesitate to contact the undersigned.

Thank you,

/s/ Alan L. Sobel

ALAN L. SOBEL
Attorney IV Legal Liaison, High Security Mission
Office of Legal Affairs

cc: R. Johnson, Warden

Exhibit BB

OFFICE OF LEGAL AFFAIRS
Jennifer Neill
General Counsel
P.O. Box 942883
Sacramento, CA 94283-0001

January 31, 2020

VIA EMAIL ONLY

Mr. Thomas Nolan
Rosen Bien Galvan & Grunfeld LLP
TNolan@RBGG.com

Re: [redacted]: Non class action allegations

Dear Mr. Nolan:

This letter is to acknowledge receipt of the advocacy letter received from your office on January 17, 2020 concerning inmate [redacted] (CDCR No: [redacted]) currently located at CSP-LAC.

The allegations mentioned in your correspondence, were routed to the appropriate personnel at CDCR.

The Legal Liaison for the High Security Mission, Alan Sobel, will provide you with information when it becomes available. If we need any additional information in order to address these matter, we will contact your office.

Sincerely,

/s/ Robin Stringer

ROBIN STRINGER
Class Action Coordinator
Office of Legal Affairs

cc: Russa Boyd, Attorney IV
Alan Sobel, Attorney IV
Tamiya Davis, Attorney III

Exhibit CC

OFFICE OF LEGAL AFFAIRS
Jennifer Neill
General Counsel
P.O. Box 942883
Sacramento, CA 94283-0001

November 21, 2019

VIA EMAIL ONLY

Mr. Thomas Nolan
Rosen Bien Galvan & Grunfeld LLP
tnollan@rbgg.com

Re: [redacted]: Non class action allegation(s)

Dear Mr. Nolan:

This letter is to acknowledge receipt of the advocacy letter received from your office on November 15,2019 concerning inmate [redacted] (CDCR No: [redacted]) currently located at CSP-Los Angeles County.

The allegation(s) that were presented in your correspondence were routed to the appropriate personnel at CDCR.

The Legal Liaison for the High Security Mission, Alan Sobel, will provide you with information when it becomes available. If we need any additional information in order to address these matters, we will contact your office.

Sincerely,

/s/ Erin D. Anderson

ERIN D. ANDERSON
Litigation Coordinator
Office of Legal Affairs

cc: Russa Boyd, Attorney IV
Alan Sobel, Attorney IV
Tamiya Davis, Attorney III
Nicholas Weber, Attorney III

Exhibit DD

OFFICE OF LEGAL AFFAIRS
Jennifer Neill
General Counsel
P.O. Box 942883
Sacramento, CA 94283-0001

August 26, 2019

VIA EMAIL ONLY

Ms. Cara Trapani
Rosen Bien Galvan & Grunfeld LLP
ctrapani@rbgg.com

Re: [redacted]: Non class action allegation(s)

Dear Ms. Trapani:

This letter is to acknowledge receipt of the advocacy letter received from your office on August 8, 2019, concerning inmate [redacted] (CDCR No: [redacted]) currently located at CSP-Los Angeles County.

The allegation(s) that were presented in your correspondence were routed to the appropriate personnel at CDCR. The Legal Liaison for the High Security Mission, Alan Sobel, will provide you with information when it becomes available.

If we need any additional information in order to address these matters, we will contact your office.

Sincerely,

/s/ Erin D. Anderson

ERIN D. ANDERSON
Appeals and Compliance Coordinator
Office of Legal Affairs

cc: Alan Sobel, Attorney IV
Nicholas Weber, Attorney III
Melissa Bentz, Attorney

Exhibit EE

From:	Thomas Nolan
To:	Nick Weber; Melissa Bentz
Cc:	Coleman Team - RBG Only; Coleman Special Master Team; CDCR OLA Armstrong CAT Mailbox (OLAArmstrongCAT@cdcr.ca.gov); Daye, Eureka@CDCR; Mitchell, Kelly@CDCR (Kelly.Mitchell@cdcr.ca.gov); Steve Fama; "arm-plo@prisonlaw.com"
Subject:	Coleman -- Defendants" Response to Plaintiffs" Advocacy Concerning Excessive Force Against Coleman Class Member at LAC [IWOV-DMS.FID6429]
Date:	Friday, November 22, 2019 4:00:54 PM
Attachments:	Non Class Action Advocacy Letter Acknowledgement - [redacted].pdf image001.jpg TN-OLA Team, Ltr re [redacted] LAC UOF Incident, 11-15-19, 0489-3.PDF

Privileged and Confidential, Subject to Protective Orders

Via E-mail Only

Dear OLA *Coleman* Team –

We write to object to your characterization of our November 15, 2019 advocacy letter on behalf of EOP class member [redacted] ([redacted]) as "Non class action allegations." Our letter on behalf of Mr. [redacted], which raises multiple concerns regarding the use of excessive force against incarcerated persons with serious mental illness at CSP – Los Angeles County ("LAC") and Defendants' ability to monitor such force, fits squarely into the central issues of the *Coleman* case. As you know, D-Yard at LAC, where the incident took place, is entirely EOP housing, along with an EOP ASU unit.

Defendants' use of force against incarcerated persons with serious mental illnesses has been found to violate the Eighth Amendment to the Constitution at multiple points in the history of this litigation. *See Coleman v. Wilson*, 912 F. Supp. 1282, 1320 (1995) ("There is substantial evidence in the record of seriously mentally ill inmates being treated with punitive measures by the custody staff to control the inmates' behavior without regard to the cause of the behavior, the efficacy of such measures, or the impact of those measures on the inmates' mental illnesses.") and April 10, 2014 Order Regarding the Use of Force on *Coleman* Class Members at 12 (finding that "[t]he Eighth Amendment violation with respect to use of force… arises from policies and practices that permit use of force against seriously mentally ill prisoners 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.")

Our letter on behalf of Mr. [redacted] – alongside the many other letters we have sent on behalf of *Coleman* class members who have been the victim of similar use of excessive force incidents – raises serious concerns that LAC staff are not in compliance with CDCR's policies governing the use of force developed as part of the *Coleman* remedy. These policies -- which require staff to take into account a prisoner's mental health status before using force, also require the use of only the minimally necessary force in a given situation, and also prescribe a strict monitoring process following use of force incidents, amongst numerous other requirements. All of these requirements were enacted in direct response to the *Coleman* Court's April 10, 2014 Order. In that Order, the Court found that "for an extended period of time CDCR staff have been working with a broad definition of "imminent threat," noted that many incidents reviewed by Defendants' litigation expert Steve Martin "evidenced unnecessary use of force," emphasized the need to "closely monitor all UOF incidents, particularly those classified as "immediate" uses of force", and directed Defendants to "work under the guidance of the Special Master to make the additional revisions to the use of force

… [as] required by this order." ECF No. 5131 at 20-21. Defendants filed their revised policies with the Court on August 1, 2014. The revised policies defined "Reasonable Force" as "the force that an objective, trained, and competent correctional employee faced with similar facts and circumstances, would consider necessary and reasonable to subdue an attacker, overcome resistance, effect custody, or gain compliance with a lawful order" and included requirements that staff "evaluate the totality of circumstances involved in any given situation … [including] mental health status if known" and employ "verbal persuasion" before using force. Defendants' Plans and Policies Submitted in Response to April 10, 2014 and May 13, 2014 Orders, ECF No. 5190 at 22-25. The policies also include requirements that all incarcerated persons who report excessive use of force or suffer serious bodily injury as a result of a use of force incident receive a video-recorded interview within 48 hours of their allegation / the incident. *Id* at 44.

These policies are the exact ones cited in our letter on behalf of Mr. [redacted]. The claim that Mr. [redacted]'s allegations are "Non class action allegations" is mystifying. Defendants cannot shirk their constitutional obligations to prevent the application of unreasonable force against *Coleman* class members simply by claiming that these issues are not part of the *Coleman* case.

Sincerely yours,

Tom

Thomas Nolan
Of Counsel

101 Mission Street, 6th Floor
San Francisco, CA 94105
(415) 310-2097 (cell)
(415) 433-6830 (office telephone)
(415) 433-7104 (fax)
tnolan@rbgg.com

OFFICE OF LEGAL AFFAIRS
Jennifer Neill
General Counsel
P.O. Box 942883
Sacramento, CA 94283-0001

November 21, 2019

VIA EMAIL ONLY

Mr. Thomas Nolan
Rosen Bien Galvan & Grunfeld LLP
tnollan@rbgg.com

Re: [redacted]: Non class action allegation(s)

Dear Mr. Nolan:

This letter is to acknowledge receipt of the advocacy letter received from your office on November 15,2019 concerning inmate [redacted] (CDCR No: [redacted]) currently located at CSP-Los Angeles County.

The allegation(s) that were presented in your correspondence were routed to the appropriate personnel at CDCR.

The Legal Liaison for the High Security Mission, Alan Sobel, will provide you with information when it becomes available. If we need any additional information in order to address these matters, we will contact your office.

Sincerely,

/s/ Erin D. Anderson

ERIN D. ANDERSON
Litigation Coordinator
Office of Legal Affairs

cc: Russa Boyd, Attorney IV
Alan Sobel, Attorney IV
Tamiya Davis, Attorney III
Nicholas Weber, Attorney III

Exhibit FF

From:	Thomas Nolan
To:	Nick Weber; Melissa Bentz; Davis, Tamiya@CDCR
Cc:	Coleman Team - RBG Only; Coleman Special Master Team; Armstrong Team - RBG only; Fouch, Adam@CDCR (Adam.Fouch@cdcr.ca.gov); Miranda, Teauna@CDCR (Teauna.Miranda@cdcr.ca.gov); Vincent Cullen; Daye, Eureka@CDCR; Elise Thorn
Subject:	Coleman/Armstrong -- Request to Expedite Movement of Coleman Class Member at ICF Level of Care at KVSP Who is Experiencing Ongoing Retaliation for Working With Class Counsel In Coleman and Armstrong [IWOV-DMS.FID6429]
Date:	Friday, May 29, 2020 3:23:44 PM
Attachments:	ArmstrongColeman -- Safety Concerns From Class Member Who Complained About Staff Misconduct at LAC IWOV-DMS.FID6429.msg image001.jpg

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Dear Nick, Melissa and Tamiya,

Today we talked with Mr. [redacted], [redacted], a *Coleman* class member who was referred to ICF level of care on April 10, 2020. Mr. [redacted] is also a DLT *Armstrong* class member who has been retaliated against for reporting staff misconduct when he was at LAC. This retaliation has followed him to KVSP, after staff from LAC called him at KVSP to investigate his allegations of staff misconduct.

Mr. [redacted] is currently housed in the B-1 TMHU at KVSP, awaiting transfer to a PIP. Because Mr. [redacted] is struggling to manage his significant mental health issues at KVSP, and because he is reporting extensive and ongoing serious retaliation from staff there, including being repeatedly called a "*Coleman* snitch" as well as threats from custody staff and other ongoing staff misconduct, we request the you move him to an ICF program in one of the PIPs or at ASH as soon as possible, in order to address his urgent mental health issues and to hopefully resolve his safety issues

As noted, Mr. [redacted] has experienced ongoing staff misconduct and safety issues at both LAC and KVSP. We contacted you on May 1, 2020, about safety concerns he was having. Specifically, he was threatened with being stabbed upon return to C-Yard for being a "Coleman snitch" (see attached email).

He is continuing to have issues and is being threatened by officers in B-1. He reports that the officer that has been threatening him denied him a COVID-19 test, and documented it as a refusal.

We are concerned that this is ongoing harassment and retaliation for speaking to our office about staff misconduct and other issues in CDCR. Per the movement matrix guidelines produced on May 22, we request that this be investigated and that Mr. [redacted] be re-issued a COVID-19 test as soon as possible, as he needs it to be able to eventually move to a PIP.

Thank you,

Tom Nolan

Thomas Nolan
Of Counsel

101 Mission Street, 6th Floor
San Francisco, CA 94105
(415) 310-2097 (cell)
(415) 433-6830 (office telephone)
(415) 433-7104 (fax)
tnolan@rbgg.com