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UNITED STATES DISTRICT COURT

NORTHERN DISTRICT OF CALIFORNIA

JOHN ARMSTRONG, et al.,

Plaintiffs,

v.

GAVIN NEWSOM, et al.,

Defendants.

Case No. C94 2307 CW

[REDACTED] DECLARATION OF JEFFREY A. SCHWARTZ, PH.D.

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

REDACTED

I, Jeffrey A. Schwartz, Ph.D., declare:

1. I am Plaintiffs' retained expert. I have personal knowledge of the matters set forth herein, and if called as a witness, I could and would competently so testify. I make this declaration in support of Plaintiff's Motion to Stop Defendants from Assaulting, Abusing and Retaliating Against Persons With Disabilities.

I. INTRODUCTION

2. My name is Jeffrey A. Schwartz, Ph.D., and my office is at 1610 La Pradera Drive in Campbell, California. I am the president of Law Enforcement Training and Research Associates, Inc. (LETRA), a criminal justice training and consulting organization that has had offices in the San Francisco Bay area since its incorporation in June 1972. I have worked full time with law enforcement and correctional agencies across the United States and Canada for over 35 years, both as LETRA's president and as a private consultant. The largest proportion of my work for the last 20 years has been working with prisons and jails and assisting them in applying national corrections standards to their operations.

3. I have worked with more than 40 of the 50 state departments of corrections and with small, medium and large jails and local departments of corrections. During my career I have toured literally hundreds of prisons and jails. I believe that I have done more work on major emergencies in jails and prisons than anyone else in the United States. I have co-authored three book length monographs on preparing for and managing major emergencies in jails and prisons, and all three of those volumes have been published by the National Institute of Corrections (NIC), a branch of the US Department of Justice. I have conducted Critical Incident Reviews (also called "After-Action Reports") following some of the most high profile emergencies and disasters in jails and prisons in the United States the last 40 years, including the riots in Camp Hill, Pennsylvania; the effects of Hurricanes Rita and Katrina on the Louisiana Department of Corrections; the riot and hostage taking in Deer Lodge, Montana; the hostage taking and rape of a Correctional Counselor at the Delaware Correctional Center; the riot at the prison in Lucasville, Ohio; and others. I co-

developed a unique system of emergency preparation and response that has been used in some form by over two thirds of the State Departments of Corrections in the country. I have provided training on emergency preparedness and response to thousands of jail and prison staff, either by personally conducting that training or by training and certifying emergency preparedness instructors for various correctional agencies.

4. I have similarly done a great deal of work throughout my career on prison and jail security issues. I was appointed as the Federal Court's security expert in the U.S. Virgin Islands and reviewed security in two correctional facilities there and then testified in a long-running class action and consent decree case. On a number of occasions I have conducted detailed security audits at a variety of jails and prisons across the country, frequently under the auspices of NIC.

5. My expert witness work and my consulting and training work has included a strong emphasis on use of force issues. I have written and/or drafted use of force policies for state departments of corrections as well as county correctional facilities. I have developed and presented training on use of force to correctional staff in a number of state Department of corrections, county jails and adolescent facilities. I have trained and certified instructors in correctional agencies as trainers with a use of force training curriculum that I developed. I have also reviewed use of force investigative and review procedures in many police and correctional agencies and the largest proportion of cases in which I have served as an expert has been use of force cases. I have published six articles on use of force. I am currently a Federal Court Monitor for the Los Angeles, California, Jails in a matter that resulted in a consent decree arising out of a class action use of force lawsuit against those jails. I recently concluded work as an expert for the US Attorney's Office in the Southern District of New York (Manhattan) resulting in a consent decree between Plaintiffs and the New York City Department of Corrections that centers on use of force issues. I evaluated use of force issues in the San Bernardino County, California, jails, worked with the Court and the Prison Law Office to develop a new use of force policy for that jail/system and I currently serve as a Federal Court Monitor reviewing

progress on a use of force consent decree there.

6. I have served as an expert on law enforcement and corrections issues for more than 15 years. In the last few years, expert work has constituted approximately 15% to 30% of my total professional time. I am charging $290 per hour for consultation, document review and other preparation activities and $425 per hour for actual testimony at trial or in deposition. My compensation will not be affected by the outcome of this case. A copy of my curriculum vitae is attached to this declaration as **Appendix A**. A copy of cases I have worked on as an expert is attached to this declaration as **Appendix B**. A copy of my fee schedule is attached to this declaration as **Appendix C**. Also, my recent publications are also attached to this declaration as **Appendix D**.

7. I have requested a tour of R.J. Donovan Correctional Facility ("RJD") but that has not yet occurred as this report is written, and cannot currently because of Covid-19 restrictions.

8. Discovery with regard to this motion is ongoing. I reserve the right to add to or change the opinions in this declaration if and when additional relevant information becomes available to me after the date of this declaration.

9. In March, 2020, I was retained by Don Specter of the Prison Law Office, in Berkeley, California, and Gay Grunfeld, of Rosen Bien Galvan & Grunfeld LLP of San Francisco, California to provide opinions on the California Department of Corrections and Rehabilitation's (CDCR) inquiry, investigation and disciplinary process as it relates to allegations of staff misconduct and the discipline of staff for misconduct.

10. Upon review, it became clear that my charge was to review and analyze three separate though related systems: an inmate grievance/complaint system for staff misconduct; a use of force review/investigation system; and a staff discipline system. My review was based primarily on the review of documents from RJD in San Diego County, California. It is my understanding that, to date, Defendants have only produced documents regarding the employee discipline process from RJD.

II. METHOD

11. The crux of my effort in this matter is the integrity and the effectiveness of the CDCR investigations of inmate allegations of staff misconduct at RJD. I conducted a detailed review of more than 43 such investigations, including cases investigated at the institutional level and cases handled at the Department level, by the Office of Internal Affairs (OIA). In this report, I have included the review and analysis of 25 of those cases, which include seven institution level cases and 18 cases that were referred out of the prison to OIA, that best illustrate particular issues without becoming redundant.

12. I also reviewed portions of the CDCR Department Operations Manual (DOM) and particularly the sections on use of force, reporting requirements and employee discipline. I also reviewed the declarations of Michael Freedman and of Eldon Vail, both previously filed in this matter. In addition, I reviewed the California Office of the Inspector General's (OIG) 2015 report on staff misconduct at California's High Desert State Prison (HDSP) and the OIG's report in 2019 on staff misconduct inquiries at the Salinas Valley State Prison (SVSP). I reviewed two memoranda—a December 10, 2018 memorandum from J.L. Bishop, Associate Warden at the California Institution for Men, and a January 26, 2019 memo from Sgt. [redacted] of the Investigative Services Unit (ISU) at the California Institution for Men—that summarized and discussed inmate interviews that they conducted with many inmates at RJD, referred to in this litigation as the "strike team." CDCR has very recently promulgated emergency regulations changing the grievance and the appeal process for inmates and parolees and those new emergency rules will become effective in June, 2020. I have reviewed those new regulations. A summary of the documents I rely on in drafting this declaration is attached as **Appendix E**.

13. The case records I reviewed were sometimes incomplete. In the majority of cases I reviewed, medical records were not included although the substance of the cases make clear that medical examination or treatment had occurred. There were other relevant records, some actually used by investigators in reaching their conclusions, which were not provided. It is my understanding that these records, such as video interviews of use of

force appellants, were not provided to Plaintiffs' counsel at the time this report was drafted.

14. In reviewing the investigations and inquiries, I used essentially the same methods that I currently use and have been using for four years in reviewing use of force incidents, reviews and investigations in the Los Angeles County jails and in the San Bernardino County jails. In Los Angeles, our three-person monitoring team selects and reviews 25 or more cases per quarter, looking at each case in great detail at everything from reporting requirements to the quality of the review and/or investigation to the appropriateness of discipline imposed if the case resulted in sanctions. My review of use of force cases for the last year and one half in San Bernardino County is very similar except it is a two person monitoring team and we review 20 to 40 cases every six months. For a typical case, I read all Officer reports, medical records, inmate disciplinary reports, supervisory summaries, analyses of the case by watch commanders and command level staff, reviews by internal affairs and/or executive review committees and watch video of the incident itself from fixed security cameras and or handheld camcorders, video interviews with the subject of the use of force and video interviews with inmate witnesses.

15. With the CDCR cases I reviewed here, the information that is produced and reviewed by CDCR in making staff misconduct decisions was not comparable to the cases discussed directly above in Los Angeles and San Bernardino. The information relied on by CDCR is incomplete and does not include the detail and depth of the information that is documented and relied on in those two counties on all use of force cases. The most glaring example is the lack of video evidence available in CDCR cases because CDCR has no statewide video surveillance system. Nevertheless, enough information was available to determine what conclusion CDCR reached regarding the staff misconduct allegation and to form an opinion as to the process and the basis for that conclusion.

III. EXPLANATION OF CDCR STAFF MISCONDUCT SYSTEM

16. My understanding of the staff misconduct complaint process used system wide in CDCR is as follows. When inmates believe they have been the victim of staff

mistreatment or abuse, they may file a staff complaint, also called a Form 602 appeal. The prison may reject the appeal, request an investigation by the Office of Internal Affairs ("OIA"), or conduct an inquiry at the prison. If a prison inquiry is conducted, a supervisor—typically a Sergeant (Sgt.) or a Lieutenant (Lt.)—is assigned to work on the staff complaint inquiry, in addition to all other regular duties. That supervisor, referred to as a *reviewer* for the purposes of this process, may collect evidence and conduct interviews of the appellant, of inmate witnesses and staff witnesses, and of the staff member who is the subject of the complaint. The reviewer then provides a written report to the hiring authority based on the results of any interviews completed, along with any reports and analysis completed, and any evidence the reviewer received during the inquiry.

17. Use of Force complaints trigger specific procedures upon receipt of the allegation, including the requirement that staff conduct a video interview of the inmate. The appropriateness of the force is also reviewed by an Institutional Executive Review Committee (IERC) which review the merits of the cases and determine whether staff followed policies and procedures when using force.

18. Under CDCR's staff misconduct system, allegations are only referred to the OIA for investigation when a reasonable belief exists that misconduct occurred. As discussed in more detail below, this is backwards. Investigations are necessary to determine whether misconduct occurred, not because it is already established or likely. Unfortunately, the majority of allegations never make it past this step both because the standard is wrong but also because of the myriad problems including delays, lack of video evidence, and poor evidence collection, analysis, and reporting in staff misconduct cases.

19. Also, the fact that the facility chose to refer the case to OIA means they found it potentially more serious or more likely that misconduct occurred in that case.. When OIA rejects the referral on its face, it stands to reason the facility would then try to conduct locally the investigation they had hoped OIA would conduct. Instead, in most cases, the facility does nothing, as if the OIA rejection was a substantive and sufficient answer to the complaint. Thus, less serious complaints are reviewed or investigated at the

institution level while many more serious complaints are rejected by OIA and then ignored by the institution.

20. The purpose of this report is to highlight problems with CDCR's process, including statewide problems, that were identified through my review of staff misconduct complaints arising at RJD.

IV. OPINION: THE CDCR SYSTEM FOR INVESTIGATING MISCONDUCT AND IMPOSING DISCIPLINE IS NOT EFFECTIVE.

A. The System is Not Protecting Vulnerable Inmates

21. The CDCR inquiry, investigation and disciplinary process as it relates to allegations of staff misconduct and the discipline of staff for misconduct, including the complaint/appeal/grievance component (the "System") does not work. The primary purpose of any staff grievance/complaint, use of force review, or staff discipline process should be to protect the people incarcerated in the system. The protection of inmates is done by identifying the bad actors and holding them accountable. CDCR's system fails to do that on multiple levels, as described below.

22. As I draft this report, our country is in the midst of a national crisis brought on by the death of George Floyd at the hands of police officers. I am struck by the similarities between that awful case and what is unfolding in CDCR; multiple allegations of staff misconduct against the responsible officer and an utter failure to hold staff accountable before it is too late. There is one stark difference in the George Floyd case -- the nation is outraged by the conduct because a video of the misconduct exists. Unfortunately, we do not have video of alleged misconduct at RJD, or throughout CDCR, and that is a travesty.

B. The Situation at RJD is Horrifying

23. RJD houses large numbers of special populations, specifically including prisoners with disabilities, mentally ill inmates and developmentally disabled inmates.

24. For obvious reasons, these are among the most vulnerable inmates in the CDCR population.

25. There is substantial evidence that these vulnerable inmates are targeted and preyed upon by a significant number of staff at RJD.

26. In most correctional facilities, the units housing mental health inmates, developmentally disabled inmates and inmates with physical disabilities are staffed with individuals who gravitate toward those inmates because of empathy and specialized skills. At RJD, it appears the opposite is true.

27. These vulnerable inmate populations have been the subject of statewide class action litigation resulting in a dozens of court orders on behalf of inmates with disabilities. Despite years of litigation, *Armstrong* and *Coleman* class members have not been, and are not, protected from staff abuse.

C. California is Deliberately Indifferent to the Inmates That the System is Supposed to Protect

28. The state of California is and has been on notice for years that the system does not work, and that inmates are getting hurt. California is acting with deliberate indifference by failing to take even the most basic steps to fix it.

29. Department administrators, facility-level managers, mid-managers and supervisors, front line staff and the officers' union all either actively participate in or silently condone the failures of this system. The example of the "RJD Strike Team" illustrates this point. When alerted by *Armstrong* attorneys of widespread, serious problems on Facility C at RJD, CDCR convened a "strike team" to investigate. The "strike team" interview results are extraordinary. CDCR's own "strike team" confirmed reports of very serious problems, including alleged gang behavior among officers.

30. In response, it appears that CDCR took the individual allegations from inmates, ran a small percentage of them through the investigation and disciplinary system and concluded there was not enough evidence of problems in most individual cases to justify any action.

31. Of the 26 OIA investigations produced to Plaintiffs' counsel, nine involved allegations that were referred from "strike team" interviews. OIA rejected 7 out of 9

(78%) cases, including one case where an inmate incriminated himself, admitting to investigators that he had carried out attacks on other people at the direction of staff. OIA failed to investigate and CDCR failed to take additional action in this or most of the cases.

32. If California did nothing more than to install cameras in all of their prisons, it would be a huge step towards identifying bad actors in the system, and exonerating staff who are wrongfully accused. In most use of force situations it would provide definitive evidence of whether the force was justified or excessive. The failure to take even this first step, a step already taken by many correctional and jail systems throughout the country, demonstrates the state's indifference and further condones serious staff misconduct.

33. CDCR has done little to nothing in the face of widespread, consistent reports of fear of staff, brutality and even officer gang behavior.

34. As I have reviewed these painful and sometimes horrific cases, and as I have analyzed obvious but chronic problems, there is one almost haunting question: How can management let this continue?

35. Even an unconfirmed implication that there may be dysfunctional staff subcultures, essentially vigilante-like staff gangs, in an correctional facility should engender an immediate and massive management response. The Ramparts Division scandal in LAPD resulted in a leadership change, "house cleaning" and Department-wide reform. The "3000 Boys" scandal in the LA Sheriff's Office brought similar results plus the Sheriff and Undersheriff in federal prison. Both situations received national publicity.

36. At RJD, specific and continuing allegations of self-appointed groups of staff enforcers acting like gangs has been met with little to no response from management.

37. The only people who want and need the system to work are the inmates that the system should protect, but they have no ability to change it.

38. The OIG has produced critical reports that highlight many of the problems that I have observed. Their role in certain aspects of the staff misconduct process should be enhanced to ensure that investigations and discipline are more accurate and effective.

39. I have reviewed and actively worked with county jails and state departments

of corrections across the United States on use of force investigations, inmate grievance systems and staff discipline, for more than 30 years. CDCR's system is the worst that I have seen in that time.

V. OPINION: CASES REVEALED SIGNIFICANT PROBLEMS IN ALL LEVELS OF THE STAFF MISCONDUCT INVESTIGATION AND DISCIPLINARY PROCESS

A. Myriad Problems with Investigations Conducted by Both Institution-level Staff and OIA Investigators

40. Staff bias against inmates is deep and ubiquitous. *See, e.g.*, case below regarding Mr. [redacted]

41. Investigators do not discover all the available facts or reach reasonable conclusions based on the evidence. *See, e.g.*, cases below regarding Mr. [redacted] and Mr. [redacted]

42. Investigations are incomplete. *See, e.g.*, cases below regarding Mr. [redacted] Mr. [redacted] and Mr. [redacted]

43. Physical evidence is ignored. *See, e.g.*, cases below regarding Mr. [redacted] and Mr. [redacted]

44. Plagiarism in staff reports and other collusion is ignored. *See, e.g.*, cases below regarding Mr. [redacted] Mr. [redacted] and Mr. [redacted]

45. Investigations do not attempt to reconcile discrepancies. *See, e.g.*, cases below regarding Mr. [redacted] Mr. [redacted] and Mr. [redacted]

46. Inmate testimony is discounted or ignored. *See, e.g.*, cases below regarding Mr. [redacted] Mr. [redacted] and Mr. [redacted]

47. Investigators emphasize the disciplinary histories or other negative information about inmates filing complaints but never mention the disciplinary histories or other negative information about the staff alleged to be involved in misconduct. *See, e.g.*, cases below regarding Mr. [redacted] and Mr. [redacted]

48. Long, unnecessary investigation delays undermine the ability to sustain allegations. *See, e.g.*, cases below regarding Mr. [redacted] Mr. [redacted] Mr. [redacted]

Mr. [redacted] and Mr. [redacted]

49. There is no mandate that medical staff must report injuries that appear or are alleged to be the result of violence from staff or use of force. Homer Venters, MD, a colleague of mine, found a similar situation at Rikers Island when he was in charge of medical and mental health services there. I found, during a CRIPA investigation at Rikers for the US Attorney's Office, Southern District of New York, that Dr. Venters had relatively quickly instituted appropriate protections guaranteeing that inmates seen by medical staff with trauma likely resulting from violence, were reported to custody management immediately and fully. *See, e.g.*, cases below regarding Mr. [redacted] and Mr. [redacted]

B. Myriad Problems with Discipline

50. Imposition of staff discipline is often inappropriate or inconsistent. *See, e.g.*, cases below regarding Ms. [redacted] Mr. [redacted] Mr. [redacted] and Mr. [redacted]

51. Staff, against whom credible allegations are made, continue to work their posts even when under active investigation. With the exception of Officer [redacted] and possibly one of the officers in the case involving Mr. [redacted] all subjects of OIA investigations were apparently allowed to continue to work their posts even when under active investigation by OIA. These officers were allowed to work at RJD, with full salary and benefits, interacting with prisoners for up to a year after credible allegations of serious misconduct had been made against them.

52. No referrals are made for criminal investigations even in clear situations of assault under color of authority. Only one of the cases I reviewed was referred to OIA for a possible criminal investigation: the [redacted] case. That case was referred "based on the allegation of obstruction of justice and intimidation reported by staff." Plaintiffs' counsel has informed me that another pending case involving Mr. [redacted] is also being pursued as a criminal investigation but I am not familiar with that case. Yet, given the magnitude and scope of the problems with staff misconduct at RJD, I would have expected that the Hiring Authority would have referred more than two cases to OIA for criminal investigations.

Many of the cases I reviewed involved patterns of fact that suggested that officers had colluded in order to obstruct investigations into their misconduct.

53. In the small number of cases resulting in staff discipline, there was video evidence that could not be ignored, or it was staff reporting the misconduct. Discipline was not sustained based on inmate testimony. There was little accountability at any level. *See, e.g.*, cases below regarding Ms. [redacted] Mr. [redacted] Mr. [redacted] and Mr. [redacted]

C. Myriad Problems with OIA Rejection of Cases

54. A central problem is OIA rejection of referrals for investigations from Hiring Authorities (Wardens). Some OIA rejections of institution referrals are without explanation and seem incomprehensible. In other cases, the rejection at OIA is based on a misconception that is stunning: "There is no reasonable belief that misconduct occurred". It is simply not possible to read allegations and then arrive at that conclusion. *See*, *e.g.*, cases below regarding Mr. [redacted] Mr. [redacted] and the multiple allegations against Officer [redacted]

55. The conclusion, whether there is a reasonable belief that staff misconduct occurred, should be the end result of an investigation but it is instead used as the overarching criterion to determine whether or not an investigation should occur.

56. The point of an investigation is to sort out what actually happened. An *a priori* conclusion that there is no basis for a reasonable belief that staff misconduct occurred, can only be reached if there is an assumption that inmates always lie and staff always tell the truth.

57. In my review of cases I identified multiple cases that were rejected by OIA and should not have been. *See, e.g.*, cases below regarding Mr. [redacted] Mr. [redacted] Mr. [redacted] Mr. [redacted] Mr. [redacted] Mr. [redacted] and the multiple allegations against Officer [redacted]

D. Inmates Are Actively Discouraged from Filing Grievances/Complaints by Staff and by the System Itself.

58. The staff misconduct complaint system has little credibility among inmates. This fact was overwhelmingly confirmed by strike team interviews at RJD. It is also discussed on page 29 of the SVSP report where "many [inmates] said they felt reluctant to use [the complaint process] because they were either directly threatened or retaliated against for filing staff complaints." No staff misconduct grievance system will be effective if inmates are too afraid or too discouraged to use it.

1. Fear of Retaliation for Filing Complaints

59. Staff retaliation for using the system is rampant. A significant number of the RJD staff misconduct allegations I reviewed involved complaints that staff were harassing or retaliating against people who asked for help, or who threatened to report an officer's unwillingness to help. This same problem was highlighted in the OIG reports on HDSP and SVSP.

60. Inmates are afraid to file grievances/complaints and afraid to provide testimony during investigations. Pressure to withdraw complaints and other forms of intimidation are common. *See, e.g.*, cases below regarding Mr. [redacted] Mr. [redacted] and Mr. [redacted]

61. Inmates at RJD describe staff subcultures, tantamount to gangs, engaging in vigilante-like activities against inmates and enjoying impunity from management. This has created an environment of fear.

62. It is not just inmates who are actively discouraged from reporting staff misconduct. That is also true for staff. Dr. [redacted] an experienced CDCR psychologist has testified to that effect and another CDCR employee, Melissa Turner, has said she faced retaliation for reporting staff misconduct. The [redacted] case, that is reviewed below, includes two officers trying to talk to a third officer about his inappropriate behavior, but then facing such intense staff retaliation that they both bid out of that location. In a case involving Mr. [redacted] an Officer witnessed a Sergeant using excessive force but told

investigators she was afraid to report the incident because of fear of staff retaliation.

2. Structural Barriers that Discourage Complaints

63. The system is complex, illogical and substantially misleading in terminology. All of these factors are additional barriers to constructive inmate use of the system.

64. If an inmate alleges unnecessary/excessive force, the investigation is for "staff inefficiency". The inmate may be informed that the appeal (now called a grievance in Defendants' new AIMS regulations) is "partially granted" when the substance has been totally rejected. The inmate does not have access to the memo explaining why the grievance/complaint was denied. The inevitable result of all of this is, based on my review of cases in this case, is most grievances/complaints do not get to the third level of review, likely because inmates are discouraged from pursing their complaint that far. They are then deemed to have failed to have exhausted their administrative remedies, barring their ability to bring civil actions.

65. Almost every investigation, whether institution-level or OIA, includes a "synopsis of incident" at or near the beginning of the investigation report, However, it is not actually a "synopsis." It is a summary or recitation of the staff version of events. It is often categorically different from the inmate version of events. That "synopsis" is often repeated, even several times, throughout the investigative file. The effect of this is to guarantee strong but subtle bias toward staff at the very beginning of investigation reports. The effect of this consistent problem is magnified because the incident commander and first level management reviewer sometimes simply copy that "synopsis", adopting it as their review of the situation.

66. According to memos that appeared in files I reviewed showing when a staff member is reassigned, and evidence of subsequent allegations of misconduct, staff members accused of serious misconduct are almost always left in their current assignment while an investigation is underway. Those staff then have ongoing contact with their inmate accusers and ample opportunity to harass, intimidate or retaliate against those

inmates and potential prisoner witnesses. It is rare for a staff member to be reassigned or placed on leave pending the outcome of an investigation.

67. The CCPOA contract further discourages the reporting of misconduct because it requires allegations against staff, including any supporting documents, videotape, etc., to be shown to the staff member, furthering an environment of fear of retaliation. The CDCR complaint/grievance procedure of maintaining locked boxes on living units and having inmates put complaints against staff in sealed envelopes and then into the lock boxes, is rendered meaningless by that CCPOA contract provision. This problem was identified and reported on years ago by the OIG in its review of staff misconduct complaints at HDSP (pages 31-33) and it still has not been fixed.

VI. OPINION: CASES REVEALED ADDITIONAL SIGNIFICANT STATEWIDE INADEQUACIES IN OTHER AREAS OF CDCR'S STAFF MISCONDUCT INVESTIGATION AND DISCIPLINARY PROCESS

A. CDCR has no Early Warning System (EWS).

68. EWS are data driven algorithms designed to identify high risk staff members early on so that corrective or remedial measures can be employed to reduce the likelihood of serious preventable incidents and also so that the careers of those individuals may be protected.

69. EWS have been used by law enforcement and correctional agencies for decades. I personally helped develop an EWS for the Richmond, California, Police Department in the early 1970s.

70. It is stunning that the largest correctional agency in the United States, CDCR, has no EWS in 2020. The OIG's May 2020 Annual Report, p. 28, states that CDCR has a new electronic tracking system to monitor Use of Force cases. While this is a step in the right direction, any EWS must be broader than Use of Force cases and must be searchable by many different parameters including victim, staff, location, and type of conduct, just to name a few. Assuming the new tracking system works, which is not a given, the crucial question is how CDCR intends to use it.

71. The situation at RJD is an excellent example of the failure to employ an

EWS. I received 26 OIA cases and 135 institution-level cases, all from RJD, from Plaintiffs' attorneys. Those cases involved more than 200 allegations against individual staff. While the majority of staff members named were involved in one or two cases, two Officers were named in 10 or more cases and several other Officers were named in five or more cases.

72. Based on my review, a number of officers were the subject of two or more referrals to OIA. Officer [redacted] for example, was a subject in four different referrals to OIA for administrative investigation, with the first in 2017 involving an administrative investigation in which he was found to have not violated policy. In addition, Officer [redacted] was named in many more cases that did not involve a referral to OIA. There is no indication that the multiple serious allegations against Officer [redacted] were ever considered by local investigators conducting appeal inquiries. There is also no indication that OIA investigators took Officer [redacted] history into account when deciding to reject three requests for administrative investigation into his conduct. The same goes for Officer [redacted] Officer [redacted] Officer [redacted] Officer [redacted] and Officer [redacted] all of whom were referred to OIA on two or more occasions. Of these repeat offenders, the documents indicate that only Officer [redacted] has been disciplined. Even then, the only reason that Officer [redacted] was eventually disciplined was because his misconduct was caught on camera. Prior to that incident, OIA rejected two cases involving Officer [redacted] because it concluded there was no reasonable belief that misconduct occurred, or, in other words, there was no video evidence or staff reports.

73. In the case involving Officer [redacted] CDCR Headquarters staff submitted a referral for investigation after Plaintiffs' counsel detailed dozens of allegations against Officer [redacted] With that many serious complaints against this Officer pending, and with an apparent pattern of behavior alleged, CDCR should have done something more to investigate allegations against this officer. Instead, OIA rejected the referral outright, without further explanation.

74. CDCR does not track these statistics and has nothing in place to protect

inmates from those staff consistently engaging in borderline conduct or high frequency preventable incidents, nor does CDCR have anything in place to protect those Officers from future termination because of such incidents.

B. The CDCR Staff Discipline System Is Inconsistent and Irrational.

75. CDCR uses an Employee Disciplinary Matrix to assist hiring authorities in determining what discipline may be appropriate based on the misconduct charges. This Matrix including the charges and penalties can be found in the DOM, section 33030.19. The penalties included in this Matrix are inconsistent and do not make sense when viewed in light of the charges against the employee.

76. For example, endangerment of an inmate is only a level three offense out of nine on the Matrix. In the [redacted] case below, an officer was found guilty of endangering an inmate by failing to allow him into his cell to get his rescue inhaler to stop an asthma attack. The duty of staff to protect inmates is a fundamental and profound responsibility. In many ways, inmates cannot protect themselves and are dependent upon staff for everything from food and showers to medical care and evacuation in the event of a fire. That duty of staff to protect inmates is long standing, well-established and beyond debate. It defies logic that endangering an inmate, here the inmate's very life, would constitute a level three offense.

C. The Hiring Authority Retains Too Much Control in the Process

77. The HA (Warden) has the final say in staff discipline. This is inappropriate in any disciplinary system. Because of the nature of that position, a Warden may be more concerned with the local reaction from prison staff to the disciplinary decision, or be under pressure from the CCPOA/officer's union. Thus, the ability to set an appropriate disciplinary standard will be compromised.

78. On those infrequent instances in which discipline is imposed by a Warden, having the Warden in control of the process can result in discipline that is inconsistent. For example, in the [redacted] case below, an inmate complained that Officer [redacted] purposely and repeatedly delayed opening her cell door. Four Officers and a

Lieutenant confirmed that Officer [redacted] did that regularly. The result of the investigation was a level three sanction against the officer but a new Warden arrived at RJD and rescinded the discipline entirely, and without explanation.

D. CDCR's Case Records are Abysmal

79. The allegations in many of these cases are most serious. Yet the records assembled for these cases are not kept as retrievable packages.

80. The investigative files provided by Defendants were frequently missing key elements, whether medical assessments or interview recordings or other evidence.

81. I frequently review staff misconduct, and in particular use of force cases from other jurisdictions. The files are well organized and reports are assembled in a logical and consistent format. The CDCR files were completely unorganized and did not appear to contain any semblance of uniformity.

82. This made my review of the CDCR files more difficult. It also led me to conclude that the lack of uniformly organized, kept, and maintained, files must also make it difficult for CDCR to conduct any quick and meaningful post-hoc review of misconduct cases.

83. Put simply, the dismal state of the CDCR investigative records is a significant barrier to accountability.

VII. THE PROBLEMS WITH INVESTIGATIONS AND THE DISCIPLINARY SYSTEM ARE DEPARTMENT-WIDE

84. I acknowledge that I only reviewed cases from one prison, RJD, during this endeavor. Nevertheless, I believe that many of the central problems with investigations at RJD, including incomplete investigations, bias, lack of timeliness and unjustified conclusions, are endemic statewide.

85. The OIG reports for HDSP, SVSP, and CCI document the exact same problems evident at RJD including serious and troubling allegations of staff abuse and the failure of the staff misconduct system to protect inmates by identifying the bad actors and holding them accountable. This strongly suggests that the problems at RJD are not

idiosyncratic but are Department-wide.

86. The problems identified regarding OIA rejection of cases and bias in investigations are also endemic statewide because that process is centralized and applies to all prisons.

87. Cameras do not exist statewide and, as evident in my review of individual cases, is a common and necessary factor in identifying misconduct and holding staff accountable.

VIII. CDCR'S NEW ALLEGATION INQUIRY MANAGEMENT SYSTEM (AIMS) WILL NOT FIX THE PROBLEMS OUTLINED ABOVE

88. It appears that in the face of widespread criticism and litigation, CDCR has developed AIMS as a new system for investigating allegations of staff misconduct, and approved that system through emergency regulations.

89. It is not clear yet how AIMS will operate but it is clear that fatal flaws with AIMS already exist.

90. The most important: frequently allegations of staff misconduct concern use of force incidents. However, it appears AIMS excludes multiple types of alleged staff misconduct including staff use of force (except those that cause serious bodily injury or are unreported). That makes no sense. If there is a new and better process for staff misconduct inquiries or investigations, the area where it is most important to apply that new process is staff use of force incidents. Also, I have serious concerns about CDCR's use of serious bodily injury as the criterion after they determined that three broken ribs did not constitute serious bodily injury in the [redacted] case below.

91. The new inquiry, review and investigation process also appears to be restricted to grievances filed by inmates (602's). That is also illogical. Serious allegations of staff misconduct are sometimes sent to CDCR by an inmate's family member by phone or by letter, raised by inmate advocacy groups, or attorneys working for particular inmates or in the class actions, or by other means. Those allegations and the underlying incidents they refer to are neither less serious nor categorically different from the allegations and

incidents in inmate 602's. They should not be handled differently.

92. Based on my review of cases in this matter, including both OIA cases and institutional level investigations, and based on my review of the OIG reports from High Desert and Salinas Valley, I am skeptical that AIMS will constitute a significant improvement in the current situation. There is no indication that CDCR has the investigative expertise or capacity required and there is similarly no indication that CDCR recognizes that deficit. In the absence of that recognition, it appears likely that the new AIMS process will merely be a reorganization of inadequate resources and inadequate staff.

IX. CDCR MUST TAKE ACTION TO END ITS DYSFUNCTIONAL STAFF CULTURE

93. The situation at RJD, at its heart, is a dysfunctional staff culture. That will be challenging to change and it must be recognized that it exists in addition to, and partially because of, the identified problems with grievances and complaints, use of force reviews and investigations, and staff discipline. Changing staff culture is primarily an exercise in leadership. While the culture at RJD will not be changed quickly or easily, there are crucially important aspects of this situation that could be fixed quickly, some easily and inexpensively.

A. Install Cameras

94. In law enforcement and in corrections, Dashboard cameras, body-worn cameras and fixed security cameras have been in use for many years. They are no longer controversial. In my work as a court monitor in both the Los Angeles jails and the San Bernardino jails, over 90 percent of the use force cases, and likely over 95%, include video of the incident. Further, in almost every case in both counties, the video is at the center of the analysis of each case. Without video, the analysis is too often changed from "what actually happened?" to "who do you believe?". In light of the audit results at RJD and the other ongoing and horrific problems, the failure to install security cameras is inexcusable.

95. In my current work as part of a three person panel of Monitors working for

and reporting to the Federal Court on the status of a consent decree on the Los Angeles Jails, we submit reports to the Court every six months. Our most recent report, filed June 1 of this year, included the following paragraph:

> "The Panel reiterates that it cannot stress enough the importance of having cameras in all of the common areas of the County's jails. The vast majority of the force incidents have been captured on CCTV videos that are sufficiently clear to show the nature and extent of the force used by Department members and to enable the Panel to assess the reasonableness of the force. Further, the cameras deter assaults by inmates and excessive force by Department personnel."

96. The majority of cases I reviewed in this matter, and perhaps over 75%, would have been definitively answered had there been security camera video footage.

97. RJD already uses camcorders. They are relatively inexpensive, small, easy to store and easy to use. Requiring that camcorders be brought to the scene of any staff inmate confrontation, inmate-on-inmate assault or staff use of force, as quickly as practical, would provide visual evidence of what actually occurred in many of the situations that are currently characterized by contradictory allegations by staff and inmates. That change could be accomplished in a matter of days.

98. Ultimately, officers should be required to wear and activate body cameras in situations that have the potential to escalate.

B. Improve Use of Force Reviews

99. Every use of force should result in a competent, thorough and unbiased video interview with the subject of the use of force as soon as possible and usually within two hours of the use of force. That could be done immediately and without cost. Inmate witness interviews and staff interviews should also be timely and video recorded.

100. Staff use of force reports and witness reports should require detailed description of force used by other staff, to the extent known; detailed description of injuries to staff and inmates, to the extent known or observed; and identification of all potential inmate witnesses. Staff should be held accountable for these provisions.

101. All supervisors and managers assigned to review or investigate use of force incidents should be required to have completed a minimum of a 24 hour course on use of

force investigations.

102. Supervisors, managers and administrators should be held accountable for reviewing and approving use of force reviews or misconduct investigations that are biased, incomplete or otherwise incompetent.

103. To ensure improvement in these areas, objective and external reviews of use of force incidents, including a review of CDCR's internal review process, should be adopted. The purpose of this practice, which has been implemented successfully in other jurisdictions and has improved the staff complaint process for the most serious allegations involving force, is to improve the quality of the internal review process. This cannot be accomplished through policy alone but instead is a learned process that requires trial and oversight.

C. Implement an Early Warning System

104. CDCR should institute an EWS. I was involved in the development of an EWS for the Los Angeles County jails. That system was initiated and operational in a matter of several months. On a monthly basis, a report is generated listing all custody personnel who reach a criterion for number of use of force cases or reach a criterion for number of inmate grievances. Facility Commanders are then required to immediately review the records of any subordinate on the monthly EWS report and recommend remedial measures, placement in a performance monitoring program, reassignment, some combination of those alternatives, or no action. That decision, and its rationale, must then be reviewed by higher level management.

D. Require Reporting of Documented Injuries

105. By policy, require medical and mental health staff to immediately report to custody management and the Receiver any case in which inmate injuries appear to be the result of violence and any case in which an inmate tells medical or mental health staff that his or her injuries resulted from staff use of force.

E. Remove Suspected Staff Sooner

106. By policy, require that any staff member accused of serious misconduct be

reassigned or placed on leave so that he or she is not in continuing contact with the inmate or inmates who have lodged the complaint.

107. These are examples of important changes that could be instituted quickly and/or inexpensively. It is not an exhaustive list.

X. CASE ANALYSIS

A. Cases Resulting in OIA Investigation

1. [redacted]t [redacted] Incident March 28, 2017, S-RJD-126-17-A

108. This incident is unusual because it was captured on video from two fixed security cameras. It is an OIA investigation that comes close to presenting a catalog of everything that is wrong with the CDCR system of grievance/complaint/investigation and staff discipline.

109. The undisputed facts in this case are that on March 28 inmate [redacted] was in a wheelchair at RJD in the Unit 25 B-pod dayroom by himself using the microwave to heat food. He was wearing his mobility impaired vest. Officers [redacted] and [redacted] were in an adjoining staff control area separated from the dayroom by a closed sliding security door. Officer [redacted] noticed Mr. [redacted] using the microwave, had the door opened and went into the dayroom next to Mr. [redacted] Officer [redacted] told Mr. [redacted] that the dayroom was closed and to take his food and return to his cell, and opened the microwave door. Mr. [redacted] closed the microwave door and objected to being told he could not use the microwave, and partially stood up from his seat in his wheelchair before sitting down again. By this time, another inmate, Mr. [redacted] had entered the dayroom from another direction and walked to the watercooler near the microwave. He was not involved in the incident. Mr. [redacted] moved his wheelchair to get his food from the microwave and Officer [redacted] moved around and behind the wheelchair and grabbed the two wheelchair handles. As Mr. [redacted] reached toward the microwave to get his food, Officer [redacted] pulled the wheelchair back, causing Mr. [redacted] to fall out of the wheelchair and onto the floor. At some point during the verbal confrontation with Mr. [redacted] Officer [redacted] had called out to Officer [redacted] for assistance and

Officer [redacted] was walking toward the open doorway of the dayroom when Mr. [redacted] fell to the floor just beyond the doorway. A number of staff responded to the scene. After seven or eight minutes on the floor, Mr. [redacted] was assisted back into his wheelchair, given an unclothed body search and placed in a holding cell for about 90 minutes. Approximately 3 ½ hours after the incident, Mr. [redacted] was evaluated by medical. His injuries were documented as pain to his head, pain and a reddened area on his neck, an abrasion/scratch on his back, and an abrasion, dried blood and bleeding on his knee. As a result of the incident, Mr. [redacted] received an infraction report for resisting an officer.

110. The three individuals involved differed dramatically in their version of these events. Mr. [redacted] said that he objected to being sent out of the dayroom and told he could not use the microwave, because it was common practice for inmates to be able to use that microwave even though the dayroom was closed, as long as only one person at a time used it. He acknowledged yelling at Officer [redacted] but said that Officer [redacted] "yanked" his wheelchair out from under him, intentionally dumping him on the ground.

111. Officer [redacted] said that he did not witness any use of force. He provided a supplemental report stating that as he responded to the situation, he was looking down at the ground and did not see anything until he saw Mr. [redacted] on the floor. He acknowledged that it was standard practice to allow inmates to use the microwave when the dayroom was closed and he expressed concern that Officer [redacted] had yelled at several other inmates who had tried to use the microwave prior to Mr. [redacted] He also said that he had wanted to talk to Officer [redacted] about the way he was dealing with inmates but he had decided he was not in a position to do that because he had only been out of the academy for four months and Officer [redacted] was more experienced.

112. Officer [redacted] said in his report and later in his interview that when he approached Mr. [redacted] and opened the microwave door, Mr. [redacted] had slammed the door shut narrowly missing the Officer's hand. Officer [redacted] then said Mr. [redacted] stood up out of his wheelchair and lunged toward him. He said he called for

his partner to assist and put out a Code One, and then told Mr. [redacted] to stop his aggressive behavior and to remain seated but that Mr. [redacted] threw his arms out toward Officer [redacted] made a growling noise and jerked his body toward the Officer. Officer [redacted] said he was fearful of being assaulted and moved behind the wheelchair and took its handles in order to take Mr. [redacted] into custody. Mr. [redacted] then lunged for the microwave and fell to the ground.

113. The video evidence does not support either Officers' version of events. When Officer [redacted] pulls the wheelchair from Mr. [redacted] Officer [redacted] is quite close and walking directly toward them. Even if he had been looking down, at that distance he still would have seen the incident, initially with his peripheral vision. Also, the incident did not take place in a fraction of a second. However, even that explanation is implausible. When an Officer's partner asks for assistance and is engaged with an inmate, it is a basic instinct to look at that interaction as you approach it. That is not only instinct, it is also the safety training officers receive. Is there a weapon involved? Is someone already injured? etc. On this point, the video shows Officer [redacted] suddenly speeding his approach as Mr. [redacted] falls to the ground. The video simply does not support that Officer [redacted] saw nothing until he saw Mr. [redacted] on the ground. Officer [redacted] should have been disciplined for failing to report a use of force as a witness and for making false statements to OIA investigators. He was not. He received no discipline.

114. The video similarly provides physical evidence contradictory to Officer [redacted] report and interview testimony. Mr. [redacted] stands up partially but never stands up fully or stands out of his chair. He does not lunge toward the Officer. The second time Mr. [redacted] moves in his chair, he does not throw his arms toward the Officer nor does he jerk his body toward the Officer. The videotape also contradicts Officer [redacted] claim that Mr. [redacted]'s hands were balled into fists. It is obviously not possible to know from the videotape whether Mr. [redacted] made a growling noise but that was not reported by Officer [redacted] or by Mr. [redacted]. When Officer [redacted] first approaches Mr. [redacted] and motions for him to leave the area, and then opens the

microwave door, it appears that Mr. [redacted] does shut the door again but there is no indication on the video of Officer [redacted] recoiling or otherwise reacting to almost getting hurt. It appears from the video that Mr. [redacted]'s reaction to the Officer telling him to leave the dayroom, was to put both his arms out wide in a gesture of "what are you talking about?" or "why are you doing this?" It appears that the second time he moves in his wheelchair, it is the same kind of gesture but less dramatic. There is no indication in the video footage from either camera of a physical threat toward Officer [redacted] There is no indication of a verbal threat reported by either Officer or Mr. [redacted] except for Officer [redacted] mention of the growling noise. At that point in the video when Officer [redacted] moves behind the wheelchair, it is obvious there is no imminent physical threat to the Officer and Mr. [redacted]'s attention is on his food in the microwave. It is important to note that when the wheelchair is pulled from under Mr. [redacted] it does not happen in a split second and it does not happen because the wheelchair was moved a foot or two. It took two steps backward by Officer [redacted] to move the wheelchair fast enough and far enough that Mr. [redacted] was thrown to the ground. It is important to emphasize that the force was used when Officer [redacted] was behind Mr. [redacted] when there could not have been any imminent physical threat. Any threat that might have existed was over once Officer [redacted] was behind Mr. [redacted]

115. Both Officers [redacted] and [redacted] were allowed to review video evidence before writing their reports; that is a poor practice that is a barrier to accountability. Additionally, Officer [redacted] told investigators that he spoke with a Sergeant and Lieutenant before writing his report, raising the possibility that there was collusion to create a story that fit with the difficult video.

116. Just how much threat did Mr. [redacted] pose to Officer [redacted] Certainly, almost all things are possible. A quadriplegic inmate might assault an officer and a blind inmate could have a shank. However, those kinds of things are rare. This is one of many cases at RJD in which officers allege a mobility impaired inmate in a wheelchair aggressively and physically threatened an officer, forcing the officer to use force. The

number of times in these cases in which an inmate is reported to have stood up from his wheelchair and walked toward an officer with his fists clenched, is cause for concern. In many cases the inmate involved has other medical problems. The officers involved are often bigger, younger and in better physical condition. That does not make an assault impossible but it does make it unlikely. The pattern in these cases is that the inmate is reported to walk toward the officer aggressively but slowly enough that the officer is able to unholster and use his OC. If the inmate moved faster or ran, then the inmate would be able to get in the first punch, which is not the case in most of these situations as reported.

117. The elephant in the room in this case is that the entire incident was unnecessary and caused entirely by Officer [redacted] unprofessional behavior. That is discussed nowhere in this voluminous record. It should have been central to the OIA investigation; instead it was ignored. It is clear from the interviews of Officer [redacted] Mr. [redacted] and Mr. [redacted] that it was well established practice to allow inmates to use that microwave when the dayroom was closed. Even if Officer [redacted] had decided to strictly enforce the closed dayroom, which probably should have involved a supervisor so that the rule was consistent across shifts, he was still obligated to explain the change in practice to inmates used to the past practice, and to do so reasonably.

118. The investigation in this case should have been expanded to include Officer [redacted] unprofessional behavior and his failure to attempt de-escalation techniques when a verbal confrontation developed. It is important that investigators are free to follow the evidence, wherever it may lead. In OIA investigations, it appears the opposite is true and a situation with allegations of serious but diverse problems can only be investigated with regard to a previously enumerated issue.

119. In the Skelly hearing, the CCPOA representative made the point that all managers and Lieutenants who reviewed this incident stated that the use of force was reasonable. This comment underscores that CDCR officers collude to protect each other.

120. RJD Associate Warden Covel presented a lengthy and detailed, if one-sided, defense of Officer [redacted] emphasizing that he had acted reasonably because he had

perceived a threat and that the ceiling mounted video camera did not have the same perspective as the Officer at eye level. AW Covel did not mention that the Officer created the incident by changing the practice in the day room and by his unprofessional behavior with inmates. In citing some elements of Constitutional law governing use of force, she failed to note that a subjective perception of threat is not enough to justify force in and of itself and that there must be an objective element as well. CDCR cannot be successful in reforming the staff culture at RJD while a top administrator at the facility is presenting an impassioned defense of a staff member who has clearly used unnecessary force and acted unprofessionally in other ways, such as by filing a significantly inaccurate and self-serving report

121. Another aspect of the situation that was raised and then dropped has to do with the medical evaluation of Mr. [redacted] after the incident. Mr. [redacted] was taken from the incident scene to a holding cell where he was held for 90 minutes. Even that does not explain why the medical evaluation of Mr. [redacted] occurred 2 ½ hours after the incident. The OIA investigator raised this question in a note on one of the summaries and someone answered, writing "we did not think it was necessary", referring to a medical evaluation. That does not make sense and I do not understand why OIA dropped that inquiry. Two and one half hours after the incident, Mr. [redacted] had dried blood on his knee and it was still actively bleeding. Setting aside his abrasions and pain, if Mr. [redacted] was bleeding from a wound on his knee, why would he not have been taken for a medical evaluation immediately? Here again, the particulars of this case point to a larger problem. After a use of force, medical evaluation should not be discretionary with staff, and it is a blatant conflict of interest to allow the staff involved in the use of force to determine whether medical evaluation is needed. Good policy makes medical evaluation mandatory as soon as possible after any use of force and if an inmate declines that medical evaluation, he or she should be required to decline to a medical staff member in writing rather than to a custody person.

122. This is another case in which the inmate's failure to make allegations of unnecessary or excessive force on the day of the incident, later weighed against the inmate. But if after a use of force incident, the inmate on whom force was used is put in a holding cell or taken into segregation, and is not interviewed by a supervisor or manager, it will frequently be the case that there is no one to hear the inmate's allegations.

123. Every use of force should be reviewed, not necessarily fully investigated, but seriously reviewed. That is basic. If every use of force required medical assessment as soon as possible, unless the inmate declined, and also required a videotaped interview of the subject of the force by an uninvolved supervisor or manager as soon as possible, that would provide important safeguards and substantially increase accountability.

124. The staff interview with Mr. [redacted] was videotaped and informative. It was the only videotape interview I was able to review in all these cases. The most striking aspect of the interview was that it was 3 ½ minutes long and most of that time was spent on the staff introduction and on asking Mr. [redacted] about his injuries. Mr. [redacted] was asked one question about what occurred, essentially "Can you describe what happened"? Mr. [redacted] answered slowly in two or three sentences explaining that the Officer opened the microwave door and that Mr. [redacted] reclosed it because his food was still heating. Then he said that the Officer threw him out of his wheelchair. That was it. The interviewer, a Lieutenant, asked nothing else. Not, "What did he say to you?", not, "Did you get out of your chair?" Nothing was asked that might shed light on the contradictory versions of events. There was no follow-up to anything and no inquiry specific to this incident.

125. Given the nature of this case, it would have been helpful to review Officer [redacted] history of complaints and grievances against him and to review his history with use of force incidents. None of that was done.

126. The end result of this case was that Officer [redacted] received no discipline. The Hiring Authority's language in exonerating [redacted] states: "he may not have viewed the UOF by [redacted] due to obstruction by the door." This conclusion, in light of the video

that clearly shows him reacting to the use of force (without the door obstructing his view), is absoultely untenable and another manifestation of staff bias. Officer [redacted] was recommended for discipline at level three, a 5% reduction in pay for three months, and that was negotiated down to level one, a letter of reprimand. He was not charged with dishonesty, even though he told investigators that Mr. [redacted] lunged at him aggressively and threw himself out of the wheelchair and claimed that Mr. [redacted]'s fists were clenched. It is outcomes like these that assure staff that no matter what they do, they will likely get exonerated or at worst get a slap on the wrist. These outcomes compromise the integrity of the inmate complaint/grievance system and, in important ways, of the entire Department.

2. [redacted] [redacted] Incident September 29, 2017, S-RJD-397-17-A

127. This is a staff misconduct case that does not involve use of force. It was accepted by OIA and investigated by OIA and it resulted in discipline for Correctional Officer [redacted] The primary importance of this case is as a contrast to other cases I reviewed. This case involved staff allegations against another staff member. That made all the difference. This case began with an inmate complaint. But when two staff members leveled allegations against another Officer, consistent with the inmate complaint, the local investigation was appropriately stopped, the matter was referred to OIA, where it was accepted quickly and investigated very fully compared to cases that only involve inmate complaints.

128. The fact situation is not overly complicated. On September 29, 2017, in the evening, Mr. [redacted] was having trouble breathing and returned to his cell. He stood outside the door with his arm raised, which is the standard signal from an inmate to the tower Officer to open the cell door. Mr. [redacted] had COPD and asthma and had been issued a rescue inhaler. He needed to get back into his cell to use the inhaler. The tower Officer, Officer [redacted] ignored Mr. [redacted]'s signal and did not open the cell door. Mr. [redacted] walked over to the tower and asked Officer [redacted] to open his cell and Officer [redacted] said, “no”. Mr. [redacted] repeated his request and Officer [redacted] again

refused to open the cell door. Mr. [redacted] then went to the two floor Officers, Officer [redacted] and Officer [redacted] and told them the problem. They said they would contact Officer [redacted] and ask him to open Mr. [redacted]'s cell door. Mr. [redacted] saw one of the two Officers get on a landline, so he assumed the cell door would be opened and returned to his cell. The door did not open. Mr. [redacted] returned to the two floor Officers and they said to him that they had contacted Officer [redacted] and told him that the door needed to be opened. At some point after that, the cell door did open and Mr. [redacted] was able to get his inhaler. There were no injuries or other serious adverse outcomes to this situation. Mr. [redacted] estimated it had taken 20 minutes for Officer [redacted] to open his cell door after the initial request.

129. The following day, Mr. [redacted] talked with Sgt. [redacted] about the incident. Mr. [redacted] saw Sgt. [redacted] go into the tower and speak with Officer [redacted] After that, Officer [redacted] racked Mr. [redacted]'s cell door, quickly opening and shutting it several times to taunt Mr. [redacted] Mr. [redacted] filed a complaint and said that he would not have done so, except that he had witnessed Officer [redacted] taunting other inmates by opening or closing their cell doors without allowing adequate time for them to enter or exit.

130. After Mr. [redacted]'s complaint, Lt. [redacted] interviewed Mr. [redacted] and Officer [redacted] When Officer [redacted] essentially corroborated Mr. [redacted]'s complaint, Lt. [redacted] stopped his investigation and recommended a referral to OIA. On November 21, 2017, the Warden requested an OIA investigation. OIA accepted the case and assigned [redacted] as the investigator on December 19, 2017, less than one month after the case had been referred. Mr. [redacted] interviewed Mr. [redacted] Lt. [redacted] Sgt. [redacted] Sgt. [redacted] Officer [redacted] and Officer [redacted] Officers [redacted] and [redacted] provided information that reinforced Mr. [redacted]'s complaint. Their version of events was essentially the same. In addition, Officer [redacted] said that she had received a phone call at about 3 a.m. from Officer [redacted] to tell her that she was going to be interviewed by OlA. She did not know how he knew that. Sgt. [redacted] confirmed that,

prior to this incident, he had spoken with Officer [redacted] about failing to open cell doors when requested by floor Officers.

131. The Warden imposed a Level four penalty of 10% salary reduction for 12 months. A *Skelly* hearing was held on August 1, 2018 and the sanction was upheld.

132. In addition to the huge disparity in the way in which this case was handled because it did involve a staff complaint against another staff member, there are additional troubling aspects of this case. Here, the OIA investigator did not draw conclusions about culpability in the report. By regulation, OIA is supposed to simply discover and compile the evidence. Instead, there are many cases where investigators color the evidence, especially statements from inmates, with judgements about credibility which undoubtedly impact the final decision.

133. There is also a major difference in this case regarding bias. In this case, it is largely absent from the investigation itself. That is, Investigator [redacted] asks the relevant questions and summarizes the answers. There are no side discussions of why inmates lie nor those comments in the interview summaries about whether a particular staff member had sworn to tell the truth or was trained to follow the department's policies and procedures.

134. The actual allegations sustained in this case against Officer [redacted] included, "discourtesy to [redacted] and floor Officers re: not providing access to cell for inhaler." But the charge that Officer [redacted] was negligent for not letting Mr. [redacted] into his cell for inhaler was not sustained.

135. The two floor Officers were not charged with failing to report misconduct. They should have been so charged. If it were not for Mr. [redacted]s complaint, it is unlikely any of this would have come to light.

136. Officer [redacted] should have been charged, in addition, with lying to investigators when he claimed that he opened the cell door one minute after he was asked, with interfering with the investigation by calling one of the witnesses in the middle of the

night, and with endangering Mr. [redacted]'s safety. None of those allegations were made or reviewed.

137. Another compelling part of this case is the fact that Officer [redacted] adamantly denies receiving a phone call from the floor Officers, but is contradicted by both floor Officers, Mr. [redacted] and the phone records, which indicate that a call was placed. That seems to constitute very strong evidence of dishonesty on the part of Officer [redacted] when talking to OIA investigators.

138. The sanction does not make sense. At the *Skelly* hearing, Officer [redacted] acknowledged a similar prior offense. In this case, Mr. [redacted] could have had an asthma attack with serious consequences. "Endangering an inmate" is only a level three offense in the matrix of staff discipline that ranges from level one to level nine. The matrix should be revised.

3. [redacted] [redacted] November 7, 2017, S-RJD-427-17-A

139. Mr. [redacted] is completely deaf and unable to speak. He had had dental surgery and was waiting in line for pain medication, when there was some confusion about whether he should wait while the nurse got approval for his medication, or whether he should return to his cell. Officer [redacted] told him to return to his cell and he did. Later, Officer [redacted] returned to the cell and told him he was going to be moved to a different cell. There was some verbal conflict. Mr. [redacted] is fluent in American Sign Language (ASL), but Officer [redacted] does not know ASL, and another inmate attempted to interpret, but the inmate was using gang signs rather than ASL. Mr. [redacted] did not understand why there was not a written notice of his cell move and he wanted to speak to a Sergeant. Officer [redacted] did not get a supervisor and later said that he communicated with Mr. [redacted] partially, with notes handwritten on paper. (Those notes are not in the investigation file in spite of the requirement in the *Armstrong* settlement agreement that such notes must be kept.) Officer [redacted] and Officer [redacted] handcuffed Mr. [redacted] and placed him in a locked shower area. Later, the officers alleged that when they took Mr. [redacted] to the shower area, he pulled his arm back with a clenched fist as if

he was going to punch one of them. They took him to the ground and handcuffed him. That incident happened at 6:50 p.m.. At 7:46 p.m., Mr. [redacted] was examined by LVN [redacted] who found no injuries and noted that Mr. [redacted] made no comment. How could he, since he cannot speak? At 8:40 p.m., Officer [redacted] escorted Mr. [redacted] to a holding cell in the gym. After approximately an hour and a half in the holding cell ("cage"), Officer [redacted] escorted Mr. [redacted] to another medical assessment conducted by RN [redacted] which occurred at 10:35 p.m., and evidently also done without a sign language interpreter. RN [redacted] noted in her medical evaluation that Mr. [redacted] had an injury to the top of his head, a front tooth broken off with the roots exposed, an injury to his lip and mouth, and pain to his torso. He was sent to Sharp Medical Center, where they confirmed that his broken tooth would need urgent surgery and documented his other injuries.

140. Mr. [redacted] alleges that he was beaten by staff twice on November 7. He said that the first time was by Officers [redacted] and [redacted] in the shower area. He said that they had left him in handcuffs in that area, but that the handcuffs were loose and one of the handcuffs slipped off. He said when the Officers saw that, they became upset, came in and took him to the floor and punched him. This is the first force incident. He also alleged that after that the first incident, when Officer [redacted] and at least two other Officers took him to the gym, they beat him badly, punching him in the face and body. He alleges that his front tooth was broken off during this incident. He said he was afraid he would die.

141. This case was referred to OIA. OIA's initial response was to ask the facility for additional information. On November 5, 2018, one year after the incident, Officer [redacted] was notified that the charges against him had not been sustained, and that there would be no discipline in the matter.

142. One of the most interesting aspects of this case is that Mr. [redacted] did not make allegations against either LVN [redacted] who conducted the first medical evaluation, or against RN [redacted] who conducted the second medical evaluation, also

on November 7. However, the Warden chose to open investigations against both of those medical staff members based on the disparity between the two sets of findings. That appears to defy logic. If Mr. [redacted] was subjected to two separate uses of force, as he alleges, and if the first use of force did not produce any serious injuries to him, but the second use of force did, then it would follow that the medical assessment after the first use of force might show no injuries. The second medical assessment, conducted after Mr. [redacted] had been taken to the gym and held there in a holding cell, might well show a pattern of injuries since Mr. [redacted] said that the severe beating, including his broken tooth, happened during the second incident as Officer [redacted] and other staff took him to the gym. This is not a matter of relying on Mr. [redacted] allegations. The medical report from the Mercy Medical Center on November 8, a day after the incident, is consistent with the medical assessment conducted by RN [redacted] the previous day. There was nothing in the hundreds of pages of case record that would lead to any doubt that RN [redacted] correctly assessed Mr. [redacted] physical condition and that his injuries were also consistent with the details of his allegations of staff use of force. In spite of this, both nurses, and particularly Nurse [redacted] were investigated aggressively and with a completely different tone than characterized the investigation of Officer [redacted] The disparity in medical reports seems to support Mr. [redacted] account of events—that he was assaulted twice and that the second assault, by Officer [redacted] caused injuries. Instead of taking this evidence for what it shows, it is turned on medical staff and used against them, rather than used to aggressively investigate the officer who allegedly caused these documented injuries. Finally, the Warden did not take issue with two separate medical evaluations conducted without the benefit of a sign language interpreter. If the Warden does not demonstrate leadership in complying with the *Armstrong* agreement, it is not surprising that his subordinate staff at RJD do not appear to consider the management of individuals with disabilities as a serious matter.

143. This is not the only case where pursuit of allegations against non-sworn staff is different than the manner of investigating custody staff. While management seems to

have little appetite for the latter, they are almost always proactive and aggressive for the former.

144. Neither the initial ISU investigation nor the later OIA investigation led to a clear picture of what happened. The OIA investigation is even more biased than most of the other cases I reviewed. The OIA investigators suggests that Mr. [redacted] could have sustained his injuries when he was taken to the floor by Officer [redacted] and Officer [redacted] That is unlikely for at least two reasons. First, LVN [redacted] would have seen Mr. [redacted]'s broken front tooth and, likely, the injury to the top of Mr. [redacted]'s head, and documented both. She did not and when she was interviewed, she maintained strongly that if Mr. [redacted] had had visible injuries, she would have documented them. Second, it would not be impossible to be taken to the floor by Officers and hit the cement floor with the front of your face, breaking off a front tooth. That is quite unlikely, but possible, but you would then not also hit the floor with the top of your head. The OIA investigator gave more weight to suggesting that Mr. [redacted] simply did not have injuries. That conclusion ignores both a medical evaluation by RN [redacted] and the medical records from Mercy Hospital and makes no sense.

145. The synopsis of this incident says that when Officer [redacted] started to place Mr. [redacted] in handcuffs, Mr. [redacted] swung at him, and then the two Officers took him to the floor. The two Officer reports do not say that. They actually say that Mr. [redacted] pulled his arm back and made a fist as if he was going to swing, and that, at that point, both Officers grabbed him and took him to the floor. The investigation ignores this discrepancy although the justification for the use of force centers on this specific issue.

146. It is noteworthy that the two Officers' reports are in part plagiarized from each other. But no one investigating or reviewing this case notices that collusion. It should have been a factor in discounting the veracity of the reports by those two Officers.

147. When Mr. [redacted] returned to RJD from the hospital, he was interviewed by Lt. [redacted] Lt. [redacted] did not use an interpreter, in violation of the *Armstrong* Remedial Plan. Mr. [redacted] was interviewed again during the OIA investigation, and he

was detailed and also consistent with his initial allegations. The OIA investigator does not comment on that. Instead, the investigator interviewed an RJD dentist, [redacted] Dr. [redacted] was Mr. [redacted] primary dentist at that time. On the morning of November 7, Mr. [redacted] had had two teeth extracted by an oral surgeon. Dr. [redacted] had examined Mr. [redacted] teeth on November 8, the day after the incident, and noted that his #8 tooth was fractured, with the crown badly damaged and the pulp tissue of the tooth visible. The investigator asked Dr. [redacted] whether Mr. [redacted] could have suffered the tooth fracture as a result of the use of force performed by Officers [redacted] and [redacted] if the tooth had struck the ground. She said that could have happened. Next, the investigator asked whether the filling in tooth #8 might have weakened the tooth and made it more susceptible to fracture. Dr. [redacted] said she did not think that was the case. Next, the OIA investigator asked Dr. [redacted] to review Mr. [redacted] complaint, that he was kicked and beaten by numerous Officers for a period of 10 to 20 minutes. The investigator reported that Dr. [redacted] concluded that she did not find any medical substantiation of the complaint in the records. That is rather astonishing. Why would an investigator ask a dentist for a medical opinion outside the scope of dentistry? Second, the dentist had just finished telling the investigator that there was a broken front tooth on November 8, that was not there the morning of November 7, when the extractions were conducted just prior to the use of force incidents. She had also said that the fracture likely occurred as a result of some kind of injury. After that, the investigator wrote that Dr. [redacted] said that Mr. [redacted] was a "frequent flyer" and "in the dental clinic, constantly complaining and making requests and that she believes he was attention seeking, hypochondriac, and medication seeking." After soliciting and presenting that biased and negative information about Mr. [redacted] the investigator presents not a word about the history of the two officers initially involved or Officer [redacted]

148. The OIA investigator, [redacted] next interviewed the chief medical executive at RJD, Dr. [redacted] Mr. [redacted] asked Dr. [redacted] to review Mr. [redacted] medical records and his complaint. Dr. [redacted] had never seen Mr. [redacted] as

a patient. If the idea was to seek a review by an objective medical expert, then choosing an individual was also an administrator at RJD was an extremely poor choice. The investigator asked Dr. [redacted] whether there was any objective medical evidence to substantiate Mr. [redacted] allegations that he was hit, punched, kicked and beaten for a period of from 10 to 20 minutes by several correctional Officers. Dr. [redacted] then commented at length on the exam findings with regard to Mr. [redacted] major organs and bodily systems: "The lung exam was normal. The heart was normal …." Part of the "findings," that the investigator summarizes as Dr. [redacted] opinion, was: "There were no noted skin tears, abrasions or scratches." That is contradicted in the next paragraph of the report in which Mr. [redacted] writes that Dr. [redacted] summarized, "There was an abrasion on the top of the scalp. There was a tooth fracture." Following that, there are seven paragraphs in the report noting all of the normal findings. "The vital signs were normal. The pulse was normal…" At the end of that review, the Investigator writes, "based on [redacted] allegations, [redacted] would have expected to find some objective medical evidence. He would have expected to see more bruising and superficial injuries. He also would have expected to see more defense injuries." The Investigator then showed Dr. [redacted] the incident report written by Officer [redacted] and specifically, where the Officer had written that Mr. [redacted] fell on the ground hitting his chest and facial area. Dr. [redacted] evidently opined that, "Some of the injuries noted in the record could be explained by this incident." In addition to the investigator using leading questions and suggesting explanations to Dr. [redacted] who was a poor choice to conduct a medical review to begin with, the investigator does not show Dr. [redacted] both medical evaluations or the Mercy hospital records, which suggest that injuries occurred between the time of the two assessments. The investigator's continuing suggestion that there was no objective medical evidence to support Mr. [redacted] allegation that he was the victim of staff use of force, and Dr. [redacted] support for that contention, is belied by a broken front tooth, an abrasion on top of Mr. [redacted] head, and acute pain in Mr. [redacted] abdomen. That evidence was found by a CDCR registered nurse and then found the next day by a

community hospital unrelated to CDCR. There may be a variety of explanations for those medical findings but to suggest that there is no objective medical evidence is simply erroneous. Mr. [redacted] went on to ask Dr. [redacted] whether he believed the medical record substantiates Mr. [redacted] claim of a 10 to 20 minute assault by correctional Officers. Dr. [redacted] opined that he did not believe the objective findings in the record supported Mr. [redacted] allegations.

149. The last paragraph of the investigation dealing with Dr. [redacted] is preposterous. The OIA investigator writes, "[redacted] has been a medical doctor since 2000. He is very familiar with patients in the medical community being dishonest to medical doctors. Patients will lie in order to obtain a secondary gain. They could be seeking pain medications. They could be seeking to create a lawsuit between doctors. Inmates frequently lie to doctors at RJD for various reasons. Inmates lie in order to get transfers to another institution or cell. Inmates also lie to obtain narcotic pain relievers. There could be any number of other reasons that an inmate would make false allegations against custody staff." Dr. [redacted] does not know Mr. [redacted] He does not know whether Mr. [redacted] was or was not victimized by staff. Dr. [redacted] knows that many inmates, many times, tell the truth in detail, just as many staff do and just as many people in the outside world do. But he does not say any of that. Instead, he provides testimony about the various reasons Mr. [redacted] might be lying. All of this shows bias, and is complete speculation, yet it appears in the OIA report as if it is a relevant fact to be relied on in this case.

150. As opposed to the OIA investigator's assumptions that Mr. [redacted] is lying, and the lengths the investigator has been willing to go to try to establish arguments that Mr. [redacted] is lying, the second paragraph of the summary of the same investigator's interview of Officer [redacted] reads, "as a correctional Officer, [redacted] is a Peace Officer. He is sworn to tell the truth. His job is to maintain the safety and security of the institution." The summary continues in the same vein. This is not an investigator warning about

perjury; it is an advocate trying to convince the reader that the subject is above suspicion, no matter what the facts may show.

151. It is difficult to understand why the investigator did not identify the second and third Officers escorting Mr. [redacted] to the gym. According to Mr. [redacted] those Officers participated in or witnessed the more serious of the two assaults on him. A similar question has to do with inmate witnesses. It is likely there were inmates in the housing unit who witnessed Mr. [redacted] being taken to the shower area by two officers

152. It is less certain but also likely at that time of day that there were inmates on the yard who would have seen Mr. [redacted] escorted to the gym by three officers. In order to identify witnesses, whether staff or inmate, the investigation will most often need to be timely. In this case, the Investigator began interviews **seven months after the incident**. When that is combined with the failure to require officers to identify witnesses in their incident reports, it is predictable investigations will proceed without key witnesses and sometimes with no witnesses.

153. Officer [redacted] said in his interview that he never saw injuries on Mr. [redacted] either when he escorted Mr. [redacted] to a holding cell in the gym or later, at 8:40 p.m., when he escorted Mr. [redacted] from the gym to administrative segregation. However, two hours later, Mr. [redacted] had visible and serious injuries when he was taken from administrative segregation to medical. Where are the records from administrative segregation and which officers were supervising that area then? And who initiated the request that Mr. [redacted] be evaluated by medical, and why? These kinds of detailed questions are usually at the heart of this kind of investigation, where the two versions of events are dramatically different. In this case the difficult details that get to the heart of what really happened here were abandoned in favor of a "who do you believe?" analysis. There is no clear explanation of why Mr. [redacted] wound up with documented injuries, including a broken tooth. Here as elsewhere, the officers said they didn't do it so that's the end of the matter.

154. One of the disturbing aspects of this case is that the situation was likely unnecessary. It is not uncommon for inmates to be unhappy about cell moves, and to

object to them. Faced with that reaction, an officer usually has constructive alternatives. If an inmate wants to talk to a supervisor, that can almost always be arranged. Giving the inmate extra time or getting a copy of the paperwork directing the move will sometimes solve or at least de-escalate those situations. Often, all that is required from the officer is reasonable communication skills. What will not work most of the time is a "my way or the highway" approach, or "the easy way or the hard way?" challenge. In correctional facilities where the baseline is frequent, informal and positive staff-inmate communication, the chance that something minor will spin out of control is quite low.

4. [redacted] Incident November 10, 2018, S-RJD-049-19-A

155. Mr. [redacted] attempted suicide on November 10, 2018 at RJD. In tort litigation over inmate suicides, the central questions are whether it was predictable that the individual would be actively suicidal and whether the staff had fulfilled their duty to prevent the suicide. That is not the nature of this case. In this situation, there were multiple inmate allegations that when Mr. [redacted] suicide attempt was discovered, staff did not respond in an appropriate or timely manner and that Mr. [redacted] death was preventable. Unlike the majority of cases I reviewed in this matter, most of the facts in this case are not in dispute. On November 10, 2018, Officer [redacted] was conducting required cell checks. When he looked into Mr. [redacted] cell at approximately 3:05 a.m., he saw Mr. [redacted] with his head in the toilet and, as he wrote in his report, "large amounts of blood, on the floor, on the bed, and on the inmate". He sounded a Code One medical alarm. Officer [redacted] was using his flashlight and could see that Mr. [redacted] was moving his hands on the toilet. He tried talking to Mr. [redacted] through the cell door but Mr. [redacted] did not respond to him. Sgt. [redacted] and Officer [redacted] arrived at the cell front in response to the Code One alarm. Sgt. [redacted] spoke to Mr. [redacted] who states that he cut his wrist(s), that he used a razor, and that the razor was in the toilet. Sgt. [redacted] directs Officers [redacted] and [redacted] to get and put on personal protective equipment (PPE). Officer [redacted] gets the paper jumpsuits, masks, and gloves, and once he and Officer [redacted] are in the PPE, Sgt. [redacted] asks for the cell door to be opened and the Officers enter and help

Mr. [redacted] to his feet and handcuff him in back and help him out of the cell into the dayroom floor. By that time, two registered nurses (RN), Nurses [redacted] and [redacted] have arrived. RN [redacted] tries to stem the bleeding and bandage Mr. [redacted] wrists but he initially pulls his arms away from her. She tells the custody officers to call 911. RN [redacted] is trying to get a glucose reading of Mr. [redacted] Two or three minutes after RN [redacted] said to call 911, Mr. [redacted] becomes unresponsive. The staff on scene initiate life saving measures, Mr. [redacted] is taken to a triage and treatment area to await the arrival of the paramedics and the ambulance and he is then transported to a local hospital where he is pronounced dead at 4:35 a.m. that morning.

156. This event occurred approximately three weeks before the three person strike team arrived at RJD to interview a large number of inmates on Facility C. In many of the cases in this matter, the detailed memos, containing inmate allegations from Sgt. [redacted] and from AW Bishop, are reproduced as relevant exhibits. Here, for some reason, the inmate allegations made during the strike team interviews are not referenced, although at least two of the inmates interviewed, Mr. [redacted] and Mr. [redacted] did refer to the recent inmate death. The investigation should have included follow-up interviews with each of those inmates, but did not. Instead, the referral to OIA was based on a review of the staff reports from Mr. [redacted] suicide and the identification of possible discrepancies in those reports.

157. There is a another, more serious, problem with this investigation, one that is stunning. There are two separate inmate declarations collected by Plaintiffs' counsel well after the incident which both state that there was an unreported staff use of force on Mr. [redacted] after he was removed from his cell, that staff use of force may have contributed directly to his death, and that both inmates reported that information to ISU staff. The investigation in this case never reports any of that information because no inmate interviews are acknowledged. That is unbelievable. When an inmate dies and the death is classified as a suicide, then whether it is a jail or prison, it is standard practice to interview inmates in the vicinity of the suicide location. Here, in spite of a 273 page institution-level review, an OIA investigation of custody staff and a separate OIA

investigation of medical staff, not one inmate was interviewed according to the investigative files. Once the strike team interviews occurred some three weeks after the suicide, it would have been reasonable to expect that the potentially explosive information from inmates about Mr. [redacted] death would have been incorporated into the ongoing investigations, even if there had been no prior intimate interviews. Nothing of that sort happened.

158. [redacted] is a transgender inmate who was housed at RJD from approximately September, 2018 until April, 2019. She is both an *Armstrong* class member and a *Coleman* class member, she uses a wheelchair, has had seizures and has dealt with chronic, serious depression. Her declaration describes abuse received at the hands of staff at RJD but then also describes what happened to her friend, [redacted] who was in the same housing unit, in November of 2018. On the day of Mr. [redacted] death, Ms. [redacted] said he was yelling from his cell that he had cuts on his arms and legs and yelling for help and banging on his cell door. Ms. [redacted] estimated that it was 30 to 45 minutes before two Officers pulled Mr. [redacted] out of his cell. She saw the two Officers slam Mr. [redacted] on the ground and said that he was not resisting. Ms. [redacted] described him as on his stomach with his face to the ground and Ms. [redacted] said that one Officer stood on Mr. [redacted] back with all of his weight while another Officer had a knee in Mr. [redacted] back. Ms. [redacted] said that the Officers were yelling, "Stop resisting, stop resisting," and that Mr. [redacted] was yelling, "I can't breathe. I can't breathe." Ms. [redacted] said that Mr. [redacted] then stopped saying anything. Ms. [redacted] said that she was interviewed by ISU about the incident and told them what she had seen and that the Officers had killed Mr. [redacted]

159. [redacted] was incarcerated at RJD for five years, ending in March, 2019. He is an *Armstrong* class member, a full time wheelchair user with other serious medical conditions. He is also a *Coleman* class member diagnosed as bipolar and has paranoid ideation. Mr. [redacted] declaration describes his abuse by staff at RJD and his own suicide attempt there. His declaration also discusses Mr. [redacted] death. He said Mr. [redacted] was mentally ill, and had just returned to Building 15 after having been on

suicide watch. Late one night, he had cut himself and was yelling for help. Mr. [redacted] declaration states that the Officers waited a long time, ignoring him, but after about 30 minutes, Mr. [redacted] saw Officers [redacted] and [redacted] pull Mr. [redacted] out of his cell. His declaration continues, "I could see that [redacted] was pleading and he was in his boxers. I saw that Officers [redacted] (sic) and [redacted] were on top of him holding down. The Officers yelled at him, 'You woke us up motherfucker! Stop resisting!' I saw Officer [redacted] who is about six feet three inches tall and probably about 200 pounds—start standing with both feet on top of [redacted] back while [redacted] was lying face down on the ground. Officer [redacted] hands were up on the wall so his entire weight was on [redacted] back. [redacted] was yelling, 'I can't breathe! I can't breathe!' I saw Officer [redacted] had his knee on [redacted] back holding him down and [redacted] just stopped yelling and went still". Mr. [redacted] said that he was interviewed a few days later by ISU about Mr. [redacted] death and that he told them what he had seen.

160. After an inmate suicide, it is common practice to interview inmates housed in the vicinity of the inmate who committed suicide, as well as inmates who may have had contact with the inmate in the hours or days before the suicide. Ms. [redacted] and Mr. [redacted] were evidently housed in very close proximity to Mr. [redacted] as they were both able to provide eyewitness accounts of what transpired when Mr. [redacted] was removed from his cell. It does not seem possible that RJD, in the aftermath of the suicide, would not have interviewed both of those inmates as well as other inmates who might have witnessed some aspect of the incident. There is no ISU record of such interviews with Mr. [redacted] Ms. [redacted] or other inmates in that area. That does not make sense, and particularly, because there were concerns raised about the staff response to Mr. [redacted] suicide attempt. Obviously, if Mr. [redacted] and Ms. [redacted]'s declarations under oath are true, and they are consistent with each other, then the accounts of the staff response to Mr. [redacted] prior to the arrival of the nursing staff may be false and missing crucial information. In most major prison and jail systems, this would not even constitute a serious question, as there would be fixed security camera coverage of the dayroom area

outside the cells. The escort of Mr. [redacted] from his cell to the dayroom floor would have been on camera and recorded and whether or not one of the Officers stood on Mr. [redacted] back while another Officer put a knee on his back would have been obvious on the video footage if it occurred.

161. This is perhaps the most troubling issue in this entire matter and all of these cases. The case record does not include any discussion of or mention of the ISU interviews of Ms. [redacted] and Mr. [redacted] Each of those inmates in independent interviews with a strike team member said that they had previously been interviewed about the suicide by ISU and that they had described the staff use of force on Mr. [redacted] that they had witnessed. It seems implausible that both inmates would have described talking to an ISU investigator unless that happened. How is it possible that the information about alleged use of force against Mr. [redacted] just before his death, was not pursued in some fashion? Did RJD decided to expunge that information from record because it was potentially explosive? This question requires follow-up even at this late date.

162. Even within the very restricted scope of this investigation, there are other major concerns. For the question of whether staff waited too long to call 911, the OIA investigation is persistently and strongly biased. The investigator tries to make the case that it was too dark for the staff members present to see Mr. Mr. [redacted] wounds well, and that the amount of blood on Mr. [redacted] wounds also interfered with their ability to assess the severity of his condition. The investigator also, in his interviews, highlights the fact that most of the responding staff did not see a great deal of blood, a conclusion that is contradicted by Officer [redacted] initial report stating that there was "large amounts of blood on the floor, the bed, and on the inmate". That suggestion that there was a great deal of blood was reinforced by Officer [redacted] report which stated that at the triage and treatment area, "Inmate [redacted] was lying on a hospital bed covered in blood". So much for the argument that staff did not think the situation was life threatening because there wasn't much blood. A second direction pursued by the investigator in trying to establish that staff had done nothing wrong was the notion that Mr. [redacted] wounds could not be

reasonably evaluated because he was resisting so much. RN [redacted] did write in her report that when she first attempted to bandage Mr. [redacted] wrists he had pulled his arms away from her. Of the first five other staff to first arrive on the scene and deal with Mr. [redacted] only one reported any resistance from Mr. [redacted] and that was minor. Subsequent to the initial reports from various staff members, the investigator secured a report from a nurse not on the scene who talked with the staff who had been there, and then wrote a report describing a great deal of resistance and kicking and thrashing by Mr. [redacted]

163. The investigation is also noteworthy for what it does not do. The Warden's initial referral identified a 17 minute gap between the time Mr. [redacted] suicide attempt was discovered and the time the 911 call was placed. The suicide review identified one of the problems in this situation as an eight to 10 minute delay in calling 911. That is consistent with RN [redacted] report that she told the custody Officers on the scene to call 911 and that that had happened two or three minutes before Mr. [redacted] became unresponsive. Within the restricted focus of the investigation, the emphasis should have been on corroborating what happened at what actual time, from when Mr. [redacted] suicide attempt was discovered, until 3:22, which is well documented as the time the 911 call was requested and made. That did not happen. The "timeline" developed in the OIA investigation is very general and clearly does not seek to establish whether this policy violation did or did not occur. Worse, all of the Officers use exactly the same time for various events, to the minute, although they usually say "approximately". There are a limited number of ways in which Officers can all arrive at exactly the same time estimates, to the minute. It is possible that the Officers checked with records and that those times were entered on logs or other documents created contemporaneous with the events. A second way in which the Officers might all be in agreement to the minute on the time of various events would be that they checked with each other before writing their reports, or were given those times by a staff member directing the writing of those reports. If that happened, it would be a serious policy violation and collusion. This could be cleared up by interviewing the officers to determine how each of them arrived at the times included in

their reports to see if they did so consistently. Instead, the investigator never raised the issue of how the various staff members arrived at the same estimates of time for the various events. More importantly, with the timeliness of the response at the center of this investigation, it would have been basic for the investigator to review the various handwritten logs and electronic records of these events. Inexplicably, that did not happen.

164. There are other problems with this investigation. Like all staff incident reports, RN [redacted] report has a space for his signature and date and then a space for a reviewer's signature and date. The reviewer is Sgt. [redacted] RN [redacted] report is largely medical terminology. How can a custody Sgt. review the report of a licensed healthcare professional and determine that it is sensible, that it is appropriately detailed, etc.? This investigation appears to be completely independent of the suicide review conducted by the Department after the suicide. The suicide review is detailed and extremely comprehensive, covering Mr. [redacted] mental health history, his criminal history, his addiction and gang membership history, his childhood development, treatment issues and much more. That information and those findings should have informed this investigation but they did not. Many of the key interviews in this investigation were conducted some eight months after the suicide. That kind of delay has been characteristic in many of the cases I have reviewed in this matter, but that does not lessen the damage those long delays can create for the integrity of the investigations.

165. All staff involved in this incident were exonerated of all charges. As opposed to the suicide review, which found a substantial delay in calling 911, the staff misconduct investigation found that all staff had acted properly.

166. In the larger picture, the suicide review was thorough, complete—if the question of use of force is ignored—and untainted by the kinds of bias that characterized this investigation. Importantly, in terms of suicide prevention and whether Mr. [redacted]'s death could have been foreseen, the suicide review noted that when he was in a crisis bed at the Los Angeles prison, Mr. [redacted] had objected to being transferred back to RJD for several reasons, including that he had made suicide attempts there in the past and was not

sure he would be stable there, and that he had trouble with and had complained about staff there. He was transferred to RJD in spite of that, leading to one of a number of criticisms arrived at by the suicide review, noting that the review of his file history had not been adequate. Mr. [redacted] concerns turned out to be realistic, and unfortunately fatal in his case. Once transferred to RJD, he noted that he did not feel safe and was being harassed by staff on the yard, and he was on suicide watch. This death was preventable on many levels.

5. [redacted] [redacted] Incident September 13, 2018, S-RJD-363-18-D

167. Ms. [redacted] a transgender inmate, complained that Officer [redacted] the tower officer in Building 13 on Facility C, did not open Ms. [redacted] cell door for breakfast, mental health appointments, for education ducats, and for her MAC representative duties. Officers [redacted] and [redacted] who both worked regularly as floor officers in Building 13, also submitted memos that they had directly observed Officer [redacted] refuse requests made by floor officers to open inmates' yes door. Officer [redacted] and Correctional Counselor [redacted] wrote memos noting that other inmates had complained of this behavior. Lt. [redacted] also wrote a memo noting that Officer [redacted] refused to let people out of their cells on a timely basis for RVR hearings, and had been counselled for his conduct.

168. Sgt. [redacted] informed Captain (Capt.) [redacted] about Ms. [redacted] allegations, which were initially reported in a clinician's memo. On September 14, 2018, Capt. [redacted] referred the case for administrative review, noting multiple complaints from inmates, alleged discrimination against transgender people, and staff reports of his unprofessional behavior. On September 24, 2018, AW Armenta re-assigned Officer [redacted] away from Facility C and all control booth positions. OIA launched a subject-only interview investigation. The hiring authority elected to sustain one charge—that Officer [redacted] failed to release people from their cells for schedule appointments from July 2018 through September 2018—and found the other charges—referring to transgender inmates

by the wrong pronouns, discriminating against transgender inmates, and failing to open cell doors from May 1 to September 14, 2018—could not be sustained.

169. Officers [redacted], [redacted], [redacted] and Correctional Counselor [redacted] were all interviewed by the facility Lt. and submitted memos corroborating the allegation. Lt. [redacted] also corroborated the allegation by noting that [redacted] delayed in releasing people for RVR hearings.

170. In his OIA interview, Officer [redacted] denied intentionally failing to release someone from their cell, and stated that he always opened doors as directed by floor staff. When asked whether he failed to release people from their cells for appointments, he said, "That is not true, that did not happen." When confronted with the allegations of other staff, Officer [redacted] simply said that they weren't true.

171. It would appear there was good cause for a dishonesty charge against Officer [redacted] based upon his categorical denials to the OIA investigator, but that case was not brought.

172. This case was pursued reasonably and the level three discipline was appropriate, if lenient. Three issues in this case are worth noting. First, an actual investigation was conducted and discipline imposed because there were multiple staff allegations against this officer. Second, the complaints from inmates about discriminating against transgender people, and other unprofessional behavior, were not taking as seriously as the staff complaints—likely because they were not corroborated by staff. As is the norm in the cases I reviewed, allegations that were supported only by the statements of inmates went nowhere. Third, when a new Warden, Warden Pollard, arrived at RJD, he rescinded Warden Covello's level three discipline against Officer [redacted] without explanation, so that in the end nothing happened and there was no accountability after the findings had been sustained.

6. [redacted] [redacted] Incident June 12, 2018, S-RJD-282-18-A

173. On June 12, 2018, Mr. [redacted] filed a 602 alleging that Officer [redacted] who was regularly assigned as the control tower Officer in Building 2, did not allow

inmates out of their cells for showers, medication distribution, and medical attention. It was also alleged that Officer [redacted] made discourteous comments over the loud speaker, including calling out people's former sensitive needs yard ("SNY") status, thereby putting people's safety at risk. Mental health staff also had submitted memos reporting that Officer [redacted] was denying their patients access to psychotropic medication and mental health services.

174. After receiving the memos from mental health staff, Capt. [redacted] wrote a memo to the AW and the Facility A Captain noting that the issue could not be resolved through the grievance process. After administrative review, the allegations were referred by Warden Paramo to OIA without any local inquiry. OIA accepted the case and conducted an administrative investigation. More inquiry probably should have been conducted. For example, the daily medication administration record (MAR) should have been consulted for the days on which class members alleged that they were denied access to pill line.

175. The OIA investigation consisted primarily of interviews. Senior Psychologist [redacted] said that she had had a complaint from an inmate, Mr. [redacted] alleging Officer [redacted] would not let him out of his cell to get prescribed medication on multiple occasions and that the same officer made derogatory comments about inmates over the loudspeaker. Dr. [redacted] also told investigators that she had received memos from three other psychologists that she supervised, reporting they had received similar complaints from other inmates. She gave those memos to the investigators.

176. Interviews with the three psychologists were similar, with each identifying specific inmates who had complained and the details of the inmate complaints. Psychologist [redacted] reported an inmate, Mr. [redacted] had told him that Officer [redacted] would not let him out of his cell so he could shower on two specific days. Dr. [redacted] had written four separate memos documenting complaints about Officer [redacted] he had received from inmates. Psychologist [redacted] told OIA investigators

that she had received similar complaints about Officer [redacted] beginning in 2015. She said that complaints about him were more frequent than about any other staff member. Dr. [redacted] told investigators that the complaints included calling an inmate "a piece of shit" over the loudspeaker, ignoring inmate requests and refusing to open cell doors wide enough for mobility impaired inmates to go in or out.

177. Psychiatric Technician (PT) [redacted] confirmed that inmates who did not show up for their psychiatric medication sometimes complained that Officer [redacted] had refused to let them out of their cell. When PT [redacted] asked Officer [redacted] about that, she understood his answer to mean that sometimes he intentionally refused to let certain inmates out. She said that after some time she had had a meeting with Officer [redacted] to discuss the situation, and that they had not had a problem after that.

178. In all, the investigators had detailed complaints from six different inmates and they interviewed four of those individuals. The inmate interview information was consistent with what they had received from the four psychologists and from the psychiatric technician.

179. The investigators should have emphasized a review of records because some of the events at the heart of these allegations are recorded in detail. In some situations there are daily records of inmate showers and inmate medications are always recorded on a form designed for that purpose (the MAR). If an inmate does not take his prescribed medication, that is documented along with the reason. The OIA investigator's review of shower records, medication records and records of attendance at groups was minimal and superficial but the results were consistent with the inmate allegations.

180. Officer [redacted] was interviewed and denied all the allegations. In spite of what seemed to be a mountain of evidence supporting the allegations, Warden Covello elected to not sustain any of the charges. It should also be noted that Officer [redacted] was frequently implicated in the class member declarations I reviewed, as well as a few of the institution-level inquiry cases, and many of these allegations were very similar in nature to the ones at the heart of this case. Despite this, it does not appear that Warden Covello

considered the volume of complaints against Officer [redacted] when deciding to not sustain the charges against him.

181. The primary difference between this case and the [redacted] case directly above is that in this case there were no custody staff complaining about Officer [redacted] The conclusion is inescapable that what an inmate writes and says, is not discounted; it is ignored. Sadly, non-custody staff are not taken much more seriously.

7. [redacted], Incident October 9, 2018, S-RJD-439-18-A

182. Mr. [redacted] is 63 years old and approximately 170 pounds. He uses a wheelchair and has a mobility vest. The extent of his mobility without the wheelchair, a walker or a cane is not clear in this case record. He was asked during an interview whether he could stand without the wheelchair and he replied that he had neuralgia and indicated that he could get out of the wheelchair if he sat on something else. Mr. [redacted] was housed in administrative segregation, Housing Unit 6, at the time of this incident. It is noteworthy that Mr. [redacted] had some history of barricading his cell or covering his cell window so that Officers could not see in during their required cell checks.

183. This particular incident appears to have started when Mr. [redacted] was escorted in his wheelchair back to his cell from the yard, during which the Officer escorting Mr. [redacted] evidently confiscated his cup of coffee when they reached Mr. [redacted] cell. There was evidently some verbal disagreement with Mr. [redacted] wanting his coffee back and the Officer refusing and also refusing Mr. [redacted] request to let him turn around and enter his cell in his wheelchair backward. According to Mr. [redacted] it was Officer [redacted] who was involved and then left Mr. [redacted] in his cell without removing his handcuffs. Mr. [redacted] responded by "papering" his cell window and barricading the cell door with a mattress and his wheelchair.

184. When staff saw that Mr. [redacted] had his cell window covered and would not respond verbally, a Code One was called and several Officers and a Sgt. responded to Mr. [redacted] cell. Mr. [redacted] had already told the first Officer on the scene that he would uncover his cell window in return for a cup of coffee, but that was lost as events unfolded.

Sgt. [redacted] was unsuccessful in getting Mr. [redacted] to uncover his window or take down the barricade. One of the Officers got a tool that is designed to move barricades and it was used to push the mattress and wheelchair away from the cell door and the food port.

185. What should have happened next were extensive efforts to get Mr. [redacted] to cooperate and uncover his window, including using crisis intervention and de-escalation techniques, non-custody staff and other methods prescribed in the controlled use of force protocol. That wasn't done. It is not certain what was done because the various staff accounts have glaring inconsistencies. It appears that what happened was that Sgt. [redacted] and perhaps some of the other Officers present, were sufficiently frustrated with Mr. [redacted] non-compliance that two of them, Sgt. [redacted] and Officer [redacted] each sprayed him with OC through the food port, then closed the food port and did nothing more until Lt. [redacted] and Correction Counselor III (CCIII) and Administrative Officer of the Day [redacted] arrived at the cell front and CCIII [redacted] talked Mr. [redacted] into coming out of the cell voluntarily.

186. There is video coverage from a fixed security camera of the area that includes the cell fronts of a group of cells that include cell [redacted], where Mr. [redacted] was housed. The OIA investigator on this case, Mr. [redacted] relied on that video footage in structuring his investigation and in conducting specific interviews. My analysis of this situation is that after spraying Mr. [redacted] with OC through the food port, the involved staff realized that that was a clear violation of the use of force policy, and actionable, and invented a story about Mr. [redacted] having some sort of weapon in his right hand and trying to use it on staff. The story that the Sgt. and the five correctional Officers told, more or less, was that after pushing aside the barricade from the cell door and food port, the Sgt. and Officers could see something in Mr. [redacted] hand that appeared to be a weapon and that he tried to swing it at the Officers and refused their commands to drop it and that the OC spray was because they feared he would injure an Officer or himself.

187. Quite simply, the Officer and Sgt. incident reports and interviews make no sense and the investigation is both incomplete and incompetent. In reviewing the

videotape, the investigator noted the presence of an additional correctional Officer outside cell [redacted] during much of this incident. The other staff either said they did not notice another Officer present or did not know who the Officer in the videotape was. The OIA Investigator, Mr. [redacted] checked the attendance and assignment records and found that an Officer was assigned to the general area at the time in question. Then the investigator does not interview that person, Officer [redacted] or any other Officer who might have been present, although that Officer committed a serious violation of policy by failing to report that he had witnessed a use of force.

188. None of the Officers, including the Sgt., could describe the weapon that Mr. [redacted] purportedly held in his right hand. It would be plausible if one or two Officers said they saw a glint of metal or if they said that the way in which he was holding his hand indicated that he was holding something but for five different staff members to each say that they thought he had a weapon but none of them could describe it, is no longer plausible. Additionally, the supervisor on scene, Sgt. [redacted] provided three different and somewhat contradictory descriptions of Mr. [redacted] brandishing a potential weapon and all three of those descriptions were dramatically different than what Sgt. [redacted] wrote in his incident report, at least raising the question of whether Mr. [redacted] actually had a weapon. That issue is linked to another question: whether or not Mr. [redacted] was in handcuffs in his cell during this entire time? It appears certain that that was the case. Mr. [redacted] described being placed in the cell by an Officer [redacted] and that they had a verbal confrontation and Officer [redacted] slammed the cell door but did not remove Mr. [redacted] handcuffs. Beyond that, every one of the staff members present indicated that Mr. [redacted] never became cooperative in any way until the end of the incident when he was talked into leaving the cell voluntarily by CCIII [redacted] There is also agreement on the part of everyone present that the cell door was never opened during this incident. Thus, it does not appear that there was any occasion or any way in which Mr. [redacted] could have had handcuffs applied during the incident. That conclusion is reinforced because none of the six staff who wrote reports, including the Sgt., describe handcuffing Mr. [redacted] or seeing

handcuffs applied by some other Officer. Then, at the end of the incident, when Mr. [redacted] voluntarily leaves his cell, it is clear from the reports that he is already in handcuffs. Tellingly, none of the six staff members describe Mr. [redacted] during the incident as having handcuffs. However, if the staff members could see something in Mr. [redacted] right hand, it follows that they would have seen that that hand was also in handcuffs.

189. When the investigator asked several of the Officers how Mr. [redacted] had attempted to use the weapon against staff, each of them described something very different. Sgt. [redacted] had written in his report that Mr. [redacted] had hit him and other staff with the weapon. When asked during an interview by Mr. [redacted] Sgt. [redacted] recanted and said Mr. [redacted] had swung but had not actually hit him or other staff members. Since the cell door never opened, Sgt. [redacted] must have been indicating that Mr. [redacted] reached through the food port and swung his hand and the weapon from there. The investigator did not pursue that in detail. One other Officer described Mr. [redacted] as trying to use the weapon against staff by swinging it over his head and another staff member in his interview said that Mr. [redacted] was poking it through the food port. One of the Officers, in his interview, did not say anything about reaching through the food port, but just said that Mr. [redacted] was holding the weapon in the cell.

190. No staff member described Mr. [redacted] as posing any credible threat to himself.

191. These issues and the staff contradictory reports and interviews are central to this investigation because it is most likely that what occurred is a use of force that was a direct violation of policy. Even if Mr. [redacted] had a weapon in his hand (a shank or perhaps something like a sharpened stick), the required staff response would have been to call for and begin the controlled use of force protocol. No one described Mr. [redacted] as keeping his arm through the food port and swinging a shank back and forth so that staff could not shut the food port. That, shutting the food port, would have been the common sense security response. The Sgt. or one of the Officers should have closed the food port without any use of OC spray, and that would have effectively stopped any threat against those staff. It should be emphasized that there is agreement across American corrections, in jails as well

as prisons, that there are only three reasons that justify the use of chemical agents against an inmate who is locked in a cell. The first reason is if the inmate is hurting himself, or threatening to in a serious manner, such as cutting on himself or herself or banging his or her head against the bars or the walls. The second reason would be if the inmate had one or more cell mates and was hurting or seriously threatening them. The third reason is during a cell extraction, after all reasonable attempts at achieving non-force compliance have been exhausted. Other than those three situations, it is consensually accepted that it is unnecessary force to use chemical agents when an inmate is confined in a cell and cannot present an imminent threat to anyone. In the case at hand, while I believe the weapon in Mr. [redacted] hand was invented after the fact as a pretext to try to justify the use of force, it entirely fails as a justification, even if the weapon had been present.

192. Another major factor that supports my conclusion in this case is the failure to search Mr. [redacted] when he was taken from the cell. Correctional staff are trained to be hyper-vigilant about inmates with weapons, and with good reason. While most inmate weapons are used on other inmates, they are sometimes used on staff with horrific results. If staff are wrestling with an inmate to get an inmate under control and in restraints, and one of the staff members thinks the inmate has something or is reaching into a waistband, that staff member will yell, "Knife! Knife!," or, "Weapon! Weapon!", to alert other staff immediately. Thus, if a Sgt. and four or five correctional Officers each thought Mr. [redacted] had a weapon in his hand, the staff members would have been loud and insistent that he and his cell be searched extremely thoroughly so that that weapon was found before Mr. [redacted] was allowed to leave that cell. The fact that Mr. [redacted] was not searched as soon as that cell door was opened suggests that Mr. [redacted] had not had a weapon, as the staff members claimed, and that the officers knew that was so.

193. The cell window was papered over throughout this incident. Thus, the Sgt. and Officers outside Mr. [redacted] cell could only see into the cell and see Mr. [redacted] through the open food port. To do that, they would have to bend down substantially and look through the port because it is closer to waist level than to eye level. Even if the

window had been partially unblocked, it is a tall, vertical slit window that appears from the photographs to be perhaps three inches wide. It would be difficult for several Officers to all get a clear enough view into the cell to see that Mr. [redacted] had something in his right hand unless it were so obvious that the Officers could see what it was that he was holding. Officer [redacted] maintained that he did not see Sgt. [redacted] use OC and during his interview he changed his description of his own use of force to say that he had sprayed from approximately three feet away from the cell door and that Mr. [redacted] was another five or six feet beyond that in the cell. (According to that revised version, there was no justification for the chemical agents or any use of force because if Mr. [redacted] was 6 feet inside his cell, there was no imminent danger to anyone.) Also, if Officer [redacted] had sprayed toward an open food port from three feet away, as he originally said, it is highly likely that a substantial amount of his spray would have hit the door of the cell and the "blowback" would have affected some of the staff standing there trying to see what Mr. [redacted] was holding. There is no report, however, of any of the Officers or Sgt. being affected by the OC in anyway. On a separate note, since the fixed security camera provided coverage of the corridor outside cell [redacted], including the door to that cell, why did the investigator not secure the earlier footage that would have shown whether it was Officer [redacted] who escorted Mr. [redacted] back to his cell and whether that Officer, whether it was Officer [redacted] or not, had removed Mr. [redacted] s handcuffs once he was in the cell, as should have been done?

194. Even as bad as the OIA investigation was, some facts were clearly established that should have been the basis for findings of staff misconduct. Most importantly, there was no imminent threat to staff to justify the use of force by Sgt. [redacted] or by Officer [redacted] They should have received substantial discipline. Officer [redacted] could not have failed to notice that Sgt. [redacted] discharged OC spray through the same relatively small food port either one second before or one second after he had sprayed Mr. [redacted] Officer [redacted] should have been disciplined for failing to report that use of force. Sgt. [redacted] wrote in his report that he and other staff had been hit by

Mr. [redacted] and the weapon that he was holding. Sgt. [redacted] changed that story during this interview but should have been held accountable for his false report.

195. The most challenging aspect of this case is that the story of four Officers and a Sgt. about a weapon in Mr. [redacted] hand does not hold up. Instead, it is a rather intricate example of a code of silence and collusion. All of the Officers involved in that fabrication should have been held accountable.

196. The final results of this case stretch credulity. No one was held accountable for anything, except for one Officer who was charged with failing to search Mr. [redacted] although that should have been the responsibility of the supervisors or mid-managers in charge of the situation. That one allegation was the only charge that was sustained in all of this. Then, even that single sustained allegation was dismissed by the Warden who changed the result to a need for corrective training. In its own way, this case is a poster child for what is wrong with a CDCR system of inmate complaints and grievances, reviews and investigations and staff discipline.

8. [redacted] [redacted] Incident March 31, 2017, S-RJD-086-19-A

197. The fact situation in this case is complicated and many aspects of this case are in dispute. There are, however, some undisputed facts that provide a framework for the allegations of staff misconduct and for the investigation. On March 31, 2017, Mr. [redacted] was on the yard and saw an inmate he knew well walking across the yard with Officer [redacted] Mr. [redacted] approached the other inmate and asked him what was going on. The other inmate said that he was going to the hospital but that everything was alright. At that point, another Officer, Officer [redacted] called Mr. [redacted] away from the other inmate and Officer [redacted] and counseled Mr. [redacted] about interfering with an escort. Mr. [redacted] was placed in handcuffs and escorted back to his housing unit and cell. Four days later, on April 3, Mr. [redacted] told his clinician, Clinical Social Worker ("CSW") [redacted] that he had been assaulted by staff and that afterward, he had found a piece of a broken handcuff key in his cell. CSW [redacted] declined to take the piece of metal from Mr. [redacted] but reported his allegations to her supervisor, who then notified the custody Captain, ISU and the PREA

coordinator. Mr. [redacted] was sent to medical on April 4. The medical evaluation documented bleeding from wounds on both wrists, pain in several areas, an abrasion to his ankle and an abrasion on his face. Mr. [redacted] told medical staff, "I was assaulted by custody on March 31". The medical staff sent Mr. [redacted] to an outside hospital because of concern with a possible ear injury and the hospital found he had a perforated eardrum. Mr. [redacted] filed a detailed excessive force complaint against Officers [redacted] [redacted] and [redacted] for assaulting him on March 31.

198. Mr. [redacted] version of events and allegations is as follows. The inmate he approached to talk to on the yard was someone he often walks with on the yard. Officer [redacted] did not have his baton out and there had been no escort announced, so Mr. [redacted] did not think that he was interfering with an escort. When Officer [redacted] called him away, he said that he did not know it was an escort and apologized. Officer [redacted] swore at him and took him into the EOP classroom, where he threatened him. Officer [redacted] told him to take off his clothes and called him a homosexual and a faggot. Mr. [redacted] insisted on getting his clothes back on before being escorted out of the building. Officer [redacted] put handcuffs on much too tightly. As Officer [redacted] and Officer [redacted] escorted Mr. [redacted] out of the building, Officer [redacted] shoved him against a fence, cutting his ankle. Those two Officers, with Officer [redacted] took him back to his cell. Officer [redacted] pushed him into his cell, kicked him in the legs to make him sit down and then punched him in the face and neck a number of times. While he was being punched by Officer [redacted] Officers [redacted] and [redacted] stood in the open cell door, blocking the view into the cell from other persons. Officer [redacted] was pulling on his handcuffs to try to get them off. And finally, Officer [redacted] helped remove his handcuffs. After the Officers left, Mr. [redacted] found a small piece of a broken handcuff key on the floor of his cell. Mr. [redacted] did not come out of the cell for several days, until April 3, because he was afraid. On April 3, Mr. [redacted] told his clinician what had happened and tried to give her the piece of broken handcuff key, but she would not take that.

199. In response to Mr. [redacted] complaint, Sgt. [redacted] began an investigation. He interviewed Mr. [redacted] on April 4 and on the same day, he interviewed the three inmate witnesses whom Mr. [redacted] had identified. Mr. [redacted] in his interview, provided detailed corroboration of Mr. [redacted] story. Mr. [redacted] was less detailed, but provided much of this same corroboration and was consistent with the version of events presented by Mr. [redacted] The third inmate, Mr. [redacted] said that he had not seen what happened inside the cell because two Officers were blocking his view into the cell but his description of the escort of Mr. [redacted] the Officers standing in the open cell door, and the sounds of punching from within the cell, were all consistent with Mr. [redacted] complaint. Sgt. [redacted] also had access to the medical assessments of Mr. [redacted]

200. Sgt. [redacted] draws a number of conclusions and, at the end of his investigation report, says that no further action is required. His report is so badly done that it is difficult to take it seriously. He says that there were notable inconsistencies in the report given to Ms. [redacted] by Mr. [redacted] First, he states that Officer [redacted] had no key access to the EOP classroom. That does not seem compelling because a number of the other Officers on the yard did have key access and another Officer may well have opened the door when Mr. [redacted] and Officer [redacted] went in. Second, he argues that a review of the key chain used by Officer [redacted] did not show a broken handcuff key. However, the handcuff key could have been Officer [redacted] or Officer [redacted] His third inconsistency is that Mr. [redacted] did not turn in the piece of handcuff key when he found it. Mr. [redacted] did, however, turn the broken piece of key in as soon as he talked to anyone about what had happened. That is corroborated by CSW [redacted] The fourth inconsistency mentioned by Sgt. [redacted] is that the piece of handcuff key was recovered by the transport Officer while they were taking Mr. [redacted] to the hospital. However, that escort Officer simply asked Mr. [redacted] for the piece of metal and Mr. [redacted] immediately gave it to him. It is not like Mr. [redacted] was keeping it for some nefarious purpose and it was discovered during a search. The fifth inconsistency Sgt. [redacted] describes is that Mr. [redacted] might have been keeping the broken handcuff key in order to test the transport security measures, as a

possible escape mechanism. That is a bizarre idea. The broken piece of key is very small and does not have the ridges or anything else that would likely activate the handcuff locking mechanism. There is nothing that Mr. [redacted] did that would actually test any security transport procedures except to get sent to the hospital. If Mr. [redacted] had been concerned with the escape potential of the small piece of handcuff key, then he would not have tried to surrender it to his clinician nor would he have voluntarily produced it when asked by one of the Officers transporting him. Sgt. [redacted] report goes on to state, "It is my belief Mr. [redacted] has an ulterior motive as he did not inform staff for four days (about the incident)". Mr. [redacted] did explain why he stayed in his cell for four days and whether Sgt. [redacted] believes that explanation or not, his suggestion of an ulterior motive requires that he explain how Mr. [redacted] was better served by waiting four days before voicing his complaint. After that, Sgt. [redacted] writes, "any reasonable person would conclude that if any Officer utilized unnecessary force, these actions would have been documented appropriately and in a timely manner". If Sgt. [redacted] statement is to be taken at face value, it suggests that any reasonable person would know that no staff person would ever fail to report or inaccurately report a use of force. If that were true, and it obviously is not, there would be no reason to take the time or effort to investigate any inmate allegations of unnecessary or excessive force. They could be rejected out of hand, which is what Sgt. [redacted] ends up doing. The last statement by Sgt. [redacted] in his report is, "Lastly, there was no use of force utilized by any Officer and any injuries sustained were self-inflicted. As such, no further action is requested". It does not give Sgt. [redacted] pause that the three inmates he interviewed that same day corroborated Mr. [redacted] allegations. Worse, Sgt. [redacted] evidently believes that in order to justify his complaint, Mr. [redacted] gave himself wrist injuries that were still bleeding four days later and also perforated his own eardrum (a spectacularly painful injury). The investigation by Sgt. [redacted] is shocking in its bias and incompetence, and it raises the question of how first line supervisors without skill, appropriate training or experience can be relied upon to review or investigate inmate complaints of staff misconduct.

201. Two days later, on April 6, two managers at RJD recommended to the Warden that the situation needed review by a trained investigator. The Warden concurred, but waited almost a month and a half before sending a formal request for investigation to OIA. On June 26, 2017, OIA assigned [redacted] as the investigator on this case then, that same day, they transferred responsibility for the case to [redacted]. Although that transfer happened in late June, almost all of the investigative activity on the case during the next month or so was conducted by Mr. [redacted] rather than Mr. [redacted] and there is no explanation of that in the OIA records. On July 21, 2017, Investigator [redacted] interviewed Mr. [redacted] and Mr. [redacted] two of the inmates interviewed as witnesses by Sgt. [redacted] Both inmates repeated most of the same information they had provided in their earlier interviews, corroborating Mr. [redacted] That same day, rather than interviewing Mr. [redacted] Investigator [redacted] interviewed Supervising Psychologist [redacted], Ms. [redacted] supervisor. A substantial portion of the of the investigation is devoted to the question of whether Ms. [redacted] was culpable for her handling of Mr. [redacted] request that she take the broken part of the handcuff key. Eventually, Ms. [redacted] was issued a letter of instruction (LOI) which she did not contest. That was given to her on the basis that when Mr. [redacted] asked her to take the portion of the handcuff key, she should have involved custody. If she had called custody when he made that offer, it probably would have stopped his detailed discussion with Ms. [redacted] of what had happened to him. That would not have been a good outcome. Ms. [redacted] for her part, said that she felt she could not take the piece of metal from Mr. [redacted] because she thought it would put her in a position of accepting undue familiarity with an inmate. That is not an unreasonable reaction. She did report the situation with the key and it was her report that led to someone notifying one of the transport Officers, who was taking Mr. [redacted] to the hospital, that Mr. [redacted] might be in possession of a portion of a handcuff key. Most importantly, the situation with Ms. [redacted] Dr. [redacted] and the chief psychologist had little to do with the merits of Mr. [redacted] allegations, except for the initial meeting between Ms. [redacted] and him.

202. On August 1, Investigator [redacted] interviewed Mr. [redacted] On August 16, 2017, Investigator [redacted] separately interviewed four inmates as potential witnesses in this matter and similarly, separately interviewed six different staff members as potential witnesses. Mr. [redacted] does not explain the basis on which these particular inmates were chosen to be interviewed. For example, one inmate, Mr. [redacted], said in his interview that he knew nothing about an incident on the yard on March 3 and that he also did not know and could not recognize Mr. [redacted] A second obvious problem with these interviews was that they were conducted four and one half months after the incident in question. The interview Mr. [redacted] conducted with inmate [redacted] is noteworthy because he said he was the inmate that staff assigned to clean Mr. [redacted] cell once Mr. [redacted] had left that cell. Investigator [redacted] recounts Mr. [redacted] saying that there were no signs of a struggle in the cell. That is a gratuitous observation, obviously, in response to a leading question. There is nothing in the case record, including in Mr. [redacted] description of the assault on him in his cell, that would indicate that anything in the cell was broken or that there would be signs of a struggle four days after the incident had happened. In the next paragraph of the investigative report, Mr. [redacted] states that Mr. [redacted] knew that Mr. [redacted] had had confrontations with staff in the past. Then his report says that Mr. [redacted] reported Mr. [redacted] had caused a lot of disturbances. Mr. [redacted] is then reported to have told investigator [redacted] that he knew Mr. [redacted] was a drug user and went back and forth from the Department of Mental Health in order to escape drug debts. The next paragraph of the investigative report indicates that Mr. [redacted] said that Officer [redacted] does his job and that Mr. [redacted] had not seen him violate CDCR use of force policy in the past period. None of that provides any eyewitness testimony to any portion of the incident in question. Instead, it is simply investigator [redacted] demonstrating his overarching bias by painting Mr. [redacted] history in a negative light. It is not clear why it is relevant that a particular inmate, Mr. [redacted] has not seen Officer [redacted] violate the use of force policy and says that he does his job, when the reality is that Officer [redacted] was named in many more inmate complaints of

staff misconduct than most staff at RJD. The investigators, whether at the institution-level, such as Sgt. [redacted] or at the OIA level, as with Mr. [redacted] take steps to recount the disciplinary history or negative information about inmates and their making complaints about staff. But those same investigators never present the disciplinary history, the frequency of use of force incidents or similar information about the staff that the allegations name. The Officer working in the control booth on March 31 in that housing unit was interviewed, as was the Officer working the podium area at that time. Both Officers said that if an incident had occurred, similar to what Mr. [redacted] described, they would have seen it and documented it. Neither remembered any such incident. On September 6, Mr. [redacted] was interviewed. He was the third of the inmates who had initially corroborated Mr. [redacted] story. He repeated that he remembered hearing inmates yelling at the escorting Officers to stop twisting Mr. [redacted] arms, that he saw Officer [redacted] enter the cell, and that his view was blocked by the two other Officers but that he could hear sounds that sounded like punching coming from inside that cell. Importantly, Mr. [redacted], the person being escorted by Officer [redacted] confirms that Mr. [redacted] was escorted to a classroom after the verbal altercation on the yard. This was not investigated at all, even though it is of critical relevance to the allegations. This is another stark example of bias against inmate witnesses.

203. On September 18, 2017, the investigation took an unusual turn when the Office of the Inspector General received a complaint from Mr. [redacted] stating that he had been retaliated against because of his interview supporting Mr. [redacted] Mr. [redacted] said that, after his interview with Mr. [redacted] he was taken to the gym in restraints and while he was held there, his cell was searched, and an inmate-manufactured weapon was found. He further said that Officer [redacted] along with Officer [redacted], had approached him and made comments that they had planted the shank in his cell and said things like, "Yeah, tell that to IA," and taunted him to tell the Warden, saying that the Warden was their buddy. At his RVR hearing, Mr. [redacted] was found guilty and lost 270 days of credit in addition to other sanctions. Mr. [redacted] was another inmate in whose cell a weapon was

found during the same day of searching. Mr. [redacted] was interviewed and said that he too had been targeted because he was outspoken and complained about staff and that a weapon had been planted in his cell and that staff had told him they were making sure he would be off the housing unit. Several staff interviews were conducted with Officers or supervisors working in the area of Officer [redacted] assignment on the day that Mr. [redacted] alleged that the shank had been planted and then he had been taunted. Those staff told the investigator that Officer [redacted] had not left his assigned post at any point during a shift on that day, July 21. The interviews were four months after that day and it is surprising that several staff would be certain that a particular Officer had not taken a meal break or otherwise been away from his assignment for long enough to go to the gym and back. At the end of this, the investigator interviewed Officer [redacted] who acknowledged escorting Mr. [redacted] back to his cell from the yard in March, but denied any conflict or altercation.

204. The results in this case were that all allegations were found to be "not sustained". That is not surprising considering the extent of the bias in the investigations that were conducted. Three inmates corroborated Mr. [redacted] allegations about the assault in detail. Mr. [redacted] had bleeding, handcuff wounds and a perforated eardrum, all of which were completely consistent with his allegations about the assault by staff. The Officer involved had a history of frequent inmate complaints of staff misconduct. None of that was sufficient to sustain any charges, given CDCR's flawed process and approach.

9. [redacted] [redacted] Incident April 9, 2018, S-RJD-144-18-A

205. Mr. [redacted] is a disabled inmate, who, on April 9, 2018, was in the correctional treatment center (CTC) unit at RJD and was classified as administrative segregation. He was awaiting approval for his wheelchair. That morning, Mr. [redacted] was very upset with his psychologist and papered over the window to his cell and flooded the cell by stuffing the toilet. Lt. [redacted] and Sgt. [redacted] went to the cell to see what was going on and Lt. [redacted] told Sgt. [redacted] to handle it. Lt. [redacted] left the area. Officer [redacted] approached Sgt. [redacted] at the cell door and asked the Sergeant if he wanted her to handcuff Mr. [redacted] because policy required handcuffs on any

administrative segregation inmate before a staff member entered the cell. Sgt. [redacted] told her, "no," and that he "had it." Officer [redacted] walked away. Sgt. [redacted] went into the cell without handcuffing Mr. [redacted] and, according to Mr. [redacted] the Sergeant advanced toward him as he backed up toward the back of the cell and sat on the bunk. Then, Mr. [redacted] said that Sgt. [redacted] put his chest or stomach close to Mr. [redacted]'s face and then grabbed Mr. [redacted] by the throat and began choking him. According to Mr. [redacted] Sgt. [redacted] was also very angry and swearing at him. Officer [redacted] arrived at the cell door and Mr. [redacted] called to her and asked her to get the Sgt. off of him. Officer [redacted] asked Sgt. [redacted] her direct supervisor, if she should push the alarm, and he told her, "No," and told her to get out of there. Officer [redacted] left and, according to Mr. [redacted] Sgt. [redacted] seemed to come to his senses and let go of him and then the Sergeant walked out of the cell and asked Mr. [redacted] if he was going to report him. Mr. [redacted] responded that he was. Mr. [redacted] covered his cell window again and Sgt. [redacted] told him to uncover it or there would be a cell extraction. Mr. [redacted] said that he wanted to talk to Lt. [redacted] and report excessive force. Another staff member told Lt. [redacted] that Mr. [redacted] had covered his window again and the Lt. went back to that cell. Mr. [redacted] told him that he wanted to report excessive force by Sgt. [redacted] and Lt. [redacted] had Mr. [redacted] removed from the cell, put in a room and then got a camcorder and did a video interview of Mr. [redacted] regarding his allegations that Sgt. [redacted] had used excessive force on him. Mr. [redacted] was taken to medical for an evaluation, which showed abrasions to his wrist which appeared to be scratched and bleeding. Mr. [redacted] identified a nearby inmate and said he believed that inmate had witnessed the situation. That inmate was interviewed and said that he had heard the incident but had not been able to see anything. What he had heard was consistent with Mr. [redacted]'s and Officer [redacted] version of events.

206. Sgt. [redacted] when he was later interviewed, said that he had responded to an attempted suicide early that morning, and that the inmate had cut his wrists and throat and stomach and that it was a gruesome and emotional incident and that he was not 100%

afterward. Sgt. [redacted] acknowledged that he went in Mr. [redacted]'s cell without handcuffing Mr. [redacted] but said that Mr. [redacted] then came at him in the cell aggressively and that he pushed Mr. [redacted] back until they both fell on the bunk at the back of the cell and that the force that he used with Mr. [redacted] was self-defense. He also said that he was upset by his bad judgment in not using handcuffs, and because he was upset and angry at himself, he did not report the incident until the next day, violating the policy that required a use of force to be reported prior to the end of an Officer's shift.

207. Officer [redacted] wanted to report the incident and talked to Sgt. [redacted] Sgt. [redacted] was also present and told Officer [redacted] "you weren't there". Officer [redacted] later said that she was uncomfortable reporting the incident to Lt. [redacted] because she did not trust him due to his involvement in another incident of staff misconduct. She went home without reporting the incident. But one half hour later, she called Sgt. [redacted] from home and told him what had happened. She also said that she had prepared a draft of a report indicating that she had witnessed a use of force. Sgt. [redacted] according to Officer [redacted] told her that things would be okay and that since she had reported the incident to him verbally, they would work it out the next day when she was on duty and filed a report. In addition to not trusting Lt. [redacted] Officer [redacted] later said that she was hesitant to report the incident because she knew that Sgt. [redacted] brother was the ISU Lieutenant at RJD and she feared staff retaliation. She believed that Sgt. [redacted] was not going to report the use of force and that he was hoping that she would not either.

208. Following the incident on April 9, the Warden requested an OIA investigation of both Sgt. [redacted] and Officer [redacted] OIA assigned investigator [redacted] on June 8. Following the end of the investigation, the *Skelly* hearings for Sgt. [redacted] and for Officer [redacted] the HA imposition of discipline appear to be appropriate. Sgt. [redacted] was terminated. As with other cases I reviewed, officer terminations only occur if there is staff corroboration or video evidence of misconduct. Officer [redacted] received a 5% salary reduction for three months, a level three penalty in

the staff discipline matrix. Of note, Lt. [redacted] was terminated in connection with sustained allegations of misconduct in the another case where he was found to have submitted a false incident report regarding a use of force; he retired before the termination was effective and did not respond to a request from investigator [redacted] for an interview.

209. In spite of the reasonable disciplinary outcomes in this case, the OIA investigation itself is biased and incompetent. In the OIA report, Investigator [redacted] writes, "I read the summary of [redacted] (the inmate witness) interview, which was written by [redacted] the day after the incident. All of his statements in that interview were truthful and accurate." That is not close to the truth. In writing the summary of the interview of Mr. [redacted] Sgt. [redacted] emphasized that Mr. [redacted] was a mental health patient and that he had taken medication at the time of the interview, and that he was having trouble in the interview with the sequence of events. Sgt. [redacted] also noted that Mr. [redacted] confused Officer [redacted] and Officer [redacted] There is no good explanation for Mr. [redacted] statements about the witness being truthful and accurate, except that Mr. [redacted] did very similar things in another OIA investigation that I reviewed in this matter. It appears that Mr. [redacted] decides, while the investigation is underway, what is the truth of the matter and who is lying and who is not, and then characterizes the particulars in his investigation with that bias. Of much less concern, but burdensome, is the same investigator's habit of including large amounts of irrelevant information in his report. Thus, in this report, he describes what Officer [redacted] did when she first came on shift that day, although it is irrelevant to the events of this case.

210. What is most obvious about this case is that OIA accepted the referral and conducted a rather extensive investigation because staff were accusing other staff of misconduct. I reviewed many other cases in which the outcomes were more serious, some involving extensive inmate injuries, and even when those cases presented clear fact patterns and more corroboration than in this case, OIA rejected almost all of those referrals.

211. Despite findings by the HA that Sgt. [redacted] attacked [redacted] and choked him without any justification, as far as I am aware, Sgt. [redacted] faced no criminal referral or prosecution.

10. [redacted] [redacted] Incident January 21, 2019, S-RJD-086-19-A

212. Mr. [redacted] has a partially paralyzed left leg and uses a walker. On January 21, 2019, after yard release, Mr. [redacted] attempted to go to the program office wanting to notify the Sergeant that he was on a hunger strike. He was stopped by Officer [redacted] and Officer [redacted] Officer [redacted] told him he would need to return to his housing unit and get a pass if he wanted to come into the program unit. He also told him that they already knew he was on a hunger strike. Mr. [redacted] sat down on his walker there on the yard. Some words were exchanged and a use of force ensued.

213. According to Officers [redacted] and [redacted] Officer [redacted] approached Mr. [redacted] telling him he was going to place him in handcuffs, but before he could make physical contact, Mr. [redacted] "threw himself on the ground." Officer [redacted] who was behind Mr. [redacted] and his walker, reported the same thing. Officer [redacted] was five or ten yards away, but wrote a report also saying that Mr. [redacted] had "thrown himself on the ground." According to the Officers, they helped Mr. [redacted] back up into his walker in a sitting position and then when Officer [redacted] tried to handcuff Mr. [redacted] Mr. [redacted] jerked his hand and arm into the air and the Officer thought he was going to be hit in the face. In response, Officer [redacted] grabbed Mr. [redacted] and took him to the ground. Officer [redacted] placed weight on Mr. [redacted] with his foot and knee to hold him down and prevent his twisting and resisting and they were able to get Mr. [redacted] in handcuffs. He was taken to medical and medical documented active bleeding from his left cheek and a swollen area on his right forearm.

214. The synopsis of events in the case record simply recounts the version above as reflected in the staff incident reports from the three Officers. The incident commander's review, completed by Lt. [redacted] presents the same version of events in the same language and sequence and finds the force justified.

215. Mr. [redacted] was issued an RVR and his disciplinary hearing was held a month after the incident. He was found guilty and the sanction imposed included loss of canteen, packages and visiting for 30 days and 61 days of lost credit. The hearing Officer refused to review the video of the incident although that was requested by Mr. [redacted] Inmate witnesses were not interviewed for the hearing.

216. There is every indication that, absent a few coincidences, nothing would have happened to question the reports from the three Officers in spite of their extraordinary assertion that Mr. [redacted] threw himself out of his walker and onto the ground. First, the day after this incident, on January 22, 2019, Sgt. [redacted] from the California Institution for Men, was still on assignment at RJD as part of the strike team looking into allegations made by Plaintiffs' counsel for the *Armstrong* class. Sgt. [redacted] interviewed an inmate, Mr. [redacted] who described a very different incident involving Mr. [redacted] Mr. [redacted] said that he saw an Officer grabbed Mr. [redacted] out of his walker and throw him onto the ground. When Sgt. [redacted] interviewed another inmate witness, Mr. [redacted] he corroborated part of that story. Sgt. [redacted] wrote a memo to the Warden at RJD recommending that the situation be referred to OIA for investigation. The following day, January 23, the ISU Lieutenant at RJD, Lt. [redacted] reviewed the incident and the reports in response to Sgt. [redacted] memo. Second, the incident occurred on the yard for Facility C, one of the few places at RJD where there is surveillance video. As a result, the incident was captured on video. The fixed security camera is across the yard from the location of the incident and, as a result, the video quality is poor. However, the video clearly shows an Officer grabbing Mr. [redacted] from the front as Mr. [redacted] was sitting on his walker, and then throwing Mr. [redacted] to the ground. There is no question that the video is completely inconsistent with Mr. [redacted] having thrown himself out of his walker onto the ground. Based on Lt. [redacted] review, RJD stopped further review or investigation of the incident and the Warden requested an administrative investigation of Officers [redacted] and [redacted] on February 13, 2019. The Warden subsequently expanded that request to include Officer

[redacted] in the investigation. OIA assigned Investigator [redacted] to this case on March 12, 2019.

217. On May 19, Mr. [redacted] and another investigator interviewed Mr. [redacted] and Mr. [redacted] and both generally confirmed the information that they had provided to Sgt. [redacted] some three and a half months earlier. Mr. [redacted] was finally interviewed at that time. He said that he had wanted to go into the program office to let a Sergeant know that he was on a hunger strike and that he was stopped by Officers [redacted] and [redacted] He said that he did not have any history or "bad blood" with either Officer and he did not remember Officer [redacted] name but was able to identify him from the photo. He said that he was thrown from his walker onto the ground, picked up and put back in his walker, and then taken to the ground again and handcuffed. He denied that he had raised his arm and hand in an attempt to strike Officer [redacted] Mr. [redacted] also interviewed Officers [redacted] and [redacted] at length and in detail, including showing them the surveillance video and asking them whether they maintained the story they reported that Mr. [redacted] had thrown himself from his wheelchair.

218. After *Skelly* hearings, Officers [redacted] and [redacted] were terminated for submitting false reports and participating in a code of silence.

219. The key issue in this case was the video from the security camera. Once the case had been highlighted by Sgt. [redacted] interviews, the video could not be ignored. There were many other inmate interviews conducted by Sgt. [redacted] that suggested serious misconduct but resulted in no follow up or any other action. The difference was that in this situation there was security camera video footage.

220. The situation is not exemplary. The timelines are not good. As of January 22 and January 23, the dates of the interviews by Sgt. [redacted] and the review of the reports and the video by Lt. [redacted] RJD was on notice that serious staff misconduct involving false reporting, code of silence and inmate injuries might have occurred. Lt. [redacted] does not memorialize his review in a memo until February 7, two weeks after he identified the potential problem. Another week goes by before the Warden requests an investigation. It

is then another month before OIA accepts the case and assigns an investigator. Once Mr. [redacted] is assigned, he waits two months before initiating the key interviews in the investigation. Following the completion of the interviews, there was an unexplained more than six month delay before OIA completed investigations and closed the cases with a referral back to the HA. Then, after another two months, *Skelly* hearings were held and the three Officers were terminated in late January of 2020. It appears that either two of the three Officers or all three Officers remained on duty and without any assignment restrictions during the lengthy pendency of this investigation. All told, the Officers were allowed to work at RJD with full salary and benefits interacting with prisoners for a year after they threw Mr. [redacted] to the ground. All three Officers should have been placed on administrative leave until the investigation was completed or, at a minimum, reassigned away from Facility C to non-inmate contact positions. It did not make sense to leave these three Officers in positions where any of them might have tried to influence or retaliate against Mr. [redacted] or inmate witnesses or hurt other prisoners.

221. Another problem is that Lt. [redacted] the incident commander conducting the first level review of the use of force, did not request and review the surveillance video even though the incident occurred in an area of the prison with video coverage. Surveillance video should be reviewed as a matter of policy for all uses of force where video is available. Lt. [redacted] should have been disciplined or, at a minimum, received additional training as a result of his poor performance reviewing the incident.

222. By the time of the RVR hearing against Mr. [redacted] the Warden had enough information to intervene and cancel that hearing. If an Officer initiated unnecessary force against Mr. [redacted] and then three Officers falsely reported the incident, which was at least plausible at the time of the RVR hearing, why would the Warden or other top managers at RJD want Mr. [redacted] punished for his part in that incident? If he has not already been released, Mr. [redacted] should be restored his good time credits taken away through the improper RVR.

223. This is one more case where the inmate who is the subject of a use of force should have been interviewed as soon after the use of force as possible, but was not. This case also reinforces the importance of requiring every Officer reporting use of force, whether as a witness or a participant, to identify inmate witnesses to the incident.

224. Although this was the only case that I reviewed in which there was any discussion of possible staff collusion in report writing, it appears that in this case, the video had already convinced the investigators that the staff reports were false and they thus focused on the three Officers reporting that Mr. [redacted] had "thrown himself to the ground." There was no sustained finding with regard to plagiarism. The more obvious example in this case was missed by the investigators. Officers [redacted] and [redacted] in their reports, both state that Mr. [redacted] said, "I'm going to notify the Sgt. about my hunger strike. You motherfuckers are playing games!" The two Officers report that verbatim, down to the punctuation.

B. Cases Resulting in Rejection by OIA

1. [redacted] August 19, 2018, S-RJD-141-19-A

225. This is one of the most outrageous but compelling cases I reviewed. This case was rejected by OIA and, following that rejection, the institution did nothing to address Mr. [redacted]'s very serious concerns as if OIA actually addressed his complaint.

226. On August 19, 2018, Mr. [redacted] refused a cell move and said that he was then assaulted by Officer [redacted] while Officer [redacted] watched. Mr. [redacted] filed a 602 alleging unnecessary/excessive force. Later in the case file, Mr. [redacted] says that because of the beating he received on August 19, he sustained a fractured rib. There is no medical record for assessment or treatment of Mr. [redacted] on August 18, or in the days immediately after that. No investigator asked Mr. [redacted] how he knew he had a broken rib and none of the staff involved in investigations or reviews inquired about a medical record for Mr. [redacted] from that time.

227. On October 22, 2018, Mr. [redacted] was assaulted by two inmates. That assault was investigated by Sgt. [redacted] at RJD. Mr. [redacted] rejected Sgt. [redacted] request that he

participate in a video interview and also rescinded the 602 he had filed after the earlier incident in August. Mr. [redacted] had provided information about the cell number of one of his two inmate attackers and noted that the other inmate worked on the yard crew, but there was no attempt to identify or interview either of those inmates. On November 18, 2018, Sgt. [redacted] concluded his investigation, stating that there was "no compelling evidence" and that "no further action was recommended." The IERC reviewed the incidents involving Mr. [redacted] and on January 18, 2019, concluded, "no further action warranted."

228. The IERC finding is particularly troublesome because one month before its finding, in December of 2018, the three person investigative strike team was at RJD interviewing inmates to follow up the numerous allegations from lawyers for the Plaintiff class in *Armstrong*. Sgt. [redacted] from the California Institution for Men, documented that Mr. [redacted] told him that he had dropped his 602 about being assaulted in August by Officers [redacted] and [redacted] because the October 22 beating he sustained from two other inmates was in retaliation for that 602 and was arranged by Officer [redacted] Mr. [redacted] also said that he had been approached by inmates prior to the October assault on him, asking whether he was going to withdraw the 602, and he had also been threatened by Officer [redacted] indicating that he would be assaulted if he did not withdraw that complaint. Mr. [redacted] also mentioned that after the October beating by two inmates, inmates asked him whether he had dropped the 602 complaint. The medical records show that Mr. [redacted] was seen by medical on the day he was assaulted, October 22, and had bleeding, bruises and abrasions on his neck, forehead and side of his face.

229. Officers [redacted] and [redacted] had each been interviewed on November 18, three months after the use of force reported by Mr. [redacted] in August, and both Officers denied any involvement in an incident with Mr. [redacted] in August.

230. Following Mr. [redacted]'s interview with Sgt. [redacted] Warden Covello referred the matter to OIA. OIA appears to have done nothing and sent a letter rejecting the referral on April 17, 2019, indicating, "There is no reasonable belief that misconduct occurred."

231. What moves all this into the realm of the unbelievable is that, during the strike team's interviews with inmates at RJD on December 4, 2018, Sgt. [redacted] had separately interviewed Mr. [redacted] Mr. [redacted] provided chapter and verse that he had personally been involved with assaults on other inmates arranged by correctional Officers. He described how he and another inmate, Mr. [redacted] had assaulted an inmate, Mr. [redacted] at the request of Officers in November, 2016. He described how he and Mr. [redacted] had assaulted an inmate, Mr. [redacted] at the request of Officers in May, 2017, and how that assault had to be stopped by staff use of a 40 millimeter round, striking Mr. [redacted] in the chest. Mr. [redacted] told Sgt. [redacted] that Officer [redacted] and Officer [redacted] shared confidential information about inmate criminal records with other inmates, including with him, Mr. [redacted] That kind of information was shared by staff members in order to convince inmates to assault other inmates, which Mr. [redacted] said that he did. In part of that same interview, Mr. [redacted] said that he knew that Officer [redacted] had sent inmates to assault Mr. [redacted] Though Mr. [redacted] may have identified the wrong Officer as being responsible for the assault on Mr. [redacted] Mr. [redacted] report still served as substantial corroborating evidence of Mr. [redacted] allegation that the October 22 attack by inmates was arranged by staff. The information provided by Mr. [redacted] in that interview was also consistent with incident reports and medical records from the prior incidents that he described.

232. It does not seem possible that OIA concluded that there was no basis to believe that staff misconduct may have occurred. Mr. [redacted] described in detail an initial and unjustified use of force by staff, followed by pressure from inmates to withdraw his complaint; followed by one of the two Officers threatening him if he failed to withdraw the complaint; followed by his description of being assaulted by two inmates in retaliation for his complaint, with that assault arranged by staff; followed by another inmate confirming that staff had arranged for inmates to assault Mr. [redacted] in order to get him to rescind his 602 complaint; with that inmate providing details of prior occasions when he had been successfully solicited by staff to assault other inmates. If there is no basis in all of that to

believe that staff misconduct may have occurred, the logical question is whether there is any set of circumstances sufficient to convince OIA that something serious may have occurred. From the cases I have reviewed, the answer is simple. If an OIA referral is based on a staff complaint against other staff, it is taken seriously. If an OIA referral is based on video evidence, it is likely to be taken seriously because there is no way to "explain away" video evidence. If the OIA referral is based on any combination of inmate allegations and medical records, then no matter the extent of corroboration within the case file, with rare exceptions it will be rejected.

233. Mr. [redacted] made additional important points in his interview by Sgt. [redacted] Mr. [redacted] willingness to implicate himself in serious criminal assaults on other inmates, combined with the corroboration of that testimony found in medical reports, incident reports, and other records, suggests that his testimony must be seriously considered. Mr. [redacted] told Sgt. [redacted] that inmates who get into verbal confrontations with staff are often beaten by staff and that inmates are frequently taken to the gym to be beaten. He said that Officers [redacted] and [redacted] were ringleaders of the staff misconduct at RJD and he identified five staff members who provide confidential information to inmates about other inmates. Perhaps not surprisingly, the staff members that I found had been most frequently implicated in inmate complaints and grievances were among those five Officers. Finally, Mr. [redacted] made an observation that is a consistent strand through the cases that I reviewed for this declaration. He said that staff misconduct occurs because the first line supervisors, the Sergeants, do not do their jobs and that the Lieutenants and Captains also do not do their jobs, allowing this to continue.

2. [redacted] [redacted] incident April 5, 2018, S-RJD-142-19-A

234. This is an excellent example of a case rejected by OIA with the "no misconduct identified" box checked, without further explanation and in spite of strong evidence to the contrary and an incompetent institution-level investigation. It should be noted that the rejection letter from the OIA Central Intake Panel (CIP) is signed by a supervisor with an illegible signature and no printed or typed name.

235. Mr. [redacted] alleged that on April 5, 2018, he was walking near the dining hall when an Officer grabbed him and threw him on the wall, kicking his legs apart for a pat down. Three other Officers joined the first Officer and one of those Officers held the back of his head and slammed his face into the concrete wall twice. Mr. [redacted] also said none of the Officers filed a use of force report and that he was denied medical attention for 24 hours.

236. The file is difficult to read because it is 79 pages and a substantial portion of the file is devoted to a 19 page memo from strike team member AW Bishop, describing his interviews with many other inmates at RJD, only one which is relevant to this case. The file also includes other allegations that are similarly unrelated to Mr. [redacted] case, including 12 pages of interview worksheet and medical records from Mr. [redacted] that do not focus on Mr. [redacted] allegations. CDCR should have a standard format for investigative files so that the same items would always be in the same order and in the same place but that is not so. Lengthy documents that are minimally relevant to an investigation should be exhibits or attached as appendices. These are not trivial concerns. The more cumbersome or convoluted the investigation report, the greater the barrier to accountability.

237. Lt. [redacted] of ISU at RJD, was assigned to investigate Mr. [redacted] allegations on May 25, 2018, six weeks after the incident. Lt. [redacted] noted that Mr. [redacted] said he was assaulted by staff at approximately 1800 hrs., and that the unit log ("daily activity report", or DAR) reflected a code 1 alarm for another inmate at 1755 and another Code One alarm for a serious assault, an attempted homicide on a correctional Officer, at 1815. Neither of those situations involved Mr. [redacted] Lt. [redacted] concluded that the Officers alleged by Mr. [redacted] to have participated in the assault on him would have been busy with those other two situations and, thus, that his allegations were false.

238. There is no way to describe Lt. [redacted] conclusion except preposterous. Certainly, the times on the DAR could be inaccurate. Perhaps more likely, Mr. [redacted]

estimate of when the incident occurred could be off by 15 or 30 minutes or even much more. Instead of considering this possibility, Lt. [redacted] conclusion is that the incident did not occur. In order to reach that conclusion, Lt. [redacted] had to ignore most of the evidence in this case.

239. On April 6, Mr. [redacted] was seen at medical and given a CT scan for his head. The April 6 photo is consistent with the injuries reported by Mr. [redacted] and consistent with his allegations of unnecessary force by staff. The investigation provides no alternative explanation for those injuries.

240. In interviews (not provided to Plaintiffs), three different inmates corroborated Mr. [redacted] allegations in some detail. Mr. [redacted] described the incident and the force used by staff consistent with the allegations and without a major discrepancy. Mr. [redacted] in his interview, supported Mr. [redacted] version of events in detail. Mr. [redacted] did not speak to the use of force but corroborated the refusal of staff to get Mr. [redacted] to medical on April 5. In order to dispense with these three eyewitnesses, Lt. [redacted] discounts Mr. [redacted] interview on the basis that he is a vulnerable individual subject to exploitation. There is no discussion or explanation of how he was exploited in this situation. Lt. [redacted] contends with the interviews of Mr. [redacted] and Mr. [redacted] by ignoring them.

241. The unsigned memo describing the interview with Mr. [redacted] acknowledges that he repeated his allegations and was consistent. Instead of considering this fact as bolstering his credibility, the interviewer negatively characterizes Mr. [redacted] detail and consistency by writing that he failed to provide additional details or evidence to support his claim. Mr. [redacted] is evidently the victim of a "Catch 22": if he fails to provide adequate detail and supporting evidence when making his claim, it is rejected out of hand; but if this claim includes detailing supporting evidence, then his subsequent interview is discounted because he failed to provide additional detail and additional evidence.

242. A major point in Lt. [redacted] investigation is that there was no timely documentation to substantiate the claim on the day of the incident. First, that is not true.

Mr. [redacted] wrote a request for medical services on April 5, the day of the incident, describing both the incident and his injuries. Second, the usual documentation would be a use of force report and a medical examination report. Since Mr. [redacted] allegations are that no use of force report was filed and that he was denied medical treatment for 24 hours, the absence of those two reports would seem to support, not deny, Mr. [redacted] allegations.

243. The four staff members alleged by Mr. [redacted] to have participated in the use of force against him were each interviewed. The interviews were evidently neither audio taped or videotaped. Each interview is described in two sentences in which the staff member either says he does not know Mr. [redacted] or says nothing happened. None of the four staff are asked about whether they participated in the two code 1 incidents that are used to discredit Mr. [redacted] allegations.

244. The investigation in this case was incompetent. . What is shocking is that anyone could review this investigation without finding it totally unacceptable. The rejection of this case by OIA based on "no misconduct identified" is incomprehensible. If Mr. [redacted] allegations are true, and this investigation certainly does not establish that they are false, then this is a cover-up of a use of force by four staff acting in concert. In most law-enforcement and correctional agencies, that would be a terminating offense.

245. In short, the inmate's allegations are supported by three eyewitnesses and the medical evidence but OIA declined to consider case.

246. It is cases like this that lead to my conclusion that OIA is either so biased against inmates or so incompetent, or both, that OIA is not a realistic alternative to institution-level investigations and cannot be relied upon without additional oversight for fair or thorough investigations of inmate complaints, grievances or appeals.

3. [redacted] [redacted] Incident May 7, 2018, S-RJD-136-19-R

247. Officer [redacted] went to escort Mr. [redacted] to a different cell. According to the Officer, as he was escorting Mr. [redacted] Mr. [redacted] first objected to the cell move and then turned around and punched Officer [redacted] in the face. Officer [redacted]

said he used his OC spray on Mr. [redacted] but without effect. Mr. [redacted] continued to aggressively approach Officer [redacted] who then grabbed Mr. [redacted] and took him to the floor. Mr. [redacted] was continuing to try to punch Officer [redacted] and in response, the Officer punched Mr. [redacted] twice in the face. Responding Officers [redacted] and [redacted] arrived and Mr. [redacted] was placed in handcuffs and leg restraints. Mr. [redacted] was decontaminated from the OC with fresh air and then cold water and taken to medical for assessment. That is the staff version.

248. Mr. [redacted] was given an RVR but declined a video interview and declined to make a statement. That is no surprise. Most staff uses of force also result in some RVR (a "write up" or administrative discipline). The inmate is then given a written form "Notice of Rights Pursuant to *Miranda* Decision." That form has five questions for the inmate to answer. The first is, "You have the right to remain silent, do you understand"? The second is "Anything you say may be used against you in court, do you understand"? The third and fourth questions are about the right to an attorney. Then the fifth question is "Do you want to talk about what happened?" The first four questions do an excellent job of convincing most inmates that they should not talk or be interviewed. While the *Miranda* warning is required if there is a reasonable chance of criminal prosecution, the vast majority of staff use of force incidents do not result in a criminal referral or criminal prosecution. This CDCR procedure is a major barrier to getting an inmate's version of the events after a staff use of force. It does not need to be that way. I am accustomed to use of force reviews in the Los Angeles County jails. Almost immediately following a staff use of force, an uninvolved mid-manager conducts a video interview with the inmate who is the subject of the use of force. Even if the inmate initially says, "I don't want to talk about it," or something to that effect, the interviewers persist with some combination of patience, open questions and silence. The result is that the large majority of use of force situations include an immediate inmate interview on the record.

249. It is important to recognize that whether a review of a particular use of force case begins with the OIA documents, if the case was sent to OIA, or whether it begins with

the institution-level documents, the first thing any reviewer will encounter is a synopsis of the incident. That synopsis is neither more nor less than the version of events presented by the staff who used force. That synopsis, often including large portions of the staff incident reports verbatim, is then repeated in the record, sometimes several times. It does not matter if an inmate has made allegations that represent a very different version of events. There is nothing to put the reviewer on notice that the synopsis of the situation may not be an accurate summary of what happened, or close. That has the effect of introducing huge bias at the outset of reviewing any case. When that is combined with the failure in many cases to obtain an interview with the inmate who was the subject of the force, and, noting that when there is an interview, it is neither comprehensive nor unbiased, then it is not surprising that, as a practical matter, most use of force situations receive no meaningful review, either at the institution-level or at the OIA level.

250. The medical evaluation of Mr. [redacted] after the use of force showed a number of injuries. He was actively bleeding under his eye and from the mouth and he had bruising on one cheek near his eye, and he had been sprayed with OC. What is shocking, however, about the medical evaluation is not only the extent of his injuries. It is what he said to the medical staff while he was being evaluated. He said, "I wasn't resisting," and "I didn't do what I was accused of." He also said, "I am in fear for my life", and "I want to go to administrative segregation." When he was asked whether he wanted to make a formal statement, he said, "No," which is consistent with his position after the *Miranda* warnings. It is not unusual for inmates to be more comfortable talking openly with medical staff than with custody staff, particularly in the immediate aftermath of a use of force incident. How is it possible for CDCR to have no mechanism requiring medical staff to formally notify management when an inmate makes statements such as Mr. [redacted] made? The only explanation that I can arrive at is that management and the Department as a whole do not want to know about situations in which the staff version of a use of force is disputed by the inmates involved. This is an abject and obvious failure of the CDCR system, and it is difficult to argue that it is other than intentional.

251. The situation is that force was used on Mr. [redacted] but he did not give a statement nor file a complaint and in spite of his injuries, there has been no meaningful review of the situation. The photos in the file purporting to show Officer [redacted] injury as a result of being punched are of such poor quality that they show nothing. As is true with other cases, some of the incident reports from officers have an illegible signature and no requirement that the officer name be printed or typed. There are no interviews with the staff involved, including Officer [redacted] who used the force in this incident.

252. Officers [redacted] and [redacted] submitted reports which appear to show plagiarism. For example, Officer [redacted]'s report states, "I offered Inmate [redacted] further decontamination to which he agreed and I provided Inmate [redacted] with access to copious amounts of cool running water in the Facility C gymnasium, until he stated, 'I feel better, CO'". Officer [redacted] report reads, "Officer [redacted] offered Inmate [redacted] access to cool running water to decontaminate. Inmate [redacted] agreed and utilized copious amounts of water to decontaminate, after which he stated, 'I feel better, CO'". Similarly, there is evidence of collusion in the incident reports of Officer [redacted] and Officer [redacted] For example, Officer [redacted] report states in part, "… assumed an aggressive stance, stating, 'fuck you! I ain't moving motherfucker!' and simultaneously swung his right fist at my face, striking me on the left side of my face." Officer [redacted]s report states, "… and yelled at Officer [redacted] 'Fuck you, I ain't moving, motherfucker!' as he swung his right fist at Officer [redacted] and struck him on the left side of the face". In another place, Officer [redacted] writes, "Officer [redacted] positioned his upper body over Inmate [redacted] upper torso, and utilized his body weight to maintain Inmate [redacted] on the ground …." Officer [redacted] wrote, "positioned my upper body over Inmate [redacted] upper torso, using my body weight to maintain Inmate [redacted] on the ground …." As with every other case, no one discussed or even noticed a single instance of potential collusion by the Officers involved.

253. This situation was essentially no inmate complaint, no inquiry, and no meaningful review at the institution-level, and nothing pointing to this case as having

potential issues. All of that was true until January 18, 2019, when the three person strike team from other institutions interviewed RJD inmates. One of the inmates interviewed was Mr. [redacted] He was interviewed by Lt. [redacted] an ISU staff member at Ironwood State Prison, and told Lt. [redacted] that he had witnessed the incident with Mr. [redacted] and that Officer [redacted] had used unnecessary and excessive force and had slammed Mr. [redacted] to the ground and then used pepper spray on him while he was handcuffed on the ground. Mr. [redacted] also said that another RJD inmate, Mr. [redacted] could corroborate what he was saying. As Mr. [redacted] was also a witness, Lt. [redacted] checked with Mr. [redacted] who verified Mr. [redacted] version of events. Following his inmate interviews, Lt. [redacted] wrote a Jan. 18 memo to Warden Covello summarizing his interviews and making recommendations. In that memo, under the heading, "Specific recommendations for immediate follow up," Lt. [redacted] describes 49 situations involving serious inmate allegations of staff misconduct. Warden Covello then referred four of the 49 situations identified by Lt. [redacted] to OIA. The incident with Officer [redacted] and Mr. [redacted] was one of those four.

254. Two months after the referral to OIA, Warden Covello was notified OIA had rejected the case because "there is no reasonable belief misconduct occurred". The Officers involved were never interviewed. Mr. [redacted] the subject of the use of force, had never been interviewed. There was no attempt to re interview Mr. [redacted] or Mr. [redacted]

255. There are other questions that should have been part of the investigation but were not. Officer [redacted] appears to be a large individual. He stated in his report that he took Mr. [redacted] to the floor with his arms wrapped around Mr. [redacted] arms and torso in order to prevent Mr. [redacted] from further trying to punch him. If he had Mr. [redacted] in that kind of hold, as they went to the floor, why was it necessary on the floor for Officer [redacted] to punch Mr. [redacted] in the face twice? Officer [redacted] the tower officer, claimed that he only saw the incident in progress, which is not plausible. There was a verbal altercation before the use of force and the alarm was activated before

force was used. In response to an alarm, the tower officer will scan the building for the incident and to provide gun coverage. That is basic.

256. The complaint from Mr. [redacted] alleged unnecessary force. Why, then, was there no IERC review? This raises an important problem in the CDCR process. All uses of force must be reviewed by the IERC, unless the local review is stopped because the incident is referred to OIA. If it is referred to OIA and the referral is rejected, IERC does not then begin its review. The matter is typically closed as if it had been investigated by OIA instead of rejected. Essentially, nothing happens and no one investigates. I do not understand how it is possible that after years and years and thousands of use of force incidents, no one has noticed this "hole" in the CDCR system of review and investigation.

4. [redacted] February 3, 2018, S-RJD-137-19-R

257. Mr. [redacted] was entering the facility C dining hall when Officer [redacted] told him to turn around and come back and use the correct door. According to Officer [redacted] Mr. [redacted] came back but threw his meal to the floor and then swore at the Officer. Then, according to Officer [redacted] Mr. [redacted] stood up from his wheelchair with clenched fists and in an aggressive stance, made verbal threats and advanced toward Officer [redacted] A two second burst of OC spray from six feet stopped Mr. [redacted] and Officer [redacted] was then able to place handcuffs on Mr. [redacted]

258. Mr. [redacted] filed an appeal on March 2, 2018. He said that Officer [redacted] swore at him, told him to leave the dining hall and come back from the proper direction. Mr. [redacted] also claimed that Officer [redacted] called him "a retard." Mr. [redacted] is designated as DD2. In his complaint, he said that when he told Officer [redacted] he was going to report him for unprofessional conduct, he was sprayed with OC, thrown to the ground from his wheelchair, and then Officer [redacted] stomped on his back. Mr. [redacted] attached three statements to his complaint, each anonymous but from an inmate who said he had witnessed the incident. All three of these witness statements confirmed the assault on Mr. [redacted] by Officer [redacted] with two of the statements saying that Mr. [redacted] was first sprayed with OC, and then thrown to the ground out of his wheelchair, while the other

statement had the opposite order. One of the three statements also said that the inmate submitting the statement had been called "snitch" by Officer [redacted] for writing down information about the assault. Mr. [redacted] complaint and all three of the witness statements he submitted each included some mention of fear of retaliation.

259. The initial incident occurred on February 3, 2018. But the video interview with Mr. [redacted] was not conducted until six weeks later, March 19, and at that time the interviewer, Lt. [redacted] stated that there was no incident connected to the appeal and no medical evaluation. Both of those assertions were factually wrong. There was a medical evaluation, reflecting OC spray to Mr. [redacted] face, from February 3. There were also incident reports from Officer [redacted] and Officer [redacted] and a rule violation report (RVR) written for Mr. [redacted] on that date. There is no explanation anywhere in the case record with regard to why Lt. [redacted] said that none of those reports existed. At the time of the video interview, and perhaps because of Lt. [redacted] conclusion that nothing happened, Mr. [redacted] asked that his 602 complaint be withdrawn.

260. With regard to reviews at the institutional level, the incident commander, Lt. [redacted] wrote that the staff actions "before, during and after the use of force were in compliance with departmental policy, procedure and training." That was written the same day as the incident without any attempt to interview the staff involved or to find inmate witnesses. The first level management review was dated 10 days later, on February 14, and Capt. [redacted] came to the same conclusion as Lt. [redacted] and used the same wording. There is then a 10 month gap before the second level management review is conducted by AW Covel, who then reached the same conclusion as the Captain and the Lieutenant had earlier. The first two of those reviews were entirely superficial. But it was after the second of those that Mr. [redacted] filed his 602 complaint, in early March.

261. The sequence of events is confusing. After the incident in early February, the managers conducted their reviews of the use of force. Then Mr. [redacted] filed his staff complaint in early March. Mr. [redacted] then withdrew his complaint on March 19. There is no explanation for that, nor is he evidently asked why he chose to withdraw his

complaint in spite of numbers of situations in which inmates describe retaliation and pressure to withdraw 602 complaints. Some nine months later, on November 28, 2018, Sgt. [redacted] requested an interview with Mr. [redacted] presumably one of the three inmate witnesses to the February incident, and Mr. [redacted] declined. There is no explanation for the long delay, how Mr. [redacted] was identified or the purpose of attempting to interview him. Then, several days later, AW Covel completes the managers' second level review and, perhaps by coincidence, that occurs the day before the three person strike force from other facilities begins to interview inmates at RJD.

262. During those strike force interviews with RJD inmates on December 4, 2018, Mr. [redacted] was interviewed and provided the same version of events that he had provided some nine months prior in his 602 complaint. The interviewer, Sgt. E. [redacted] was sufficiently concerned by Mr. [redacted] allegations to schedule a follow-up interview on January 22, 2019. In between those two interviews, on December 20, 2018, the use of force review by the IERC occurred and the IERC Representative noted Inmate [redacted] refusal to be interviewed and concluded that the IERC had determined "the inmate allegations have no merit and no further action is warranted." It would be one thing for the IERC to conclude that there was insufficient evidence to sustain Mr. [redacted] allegations, but it is different and extraordinary to conclude instead that those allegations have no merit when there was corroborating evidence and no investigation or even meaningful review had been conducted. The reality is that there was nothing in any way approaching proof the allegations had no merit.

263. On January 22, 2019, Sgt. [redacted] to his credit and evidently on his own initiative—re-interviewed Mr. [redacted] and found that his report was entirely consistent with the version of events that he had given almost one year earlier. Sgt. [redacted] recommended pursuing this matter and the Warden referred it to OIA. OIA rejected the referral on April 17, 2019, without investigation.

264. It should have been obvious to everyone reviewing this case at any point that there was collusion between Officer [redacted] and Officer [redacted] in writing their incident

reports. The plagiarism is difficult to miss. Both Officers quote Mr. [redacted] as initially yelling, "This is bullshit! You guys are fucking stupid!" Both Officers wrote that verbatim. Then both Officers quoted Mr. [redacted] again, as he threw his kosher meal to the ground, as yelling, "Fuck you guys. This is bullshit!" That is also verbatim, including the punctuation. The order of the sentences describing the incident in the two reports is the same. There are other phrases and word choices which are identical. For example, in describing the use of chemical agents, Officer [redacted] writes, "I un-holstered my state issued MK-9 from approximately (6) feet away and deployed (1) continuous (2) second burst of Oleoresin Capsicum aiming for Inmate [redacted] facial area and striking Inmate [redacted] facial area with positive results." Officer [redacted] writes, "Officer [redacted] un-holstered his state issued MK-9 and deployed (1) continuous (2) second Oleoresin Capsicum (OC) from approximately (6) feet away striking Inmate [redacted] in the facial area with positive results." Are we to believe that in spite of a fast developing, loud and angry confrontation, both Officers remembered Mr. [redacted] shouted obscenities word for word the same and that both Officers estimated the distance from Officer [redacted] to Mr. [redacted] exactly the same and estimated the length of the OC burst exactly the same? In CDCR, as in almost all correctional and law enforcement agencies, Officers are trained and required to write reports independently, based on their own knowledge, perceptions and memory. This is not just a rule violation, it is an integrity issue that can compromise an Officer's ability to give testimony in court. I found plagiarism in reports in several of the cases I reviewed, although I was not specifically looking for that. It appears that this kind of collusion is simply permitted by supervisors and managers reviewing these cases, including top managers and investigators at OIA. I do not understand why they would ignore this behavior.

265. This case is an excellent example of many of the serious problems that have plagued CDCR, uncorrected, for years. Every use of force should be seriously reviewed or investigated. If that had happened, there would have been a detailed account of Mr. [redacted] version of events on the day of the incident. The Officers involved would

have been required to identify inmate witnesses and those witnesses, along with those identified by Mr. [redacted] would have been located and interviewed quickly. The medical record of Mr. [redacted] evaluation on that day, and the Officer reports would have been available to any reviewer or investigator. There should have been video of this incident from fixed security cameras at RJD. And that video would have almost certainly answered the question of whether the Officers' version of events was accurate, or whether Mr. [redacted] version of events was accurate. The plagiarism would have weighed against the credibility of the Officers. The investigation would have been broadened to include Officer [redacted] to determine whether he threatened one of the potential witnesses in an attempt to keep that person from coming forward, as that person alleged. If OIA had been functional, and the matter had been referred to them, there would have been review of the medical records, new interviews of the involved staff and inmates, and more.

266. The most central problem, however, is the OIA rejection. Based on the allegations, there cannot be a rational or empirical finding that there is no reasonable belief that misconduct has occurred. That might be the result of the investigation but it cannot be the reason for not conducting the investigation.

5. [redacted] [redacted] Incident, October 8, 2018, S-RJD-433-18-R

267. Mr. [redacted] is a developmentally disabled inmate at level 1 at RJD. On October 8 2018, he was going to the yard and was searched with a wand. Officer [redacted] told him to submit to a clothed body search ("pat down") after that, and he told the Officer he had already been wanded. Officer [redacted] got angry and threw Mr. [redacted] to the ground and then sprayed him in the face with OC. That is Mr. [redacted] summary of the incident.

268. Officer [redacted] reported the use of force. He said that he noticed Mr. [redacted] avoiding search during yard release and told him to stop and submit to a clothed body search. Mr. [redacted] complied but became angry, according to Officer [redacted] turning his head from side to side and swearing at the Officer. Officer [redacted] report then states that Mr. [redacted] turned his body out of his grasp in an aggressive manner, and Officer [redacted] reacted by taking Mr. [redacted] on the ground and telling him to stay there. Then Officer

[redacted] called a Code One on his radio. Officer [redacted] continues that Mr. [redacted] ignored his direction and stood up and began to advance towards Officer [redacted] with clenched fists. Officer [redacted] then sprayed Mr. [redacted] in the face with OC and that was effective in putting Mr. [redacted] back on the ground. Officer [redacted] then went to the ground to put handcuffs on Mr. [redacted] and then other staff arrived and escorted Mr. [redacted] off the yard and to Medical. The medical evaluation of Mr. [redacted] showed no injuries but face and upper torso exposure to OC.

269. On the same day as the incident, Sgt. [redacted] interviewed Mr. [redacted] who said that he was walking away from being wanded when an Officer said, "let me pat you down," and Mr. [redacted] said that he had been patted down. But then the Officer took him to the ground and pepper sprayed him. That same day, Sgt. [redacted] interviewed two inmates and asked them if they had seen the incident. Both inmates said they had not. There was no indication in the case file as to why those two inmates were chosen for interviews or where they were located at the time of the incident. Sgt. [redacted] also interviewed Officer [redacted] and Officer [redacted] also on October 8. Both Officers said that they had not seen the incident.

270. The incident commander's review of the use of force was completed that same day, October 8, by Lt. [redacted] who concluded that staff actions prior, during and after the use of force were in compliance with the use of force policy, procedures and training. The first level manager's review was completed by Capt. [redacted] two days later, and reached exactly the same conclusion.

271. The second level management review was completed by AW Armenta three weeks later. AW Armenta did not concur with the prior reviews and recommended that the incident be referred to OIA. He said that Officer [redacted] had failed to articulate an imminent threat that would justify a use of force. AW Armenta also said that Officers [redacted] and [redacted] should be investigated, because the situation at yard release was such that there were Officers who would have been in the close vicinity of Officer [redacted] and that it was not believable that Mr. [redacted] was yelling and swearing at Officer [redacted]

then Officer [redacted] took Mr. [redacted] to the ground; admonished him to remain there; then Mr. [redacted] got up and began advancing toward Officer [redacted] then Officer [redacted] sprayed Mr. [redacted] with OC; then Mr. [redacted] got on the ground; then Officer [redacted] got on the ground and placed handcuffs on Mr. [redacted] and all of that happened before any other Officer saw that there was an incident taking place. AW Armenta noted in his memo recommending an OIA referral that, based on his over 20 years' experience in the agency, the incident as reported, would have lasted a minimum of 15 to 20 seconds and that would have meant that staff in the area would have observed and/or responded. AW Armenta's concerns are well founded. However, it is noteworthy that he has no problem with Lt. [redacted] or Capt. [redacted] even though they each completed reviews that failed to note either of the problems he highlighted. If neither of those managers noticed what were obvious problems with the use of force incident, on what basis would AW Armenta expect that either of those two individuals would be any more effective reviewing other use of force incidents?

272. In this case, the actual allegation against Officer [redacted] was "neglect of duty." This is one of a number of cases where the allegation is a euphemism rather than unnecessary force or excessive force.

273. The investigation at the institution-level is biased and substantially incomplete. The incident took place in a location where a number of inmates would have been standing nearby. There was no serious attempt to find inmate witnesses who had actually seen what transpired. The summary of the interview with Mr. [redacted] suggests the interview was superficial and failed to explore the key questions in this case: Did Mr. [redacted] see other staff while this was happening? Could Mr. [redacted] identify any other inmates who were in the area? After Mr. [redacted] was on the ground, did he try to get up or move toward Officer [redacted] before Officer [redacted] used chemical agents on him? How soon during the incident did other staff arrive to help Officer [redacted] Was that before or after Officer [redacted] used his OC spray?

274. The allegations against Officer [redacted] and Officer [redacted] were never taken seriously. Basically, they were each asked whether they had seen the incident and both of them said they had not seen the incident. And that was that. There was no exploration of how far they were from Officer [redacted] when the incident started or when they heard the Code One issued. The allegations against them by AW Armenta were quite serious, charging that they had intentionally falsified their reports. But no one involved in the case except AW Armenta ever focused on what either of these two Officers had done.

275. OIA quickly rejected this case, closing it on January 2, 2019. The rejection states that there was no reasonable belief misconduct had occurred, as in a number of other cases rejected by OIA for investigation. This is an illogical application of an inappropriate criterion. A reasonable belief that misconduct occurred, or hadn't occurred, would be the normal result of a complete investigation. The obvious rule that OIA should be using to determine whether or not to investigate is whether the allegations, if proven true, would constitute staff misconduct. Beyond that, it would also be reasonable for the determination about whether to investigate to include the question of whether the allegations were impossible. And perhaps, whether they were implausible, although care would have to be taken that that metric, "Is the allegation implausible", was not used as a vehicle to exercise staff bias.

276. The rejection of this case is also improper because the institution-level investigation was so poor and so incomplete, that no one should have been able to draw any reliable conclusions from that information.

277. This case is one of many examples in which a descending code of silence covers allegations of unnecessary or excessive force.

278. After all of the details in this case, and all of the issues raised, it is worthwhile to return to AW Armenta's two allegations. The first does not need an investigation to prove that AW Armenta is correct. Officer [redacted] report speaks for itself. And it does fail to describe as a predicate situation an imminent threat to the Officer that would justify a staff use of force. AW Armenta's second allegation, that the two

nearest Officers lied when they reported they did not see the beginnings of the incident or the use of force, is dependent upon some level of investigation. But as AW Armenta pointed out, anyone familiar with searches during yard release knows there are a relatively large number of inmates going through a relatively constricted area, and that staff members are trained not to become isolated in those situations. As a matter of fact, if a staff member conducting a search was assaulted by an inmate, or was otherwise involved in a serious physical altercation, and no staff member noticed or responded to assist for 15 or 20 seconds or more than that, the initial staff member might be seriously injured. That was AW Armenta's point. With staff searches during yard release, there are almost always at least several staff in the same area. And if an inmate starts yelling at a staff member, or becomes engaged in a physical altercation with a staff member, then other staff members will notice and begin to respond immediately or within a matter of a few seconds. That analysis is simply ignored. There were more than two other staff members on the yard. Where are the interviews with those staff members?

6. [redacted] [redacted] incident September 24, 2018, S-RJD-455-18-R

279. During afternoon medication pass in housing unit 11, Mr. [redacted] who has a developmental disability, is designated as DD2, and also has a mobility disability, got into a verbal altercation with Officer [redacted] According to Officer [redacted] when he told Mr. [redacted] twice to return to his cell, Mr. [redacted] approached him using obscenities. Officer [redacted] then told Mr. [redacted] to get against the wall for a clothed body search. Mr. [redacted] complied but continued to swear at Officer [redacted] Mr. [redacted] then turned and jerked his elbow into Officer [redacted]'s rib cage. Still according to Officer [redacted] he backed up but Mr. [redacted] walked toward him aggressively in spite of an order to get on the floor. Officer [redacted] sprayed Mr. [redacted] with OC, which had no effect, and Mr. [redacted] continued to move toward Officer [redacted] who feared Mr. [redacted] might hit him with his cane, so he took the inmate to the floor and handcuffed him until the other Officers arrived.

280. For his part, Mr. [redacted] admitted to getting into a verbal confrontation and to "running his mouth". He denied hitting Officer [redacted] with his elbow and denied

threatening the Officer with his cane. Instead, he reported that he was trying to leave the area when the Officer grabbed him from behind, threw him to the ground, sprayed him with OC and hit and kicked him.

281. This case is unusual in that the supervisor assigned the case at the institutional level, Sgt. [redacted] concluded that Officer [redacted] acted properly during and after the use of force but failed to comply with policy prior to the use of force because Mr. [redacted]'s developmental disabilities required additional attempts to de-escalate the situation prior to initiating a clothed body search and that because of the verbal confrontation, Mr. [redacted] should have been handcuffed prior to the search. AW Armenta concurred with Sgt. [redacted] and recommended that the Warden request an OIA investigation. Thereafter, Warden Covello formally requested approval from OIA for direct adverse action. IERC had also reviewed this case but taken no action.

282. OIA rejected this case, finding that no misconduct occurred. Instead, the CIU raised questions that might exonerate the Officer (was Officer [redacted] aware that Mr. [redacted] was disabled, and at what level? Officer [redacted] should have known Mr. [redacted]'s status. Mr. [redacted] used a cane and housing unit 11 is a DD unit). The CIU also inquired where in the institution the incident occurred, but without faulting Officer [redacted] for not including that in his report. Then the CIU agent assigned to the referral called Warden Covello to discuss the case and ask for AW Armenta's position on the case. Two days later, the CIU agent spoke with both Warden Covello and AW Armenta, convincing them to drop the OIA referral, which they did.

283. There are disturbing aspects of this case that were not reached by either the institutional level investigation or the OIA review. After the use of force, Mr. [redacted]'s video interview footage revealed an abrasion/scratch on his chest which was consistent with his allegations but inconsistent with Officer [redacted] version of events. Clarification was requested from medical but there is no answer or follow-up in the case record. Even more importantly, no one involved asks why Officer [redacted] has no abrasion or bruise from Mr. [redacted] "turning and jerking his elbow into (Officer [redacted]s) rib cage". There is an

unmistakable pattern in these cases that staff injuries are frequently nonexistent, based on pain but not visible, or the result of punching inmates (such as hand injuries). Inmate injuries, however, are often consistent with the inmate's allegations and version of events and inconsistent with staff reports. All too often, this pattern is ignored.

284. A similar disturbing pattern has to do with chemical agents. In these cases, it is frequent to find, as is found here with Mr. [redacted] that staff report physical force was necessary after OC spray was used on the inmate because the OC spray had no effect and the inmate just kept moving toward the Officer aggressively. In my experience with these situations, it is not unheard of to encounter an inmate who is entirely unaffected by OC, but it is infrequent.

285. It is important to recognize that the questions above related to the correlation between the inmate's injuries and the reported force used, and the use of chemical agents, are issues having to do with whether the force used was necessary and reasonable. That central question was never looked at in the investigation. Instead, because the Warden identified two peripheral issues in his referral to OIA, those became the focus and no one reviewed or investigated Mr. [redacted]'s actual complaint, that he was abused by staff without justification.

286. Since this incident occurred during the afternoon medication pass on the yard, many inmates would have been near the incident. There were likely a number of inmate witnesses, particularly since both parties agree there was a loud verbal confrontation. However, no inmate witnesses were identified or interviewed. Even when inmate witnesses are not identified at the time of an incident, it is standard practice during an investigation or review to determine which inmates were in nearby cells or otherwise likely to have seen the incident, and to interview those inmates. I am accustomed to that procedure in other agencies. It is accepted correctional practice that staff members using force or witnessing force should identify inmate witnesses in their incident reports. That does not happen in CDCR and it is a major reason for the lack of accountability for staff

use of force incidents. However, that failure does operate to help maintain the code of silence.

287. This is one of many cases in which the interviews conducted during the inquiry or investigation ranged from problematic to useless. The summary of the interview provided in the incident package reveals that the inmate interview was intended to fulfill a requirement rather than get at the truth. As with many of the interview summaries I reviewed, the interviewers did not rely on open questions, silence and patience. They did not seek to develop a comprehensive understanding of the incident or follow up on details. Similarly, staff interviews during local inquiries are generally not recorded and are also much too short and superficial. They do not ask about the details of inmate allegations and appear designed primarily to exculpate staff. If I encountered staff or inmate interviews like these in my ongoing work reviewing use of force cases in the Los Angeles jails and in the San Bernardino jails, I would find them far below acceptable standards.

288. The issues in this case identified by Sgt. [redacted] and AW Armenta are valid and are not answered by the rejection by the CIU. Officer [redacted] could have and should have made more attempts at de-escalation and that was particularly true when Officer [redacted] was working with an inmate with developmental disabilities such as Mr. [redacted]

289. If Mr. [redacted] was ignoring direction, acting hostile and using obscenities toward Officer [redacted] Mr. [redacted] could have been handcuffed prior to searching him, as both Sgt. [redacted] and AW Armenta suggested. He was still compliant at that point. The other alternative, ignored in this investigation, would have been for Officer [redacted] to call for backup and wait for a second officer or a supervisor before initiating the search. Either of those courses of action would have maintained Officer safety far better than what Officer [redacted] chose to do.

290. That raises the other major question that is ignored in this case. If the staff reports are to be believed, Officer [redacted] called a "Code One", then sprayed Mr. [redacted] with OC, observed Mr. [redacted] wiping the chemical agent off his face and walking toward Officer [redacted] took Mr. [redacted] to the floor, got Mr. [redacted] into a handcuff position and,

as he was handcuffing Mr. [redacted] other staff arrived. That sequence of events is not impossible but it is unusual, given the location and that the unit was in the midst of a regular medication pass. Typically, other staff would have arrived more quickly to assist Officer [redacted] but no one inquired about that.

291. Some of the structural problems with these investigation reports are apparent in this case. With no standard format, there are 38 pages of various staff versions of events before there is any indication of Mr. [redacted]'s allegations of misconduct. The Investigation report is 116 pages in total but about half of that is 54 pages devoted to reproducing the Department's Developmental Disabilities program and its appendices.

7. Correctional Officer [redacted] [redacted] multiple complainants, S-RJD-219-17-R

292. This is not a single incident or a single appeal. When *Armstrong* class counsel toured RJD, they received numerous complaints about a particular Officer, Officer [redacted] The complaints were wide-ranging, from interference with medical services to threats and harassment to excessive force. Class counsel sent a report to the Department on May 26, 2017. That report included complaints against Officer [redacted] from 14 different inmates beginning in 2015, with each complaint based upon a different incident or set of circumstances. On July 14, 2017, the Deputy Commissioner of the Department, rather than the Warden at RJD, requested an OIA investigation of this Officer and noted that in addition to the complaint in class counsel's letter, there were another eight or ten complaints against that same Officer that were newer, but pending.

293. The complaints from 2015 and 2016 had all been reviewed or investigated locally, at RJD. None had gone to OIA. The result of these reviews and investigations was that none of the allegations against Officer [redacted] had been upheld. That is not surprising, particularly considering the abysmal quality of the institution-level investigations that I have reviewed in this matter and the amount of bias in favor of staff and against inmates.

294. The request for OIA to investigate was sent on July 14, 2017 and less than one month later, on August 9, 2017, OIA rejected the request and closed their file without any new investigation and without any consideration of the allegations that were then open and pending against that same Officer. The result is perhaps more disturbing than anything I have found from OIA in this matter. It cannot be assumed that an Officer is guilty simply because a large number of inmates make accusations. "Where there is smoke, there is fire" is not a basic tenet of staff accountability or staff discipline. However, that should be an extremely strong consideration in determining what is to be investigated and what is not. With many serious complaints against this Officer and with that pattern continuing, there is no question but that the department and the institution itself have a high priority need to verify that the many local investigations are arriving at the right answer. OIA is supposed to be the highest level of investigatory training and expertise within CDCR. It is the natural avenue for recourse if there is question about investigative results at the local level. OIA ignored all of this, and rejected this matter out of hand, doing nothing but collating the local allegations and investigations that had already been completed into a several hundred page file. In spite of the size of the file, OIA did not actually do anything. Their structural model for investigation should be something other than an electric stapler.

295. There is another facet to the multiple allegations and continuing pattern of allegations against Officer [redacted] That is perception. Even if Officer [redacted] had done nothing wrong, as the local investigations contended, and continued to do nothing wrong, it is obvious that the Officer has a highly negative reputation among the inmate population. It may be argued that that is why the complaints keep coming, because inmates are swayed by the negative reputation or want to capitalize upon it. Nevertheless, this is one of those situations where perception is, to some degree, reality. If the inmate population believes that Officer [redacted] is evil, but that he is being protected and supported by the administration at RJD, that can lead to an inmate disturbance. It can also be a staff safety issue, most obviously for Officer [redacted] himself, but also for staff

working around Officer [redacted] An inmate may need to go to protective custody because of a rumor about that inmate that has gained traction in the population. Even though the rumor may be without any foundation, it can still lead to an attack on that inmate. An Officer can be in an analogous situation. That is, even though managers and other staff may be convinced that the Officer is a good employee who treats inmates with respect, there is a point at which it may not make sense to maintain the Officer in the same position. A change in assignment may be called for and there are certainly other alternatives.

296. It is useful to see some of the complaints, allegations, grievances and appeals against Office [redacted] Please note that what follows is perhaps half of the complaints that had been received against Officer [redacted] at the time of the OIA rejection. Inmate [redacted] alleged that as he was walking across the yard to be interviewed, Officer [redacted] put his hand up with his forefinger out, as if it was a gun, pointed it at Mr. [redacted] and followed him, aiming the gun as Mr. [redacted] moved across the yard. Mr. [redacted] filed two complaints against Officer [redacted] In one, he said that as he was walking across the yard, Officer [redacted] subjected him to a search and without reason, took two necklaces and another possession from him. He also alleged that when Officer [redacted] searched him, he fondled his buttocks and made homophobic remarks. It is worth noting that during the local investigation of those complaints, no inmate witnesses were interviewed. If staff have a strong code of silence, and no inmates are interviewed or taken seriously, and there is no camera coverage over most of the institution, it will be very difficult to sustain any allegations of staff misconduct. Mr. [redacted] 602 complaint alleges that he was threatened by Officer [redacted] and that, more specifically, Officer [redacted] threatened to knock him out when Mr. [redacted] did not want to report to the medical clinic when he did not have an appointment. No witnesses were interviewed in that investigation. Mr. [redacted] filed a somewhat similar complaint alleging that he had been threatened by Officer [redacted] Mr. [redacted] alleged that Officer [redacted] slammed him to the ground, kicked him, then slammed his head into the ground three or four times,

and then left him with blood pooling on the ground. Mr. [redacted] is an inmate with gender identity issues. He filed a complaint stating that Officer [redacted] used gender slurs against him. Mr. [redacted] provided a rather detailed grievance that he had gone to the clinic and had to wait much longer than expected.. Because of his medical conditions and new medication, Mr. [redacted] has to urinate frequently. He asked the nurse for a plastic urinal, but was told that they did not have those in the clinic trailers and that he would have to return to his housing unit to use the bathroom. He went outside and urinated on the side of the trailer, and Officer [redacted] infracted him, citing sexual disorderly conduct. Mr. [redacted] also said that when he tried to talk to medical, Officer [redacted] would interrupt and tell medical staff, "he's faking it". Mr. [redacted] charged that Officer [redacted] who is African American, gave preference to black inmates. He also complained that Officer [redacted] interrupted him during medical appointments and contradicted him or made comments about him to the medical staff. Mr. [redacted] said that Officer [redacted] had animus toward him and asked at least one other inmate to tell other inmates that Mr. [redacted] was a child molester, with the goal of having other inmates assault Mr. [redacted] Mr. [redacted] filed a second complaint against Officer [redacted] alleging that Sgt. [redacted] and Officer [redacted] had set up a situation in order to threaten Mr. [redacted] Mr. [redacted]'s complaint states that Officer [redacted] along with other Officers, had threatened to kill him or have him killed. Mr. [redacted] also filed a second complaint against Officer [redacted] alleging that when Mr. [redacted] new wheelchair had arrived at RJD, Officer [redacted] had prevented him from switching out his old wheelchair for the new model. Evidently, Officer [redacted] was often assigned to the medical clinic because at least ten different inmates alleged that he created an a barrier to medical access and/or that he interfered with medical services.

297. Without a comprehensive, unbiased investigation, I cannot determine the veracity of any particular allegation against Officer [redacted] nor can I determine the lack of veracity of any particular allegation. What is obvious, however, are the unusual circumstances that cry out for OIA to conduct a rigorous, unbiased and comprehensive

investigation of Officer [redacted]'s conduct and attempt to arrive at a result that would be a valid basis for management decisions about the situation.

8. [redacted] incident December 16, 2018, S-RJD-129-19-R

298. On February 26, 2019 attorney Penny Godbold of Rosen Bien Galvan & Grunfeld, LLP, wrote to the CDCR Office of Legal Affairs to ask for an investigation into a complaint by Mr. [redacted] at RJD, namely that Officer [redacted] had sworn at him when Mr. [redacted] requested an ADA shower and that Officer [redacted] had also threatened that he would have Mr. [redacted] beaten if he filed a complaint against Officer [redacted] The letter noted that, according to Mr. [redacted] Officer [redacted] was continuing to harass him and there had been a sexual harassment incident on January 26, 2019. Ms. Godbold also stated that Officer [redacted] had been the subject of a number of other complaints of misconduct by inmates at RJD. According to the letter, there have been at least two occasions when Officer [redacted] was alleged to have employed other inmates to assault an inmate he wanted to punish. Ms. Godbold stressed the importance of protecting Mr. [redacted] from retaliation, citing an instance in which CDCR had been told by the same firm that an inmate [redacted] at RJD, did not want to be identified as providing information against staff, for fear of retaliation. That warning and Mr. [redacted] plea were ignored and he was interviewed in a manner that made it obvious he was talking to investigators. As a result, he and his cellmate were attacked by other inmates and stabbed multiple times. Mr. [redacted] was taken to the hospital in critical condition. Mr. [redacted] subsequently contested the Department's conclusion that this stabbing resulted from a gang situation and instead alleged that the stabbing had been arranged by Officer [redacted] who used phones and other incentives to get inmates to assault other inmates for him.

299. The Warden at RJD changed Officer [redacted] assignment so that he would not work at facility C, where Mr. [redacted] was housed, pending the outcome of an investigation. That was proper, but it took 10 days from the date of Ms. Godbold's letter, too long given the very serious nature of the allegations.

300. Warden Covello requested an OIA investigation on March 15, 2019. The OIA investigator found that Mr. [redacted] had reported the more recent, January 26, incident on the hot line and it was investigated as a sexual harassment complaint and Mr. [redacted] had been interviewed on January 29, 2019 by Sgt. [redacted] of the RJD ISU staff. The tape of that interview is not in the investigation file sent to Plaintiffs but Sgt. [redacted] summary of the interview says that Mr. [redacted] "admitted" that it was common for staff to use a flashlight to get the attention of inmates. Sgt. [redacted] also wrote that Mr. [redacted] "admitted" that Officer [redacted] had not made statements of a sexual nature. When Mr. [redacted] mentioned "my ADA shower", Sgt. [redacted] replied that that was an improper use of the term and that what Mr. [redacted] was doing was trying to get a worker shower. Sgt. [redacted] concluded that Mr. [redacted] was "disrespectful", had "an ulterior motive", was "trying to discredit Officer [redacted] and that his actions were "a blatant attempt to shower without permission." It would be difficult to design an interview in which bias was more pronounced or more consistent. It also underscores the conflict issues that arise when the person conducting the interview with the complainant is also the primary investigator and the person making a decision about the disposition of the case. It calls into question whether the ISU staff have had any training in interviewing or in investigation, and suggests that these cannot be the individuals assigned to investigate complaints of staff misconduct.

301. After the interview about the incident of January 26, 2019, Mr. [redacted] was asked to rescind what he had written as a PREA complaint, based on the investigator's conclusion that no sexual harassment had transpired. Mr. [redacted] complied with that request. The Department then did not use PREA protocols and did not report this as a PREA complaint. That is highly improper and violates the US Department of Justice procedures for PREA reporting.

302. In spite of a 293 page package that includes many duplications and documents of questionable relevance, the result of the attorney's letter about the December 16 incident was that OIA assigned an investigator who decided based on the other, January 26, incident that there was no need for an investigation. The investigator, [redacted],

then phoned Warden Covello and convinced him to withdraw the request for an OIA investigation, which he did.

303. Here, although Officer [redacted] had multiple serious prior complaints against him, the current complaint was dismissed without investigation largely because none of the prior complaints had been sustained. Since CDCR has no EWS and maintains no accessible database of these kinds of incidents, and since the investigative process is fraught with staff bias at every turn, the percentage of complaints that have been sustained is very small. Thus, when the criterion for taking a complaint seriously is " prior sustained complaints", the bias is carried forward and self-perpetuating.

304. OIA referred the case back for local inquiry, rather than a total, "no reasonable belief misconduct occurred" rejection. And yet, there is no indication that RJD conducted any follow-up inquiry as requested by OIA (Plaintiffs have told me that Defendants have represented that there was no further follow-up or second 989 referral). Thus, in most cases, OIA rejects referrals in a manner that closes out further inquiry. Here, where OIA sends the case back for local investigation, RJD still does nothing and the matter is over.

C. Cases Not Referred to OIA and Resolved at the Institution-level

1. [redacted] [redacted] Incident April 23, 2019, RJD-C-19-02534

305. Mr. [redacted] is an *Armstrong* class member and a *Coleman* class member. He has a bullet in his spine from serving in Iraq. He has a cane, a wheelchair for longer distances, a mobility-impaired vest and a hearing aid. He suffers from PTSD, depression, bipolar disorder and schizoaffective disorder, and he is on multiple psychotropic medications. He also suffers from cirrhosis of the liver, hepatitis C, seizures and COPD.

306. On April 23, 2019, an officer told him that he was being moved. Mr. [redacted] told Sgt. [redacted] that he had safety concerns on that unit and did not want to move there. He refused to move himself at staff's request, but said that he volunteered to cuff up. According to Mr. [redacted] staff declined that offer. He said that he was in his wheelchair with a Sergeant and eight Officers on the scene and that he was sprayed in the face with

OC. According to Mr. [redacted] he then collapsed on the ground and Officer [redacted] punched him in the face and then other officers hit and stomped and kicked him. He has a specific recollection of Officer [redacted] kicking him multiple times. Mr. [redacted] said that they put a spit mask on him to hide the fact that he was bleeding from his face and took him to the gym and put him in a holding cell for 35 minutes. He was not given any decontamination for the OC spray, and says that he then blacked out and woke up in the treatment and triage area. He told the medical staff that he had been assaulted by officers. He was sent to an outside hospital for a deep laceration on his lip, a head injury, abdominal trauma and more. Mr. [redacted] continues that he was returned to RJD from the hospital on April 27 and housed for three or four days without his leg braces, his wheelchair and his other approved mobility equipment. Some days after that, three Sergeants interviewed him for 10 or 15 minutes, which he described as not thorough. He was given an RVR for spitting on an officer in the gym, which he said did not happen. He emphasized that the spit mask had been placed on him prior to taking him to the gym, and that the spit mask did not come off until he was transferred to the outside hospital. When interviewed by the three Sergeants, Mr. [redacted] said that he had three broken ribs, an injury to his forehead, lacerations to his inner and outer lip, bruises on his head, and bruises on his right side, and that one of the lacerations on his lip had required a stitch. That is the substance of the Sergeants' summary of the interview with Mr. [redacted] which is consistent with his point that the interview was neither lengthy nor thorough.

307. Mr. [redacted]'s cellmate, Mr. [redacted], was interviewed four days later. The delay was not explained. Mr. [redacted] confirmed Mr. [redacted]'s version of events in detail. It does not appear from the record as though the interview with Mr. [redacted], or the interviews with other inmates, were audio or video recorded, but I cannot be certain of that because the investigative files are incomplete. Another inmate, Mr. [redacted] was interviewed and said that Mr. [redacted] is "a piece of shit. He got what he deserves". Mr. [redacted] said that he had been in his cell and saw nothing. The investigator ignores the inherent contradiction between "I saw nothing" and "he got what he deserved." Another inmate, Mr. [redacted]

also dislikes Mr. [redacted] and was interviewed. He said Mr. [redacted] moved toward the officers, and then they sprayed him and then they tackled him. Mr. [redacted] did not say that Mr. [redacted] threw punches at any of the officers. That is a key point in that an inmate hostile to Mr. [redacted] still provided an eyewitness description that stopped short of justification for a use of force. There was no follow-up. The investigator also did not ask why Mr. [redacted] with his mobility problems and his medical problems, would attack a relatively large group of officers.

308. There are other glaring omissions and inconsistencies in this investigation. The investigator should have sought more inmate witnesses. If there was a staff member and eight officers on scene when the incident occurred, or close to that number, those officers should have been interviewed. Except for attempting to negatively prejudice anyone reading the investigation about Mr. [redacted]'s charges, what could be the possible purpose of including a statement from another inmate saying that Mr. [redacted] was "a piece of shit" or that "he got what he deserved" when that inmate was not an eyewitness, and had no information about what transpired? On page 13 of the 21 page file, the investigator writes, "a review of [redacted] 837-C incident report confirms that CO [redacted] deployed one burst of OC for two seconds from four feet away as [redacted] lunged for CO [redacted] How does reviewing what an officer wrote in his incident report confirm that it is true? One of the incident reports says that it was necessary to punch Mr. [redacted] in the face. It does not say how many times he needed to be punched in the face and the investigator never inquired about that crucial aspect of the report in the incident. According to the officer reports, in total, there was one punch to the face, a knee on the lower back, and an officer with hands on Mr. [redacted]'s upper back to hold him on the ground. It is not clear how those three specific uses of force would cause three broken ribs but the investigator does not inquire about that either. The investigator again cites Mr. [redacted]'s disciplinary record. He also gives credence to Mr. [redacted] interview, which in small parts supported the officers, ignoring that Mr. [redacted] acknowledged that he disliked Mr. [redacted] However,

the investigator chooses to ignore Mr. [redacted]'s interview although he corroborated Mr. [redacted]'s version of events in detail, and had an up-close view of the initial interaction.

309. As for the officers who were interviewed, Officer [redacted]' report states that he observed Mr. [redacted] being escorted into the gym, and that Mr. [redacted] was wearing a spit hood. Officer [redacted] says that Mr. [redacted] spit on him but other staff testimony has Mr. [redacted] wearing a spit hood at that time. The investigator does nothing about this discrepancy and no one else reviewing the investigation ever asks. Sgt. [redacted] does state that after all this happened and the incident was essentially over, she then removed the spit mask from Mr. [redacted] This is another case where there is obvious plagiarism and neither the investigator nor anyone else reviewing his case either notices or comments upon that problem. Mr. [redacted]'s complaint describes a serious assault involving unnecessary and excessive force. Why, then, is the charge being investigated called "staff inefficiency"? Officer [redacted] report states that Mr. [redacted] kicked the cell door into Officer [redacted] foot, but provides no explanation for the injuries to both of the officers' forearms.

310. In this morass of investigative problems, one issue manages to stand out. There is a policy requirement that if a use of force incident involves "serious bodily injury" (SBI) then a video interview with the subject of the force must be completed within 48 hours. When the question was raised about why there was no video interview of Mr. [redacted] within 48 hours, the response was that three broken ribs do not qualify as a serious bodily injury. That is not true with regard to policy and it is not true with regard to common sense. The policy says that broken bones do constitute SBI. Here, RJD went so far as to solicit testimony from a nurse that three fractured ribs was not a serious injury. The investigator should have acknowledged in a straightforward fashion that it was simply a mistake that Mr. [redacted] was not given a video interview within 48 hours. Instead, the investigator tries to obscure the plain language of the requirement with testimony from a nurse who should have known better than to misinterpret the Department's policy on this subject. If the Department is unable to properly classify what is and what is not SBI, then

it follows that with the new AIMS structure, many serious use of force cases that should go to AIMS will not.

311. The result of this case was that there were no findings sustained and no discipline imposed against any staff member.

2. [redacted] [redacted] incident February 6, 2018, RJD-B-18-01310

312. Mr. [redacted] alleges that he had enemies at RJD and was transferred there against his will. He said he was put in segregation housing, told that his claim of enemies was unsubstantiated, and given an infraction for refusing to go to the yard. His complaint continues that Capt. [redacted] decided he had to go to the yard and sent Officer [redacted] to his cell. He was threatened by the Officer. A week later Capt. [redacted] a Lieutenant and a Sergeant came to his cell and called him names for refusing recreation and then sent Officer [redacted] who is large and according to Mr. [redacted] has a history of beating inmates, to his cell to threaten him again. Out of fear, Mr. [redacted] went to the yard and was told that if he could identify his enemy, he would be returned to some form of protective housing. He did, and the Sgt. on the yard told him he would not go back to general population and he was put in a cage in the gym. He was left there unattended for four hours and had to use a milk carton to urinate. He alleges he was then threatened with an assault charge, pepper sprayed, handcuffed and badly beaten, and that the beating resulted in three broken ribs. He said he was taken to Mercy Hospital in the middle of the night and that is where they found three broken ribs.

313. This case file is nothing short of a travesty. Mr. [redacted] charges are specific but the sum total of the inquiry and the appeal is 25 pages and almost all of that is the initial complaint and then follow-up medical requests from Mr. [redacted] He was interviewed by Lt. [redacted] almost a month after his complaint and, for all the detail in the complaint, the only summary of the interview is that Mr. [redacted] had no new information and could not support his allegations with any evidence. The only other information in the file is that Officer [redacted] and Capt. [redacted] were interviewed and either didn't remember or

denied the accusations; and that a medical evaluation of Mr. [redacted] following the use of force found a few abrasions and/or reddened areas on his torso.

314. The use of force and incident reports from Officers are missing from the file. The medical evaluation is missing from the file. The infraction for assault is missing and it is never explained whom Mr. [redacted] assaulted, and under what conditions. Was he sent to Mercy Hospital in the middle of the night, as he claimed? That would have been easy enough to verify, but there is nothing. Did he receive three broken ribs as a result of the use of force? There is no discussion, analysis or even mention of the issue.

315. The conclusion of the complaint inquiry and the second level appeal is "the appeal is partially granted", and "staff did not violate CDCR policy". Neither of those make particular sense.

316. It is not clear whether most of the record in this case was withheld because it reflects staff culpability or whether CDCR is actually unable to assemble the relevant records in response to a detailed and specific inmate complaint about staff misconduct and unnecessary/excessive staff use of force. Neither alternative bodes well for inmate safety in CDCR.

317. Mr. [redacted] filed a second complaint several months later alleging that he was beaten by staff on July 22, 2018. He pursued that complaint to the third level. It was reviewed by IERC. The result of the case was to dismiss it based on inconsistencies in the complaint leading to a conclusion that Mr. [redacted] was not being truthful. In this second case, again, there is little of substance and obviously relevant—even central—documents are not included.

318. The case records produced by CDCR in both of Mr. [redacted] complaints render review and accountability impossible.

3. [redacted] Incident August 21, 2018, RJD-C-18-05678

319. Mr. [redacted] is mobility impaired and uses a walker. He is restricted to a bottom bunk and has an order for front handcuffing. He suffers from serious depression

and is sometimes psychotic. In addition, he is high risk with several serious medical disorders.

320. On August 21, 2018, Mr. [redacted] was notified to pick up legal mail. When he got to the mail office, he found a heavy carton from his attorney. He asked why they had not sent it to his housing unit. Officer [redacted] was on scene and refused to carry it for him. There was a verbal altercation and Officer [redacted] according to Mr. [redacted] swore at him and called him, "crippled motherfucker". Mr. [redacted] alleged that Officer [redacted] then pepper-sprayed him, hit him in the face with the OC canister, kicked him in his ribs and stomped on his face, breaking his glasses. For his part, Officer [redacted] wrote in his report that he used OC because Mr. [redacted] had spit on him, hitting him in the arm and face.

321. Officer [redacted] gave Mr. [redacted] an RVR for assaulting a staff member and Mr. [redacted] was found guilty and sent to the SHU.

322. This case was not referred to OIA and a local inquiry was conducted. On September 15, 2018. Officer [redacted] was interviewed by [redacted] (no rank shown) and Officer [redacted] described Mr. [redacted] as swearing at him, then spitting on him and then advancing toward him with fists clenched. At that point, Officer [redacted] reported that he used OC spray but without results. He said that he pushed Mr. [redacted] to the ground and told him to stay down but Mr. [redacted] got up and began advancing again toward the Officer. Officer [redacted] then sprayed Mr. [redacted] again with OC but again with negative results. Officer [redacted] again pushed or knocked Mr. [redacted] to the ground and then was able to hold him down and handcuff him. He called a Code One at that point. Officer [redacted] used the PA system to order all inmates on the yard to get down and they complied.

323. This case is a mystery in many ways. The interviewer, [redacted] does not submit a report until April 17, 2019, more than seven months after he interviewed Officer [redacted] For that interview, and conclusions drawn by Mr. [redacted] there is almost nothing in the file. If Mr. [redacted] relied upon the use of force report written by Officer [redacted] he does not mention it in his investigation report nor is it included in the file. Similarly, the

RVR given to Mr. [redacted] is not in the file. Mr. [redacted] in drawing conclusions, relies in part upon the medical evaluation conducted on Mr. [redacted] after the incident in question, but that evaluation itself is not in the file. Mr. [redacted] report also says that he based his conclusions in part upon "… and the collective interviews with all involved custody staff". What interviews with all involved custody staff? There is nothing in the file mentioning an interview with Officer [redacted] with any staff present in the mail office, or with any other staff. There is also no mention anywhere in the file of any interview with Mr. [redacted]

324. Mr. [redacted] who signs as the interviewer but who actually should be called the investigator because he draws conclusions and makes recommendations—relies in part on the medical evaluation of Mr. [redacted] which cannot be reviewed because it is not in the file. However, Mr. [redacted] notes that it shows no facial injury consistent with Mr. [redacted] having been hit in the face with Officer [redacted] OC canister. That is the point Mr. [redacted] emphasizes in his conclusion that Mr. [redacted] allegations are invented and without merit. However, there are two other aspects of the medical evaluation that do not support Officer [redacted] version of events. Mr. [redacted] has a reddened area at his right rib cage, consistent with the assault he described from Officer [redacted] but inconsistent with the force that Officer [redacted] claims he used. Also, there is no mention in the medical report of the results of Mr. [redacted] being sprayed twice with OC from a Mark-9 canister for three seconds each time at a distance of four feet and six feet. There is also no mention by Officer [redacted] or in any other fashion of decontamination procedures for Mr. [redacted] Mr. [redacted] report ends with a conclusion that his complaint is completely false with the intent of defrauding the state of monetary damages, and Mr. [redacted] recommendation that Mr. [redacted] be disciplined for a false complaint.

325. The finding after this institution-level investigation was that there had been no violation of department policy and procedure but a recommendation for non-disciplinary corrective action, sending Officer [redacted] to training. It is not explained why Officer [redacted] needs corrective training if he did nothing wrong. Other information

suggests that after this, Officer [redacted] was terminated for off-duty conduct unrelated to this case.

326. In his appeal, Mr. [redacted] astutely asks why there was no photo taken of the spit allegedly on Officer [redacted] face and no swab taken from his face or his arm.

327. This is a shockingly bad investigation. It is strongly biased, it is incomplete, it is not timely and it was conducted incompetently. There are no inmate witnesses or attempts to identify inmate witnesses. Only Officer [redacted] is identified as a potential staff witness and there is no indication that he was interviewed. Without inmate witnesses, inmate interviews, an interview with the subject of the use of force, staff witnesses, staff interviews and a medical evaluation, there is almost nothing here. It is cases like these that suggest that OIA must be much superior to institution-level investigations but the OIA review and acceptance procedure and their investigations themselves have been almost equally unacceptable.

4. [redacted] [redacted] Incident May 18, 2016, RJD-C-16-02152

328. [redacted] [redacted] is a developmentally disabled inmate (DD2) who also suffers from Alzheimer's. He filed a complaint stating that on May 18, 2016, he was on the yard carrying his laundry bag when Officer [redacted] took the laundry bag, looked through it and then dumped it on the ground. Mr. [redacted] objected and asked for the Officer's name but the Officer continued to walk away. Mr. [redacted] alleged that he then approached Sgt. [redacted] asking him for the Officer's name. When Sgt. [redacted] did not respond, Mr. [redacted] walked after Officer [redacted] who turned around and sprayed Mr. [redacted] with OC.

329. Officer [redacted] wrote a use of force report stating that he confiscated the laundry bag because it was a plastic garbage bag, which was improper. He said that Mr. [redacted] yelled at him and then advanced toward him aggressively, with his arms raised and his hands balled into fists. According to the incident report, when Mr. [redacted] continued to advance in spite of verbal direction to stop, Officer [redacted] used OC spray.

330. Lt. [redacted] was assigned as the interviewer but that term is deceptive because he is really the investigator, drawing conclusions and making decisions. Sgt. [redacted] was interviewed and said that he did not see the situation until after the use of force. Four inmate witnesses were identified and interviewed. The first two interviews corroborated Mr. [redacted]'s version of events exactly. The third inmate interviewed also corroborated the allegations with one exception. Instead of saying that the Officer put or threw the inmate's clothes on the ground, he said the Officer through them against a wall. Otherwise, his version of events matched the inmate allegations and the first two inmates interviewed. The fourth inmate interviewed did not describe the situation leading to the use of force but did see the Officer spray the inmate.

331. The third inmate interviewed, Mr. [redacted], contradicted Sgt. [redacted] and said that the Sgt. was behind Officer [redacted] when he sprayed Mr. [redacted] That is also consistent with Mr. [redacted]'s allegations but is ignored by the investigator.

332. The investigator, Lt. [redacted] concluded "There is no indication that staff used excessive or unnecessary force in this matter." He went on to explain, "With consideration to the four inmate witness interviews, it became very apparent during the interview process that the inmates' actual account of the events varied greatly. … in an attempt to validate their accounts of the events that transpired, the witnesses made significant statements that contradicted one another. Therefore, due to their own conflicting statements, their individual accounts of events were considered not reliable or accurate by this interviewer." This is an extraordinary exercise in pure bias. The reality is multiple eyewitnesses almost never agree exactly. The first three inmates interviewed were unusually consistent and clearly corroborated Mr. [redacted]'s allegations. The Lt. conducting the investigation chose to disqualify those three witnesses without any basis.

333. It is noteworthy that this is one of a large number of cases in which staff describe an inmate walking toward the staff member aggressively but never reaching the staff member in time to throw a punch, and in which the staff member is able to take the

aggressive inmate to the ground. It is certainly not unheard of for an inmate to walk toward a staff member or a group of staff aggressively, as if the inmate wants to start a fight, but it is certainly not common. Most inmates know that they will get the worst of such an encounter, in addition to time in segregation and perhaps more serious consequences. Unfortunately, neither the incident reports or the medical reports document the size of the inmates involved. Certainly, some inmates are large and some are very capable physically. However, a disproportionate number of correctional Officers are large and/or physically capable, further discouraging many inmates from initiating a physical confrontation. That is particularly true in Facility C at RJD where many of the inmates have combinations of physical disabilities and serious medical or mental health problems.

334. The final note on this case is that Officer [redacted] is one of the individuals at RJD with the highest number of complaints/grievances lodged against him. The Department's failure to keep records of that sort in any form of accessible database combined with the CDCR failure to use any kind of EWS, means that every grievance or complaint against Officer [redacted] must be investigated in a vacuum, without regard to any pattern of behavior that may be obvious.

5. [redacted] [redacted] Incident April 21, 2018, RJD-A-18-2814

335. This incident did not result in serious injury and did not reach the OIA level. The case record is not voluminous. Nevertheless, this case is an excellent example of many of the serious problems with the CDCR system.

336. Mr. [redacted] alleged that as he was returning his cell in his wheelchair, the female Officer working the tower closed his cell door too quickly, knocking his wheelchair over and knocking him to the ground. His complaint states that he had back pain and elevated blood pressure, that staff called "man down" and took him to medical but that medical did no x-ray or MRI.

337. The Warden received Mr. [redacted]'s letter of complaint on April 26. The Warden later wrote Mr. [redacted] was properly interviewed within 48 hours of his complaint. In reality, that interview took place on June 8, some six weeks after the incident and the

complaint. In the cases I reviewed, it was common for inmates to be interviewed weeks or months after the incident giving rise to the complaint or grievance. It is consensually accepted that the longer the time lapse between an incident and the interview about that incident, the less accurate the information in the interview and the fewer details that will be remembered. Even 48 hours is a poor standard for video interviews after a use of force incident. The standard should be "as soon as possible" and there is no reason most video interviews should not be conducted within two hours of the incident itself.

338. I did not have access to the video interview of Mr. [redacted] on June 8. Reviewing that interview would have been important for this analysis. According to the interviewer (a Sergreant whose signature is not legible and whose name is not typed, another basic but chronic problem), Mr. [redacted] chose to withdraw his complaint, stating "I just don't want any staff member to be closing the doors on me." According to the investigator, Mr. [redacted] also said that an inmate on the yard had helped him write the complaint, for financial gain. It is not clear whether the "for financial gain" is what Mr. [redacted] said or whether it is the investigator's conclusion. The fact that another inmate helped Mr. [redacted] prepare his complaint is not a factor that should have been considered to determine whether the complaint had merit.

339. The problem with this investigation is that there is no "there" there. When Mr. [redacted] appealed the initial decision that his complaint was without merit, he was then interviewed and in agreeing to drop his complaint, his comment clearly indicated that he continued to believe that his cell door had been shut too quickly, intentionally. Since complaints at RJD from mobility impaired inmates in wheelchairs and walkers about staff intentionally opening and shutting cell doors without the allowing adequate time for the ingress or egress of disabled individuals had been frequent and long-standing, the matter should not have been dropped. If management cared about these kinds of issues, they would have directed that this investigation continue whether the inmate dropped his appeal or not.

340. In the more than three months between the initial inmate complaint and the closing this case, the staff member identified by Mr. [redacted] as intentionally closing his cell door on him was never asked about the incident. No attempt was made to determine if there were inmate witnesses. When Mr. [redacted] was initially discovered by staff and taken to medical after he fell from his wheelchair, it would have been important to talk with those staff to see if Mr. [redacted] had told them either "I fell" or "she closed the door on me". That immediate reaction from Mr. [redacted] would have been important in trying to sort out what actually happened. These kinds of investigative procedures are not subtle and they are not technical. These are issues that are obvious to everyone in the audience when a mystery is on television. The bigger mystery is why they do not occur to CDCR investigators and why management reviewers, refuse to recognize them.

341. The investigator concluded "This interviewer deems the appellant's complaint unfounded and without merit." That conclusion is unjustified. Since almost no investigation was conducted, the investigator cannot know whether the complaint had merit. Since there is a medical record from April 21, it does appear Mr. [redacted] fell out of his wheelchair. The investigator found out exactly nothing about how that fall occurred.

342. The investigator concludes with: "It is inconclusive if the appellant knowingly or maliciously submitted the appeal as a false allegation against this Officer." That is part of a pattern of emphasizing potential penalties for filing false allegations, creating a climate in which inmates are afraid to grieve or complain.

343. The IERC concurred that the inmate allegations had no merit. That is stunning because it demonstrates that at what is supposed to be the highest institutional level, there is no understanding of the difference between "unsubstantiated" and "proven false". In this case, it is accurate to say Mr. [redacted]'s allegations were not substantiated (that is, were not proven) but it is fundamentally wrong, and false, to say that it was established that they had no merit.

6. [redacted] [redacted] Incident May 17, 2019, RJD-A-19-03144

344. Mr. [redacted] filed a complaint alleging Officer [redacted] swore at him and made racial remarks to him. In addition, he said that Officer [redacted] refused to let him out in time for his work assignments. Mr. [redacted] was interviewed on August 22, three months after the incident. The investigator interviewed two other staff and two inmates who, like Mr. [redacted] were inmate workers. The two inmates had not seen any incident and said they had not seen Officer [redacted] act unprofessionally. The investigator did not note that inmate workers are often reluctant to say anything against staff for fear of losing their jobs. The two staff members were asked whether they had seen Officer [redacted] act unprofessionally and both said they had not. The investigator did not say whether the interviews with staff were by phone or in person.

345. Up to this point, the investigation seems reasonable. With no force and no injuries, it can be difficult or impossible to sort out an allegation of this sort without eyewitnesses. However, rather than follow established investigatory procedures (perhaps checking the record to see whether Mr. [redacted] had been late to his work assignments, which would be expected if Officer [redacted] had been delaying him), the investigator devolves into bias. While mentioning that Mr. [redacted] had a four month work history of consistent attendance and no negatives, the investigator emphasized that Mr. [redacted] had three disciplinary infractions, but did not say over what time period. He concluded that Mr. [redacted] had "a history of disruptive behavior toward staff and inmates". There is no comparable review of Officer [redacted] disciplinary history.

346. The investigator then states that while Officer [redacted] is in the workplace, "she conducts herself in a manner that is consistent with policy and procedure and takes necessary steps to ensure she has done everything possible to maintain an appropriate working environment". He could not know that nor is there anything in the investigative report that would lead to that conclusion. It is as pure a statement of bias as I have encountered.

347. The response to Mr. [redacted] said "Appeal partially granted". Many inmates, and many other people, would understand that to mean that the allegations were sustained in part. In turn, that might lead some complainants to decline to appeal to the second or third level, failing to exhaust their administrative remedies. The response also said "staff did not violate CDCR policy", which is both the real answer to the inmate complainant, and a wrong conclusion. The appropriate conclusion would have been "we were unable to determine the validity of your allegations".

7. [redacted] [redacted] Incident February 4, 2018, RJD-A-18-01338

348. Mr. [redacted] filed a complaint stating that on February 4, 2018, two Officers searched his cell in a disrespectful manner, leaving it trashed, and failing to give him a receipt for his property when requested. The complaint was dismissed on the basis Mr. [redacted] failed to demonstrate substantial harm to his welfare. Mr. [redacted] filed a second level appeal. He got a second letter in May, 2018 reiterating that he had failed to establish substantial harm to his welfare. In spite of that, an investigator was assigned and Mr. [redacted] was interviewed at the end of May and again in mid-August. The interviews are characterized as Mr. [redacted] failing to produce evidence that his cell had been "trashed".

349. This case makes little sense. It was handled entirely at the institution level. There is, essentially, no investigation and almost nothing in the case file. There is no attempt to determine if the records reflect that Mr. [redacted] cell was searched on the day in question. The staff accused were not interviewed. Inmates in nearby cells were not interviewed. The length of time between the alleged incident and the initial interview of Mr. [redacted] makes it unlikely that the incident, if it happened, could be reasonably investigated.

350. There is a suggestion in the case record that the investigator assigned, Sgt. [redacted], addressed some of these issues in the Appeal Log, but there is no copy of that log in the case record.

351. It is not clear why unprofessional behavior, such as "trashing" a cell during a search, is not proper grounds for a staff misconduct grievance but unprofessional behavior, such as using racial slurs against an inmate, does constitute proper grounds.

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 Campbell, California this 1st day of June, 2020.

Jeffrey A. Schwartz, Ph.D.

APPENDIX A

Jeffrey A. Schwartz, Ph.D.

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SUMMARY

Thirty years experience in criminal justice management coupled with a psychology Ph.D. in research methodology. Detailed, hands-on experience with police, prisons, jails, community corrections; adult and juvenile; local, state, federal and foreign correction agencies. Development of innovative training programs and new approaches to training methodology. Planning for "turnaround management" and culture change in troubled institutions and agencies.

PROFESSIONAL EXPERIENCE

LETRA, Inc., Campbell, CA (1972 - present), A non-profit training and research organization, serving criminal justice and other governmental agencies, business and industry.

Founder and Chief Executive Officer:
All phases of corporate and fiscal management, supervision of professional staff, consultants. Policy development and procedures for emergency preparedness, use of force and conflict resolution. Design of new training programs and training of trainers.

RICHMOND POLICE DEPARTMENT, Richmond, CA (1968-1976)

Administrative Consultant to the Chief of Police:
Organizational development, research, program evaluation, new training programs and grants. Developed first generalist police crisis intervention training program in the U.S.. Planned and organized innovative department-wide juvenile diversion project, used as state model. National research on female and minority employment in policing.

PALO ALTO VETERAN'S HOSPITAL, Palo Alto, CA (1969-1971)

Chief of Program Evaluation Unit:
Founded, organized and managed new applied research unit in large medical/psychiatric teaching hospital. Developed research and statistical strategies for evaluating effectiveness of clinical programs. Served on Hospital Director's Executive staff.

EDUCATION

1960-1964	Western Reserve University	B.A. Chemistry and English Literature.
1964-1965	Toledo University	Graduate work: Psychology
1965-1968	Denver University	M.A. & Ph.D. Experimental Psychology (Research Methods, Learning, Statistics)
1968-1969	Palo Alto Veteran's Hospital	Internship: Clinical and Community Psychology

CORRECTIONS EXPERIENCE (representative sample)

National Institute of Corrections: Thirty years experience working with NIC. Conducted two large national management training programs over three years. Developed original curriculum, innovative training methodology, trained 500 managers from all areas of corrections from all 50 states in a residential 7-day, intense corrections-specific management skills training program. Administrated all aspects of these projects. Project Director for more than 10 major NIC grants / cooperative agreements; technical expert on more than 25 NIC technical assistance projects from all four NIC operating Divisions; authored 3 book length NIC publications. Helped plan new NIC courses and evaluated NIC operating procedures.

Shelby County, TN (Memphis) Jail: Comprehensive operational review of deeply troubled large jail system after Federal Court found the county in contempt of all five major elements of consent decree (2000). Developed plan to cure contempt findings, drafted response to Civil Rights Division of US DOJ to avoid second1983 suit, worked on transformation of jail to direct supervision and on population management, use of force, inmate grievance system, management training and practices. Achieved discharge from Federal Court supervision in 2005 and from DOJ supervision in 2009.

California Youth Authority (CYA): The development of Conflict Management and Crisis Intervention procedures in all Youth Authority institutions; training and procedures for the management of hostage situations; training of trainers. LETRA's Crisis Intervention training program has been required by policy of all CYA institutional staff and in use for over 15 years, and LETRA's Emergency Preparedness course was in use state-wide for over ten years.

Montana Department of Corrections (DOC): After the maximum security unit riot and hostage situation at the Montana State Prison in Deer Lodge, in 1991, selected by NIC to head the seven person Administrative Inquiry Team commissioned to investigate the events leading to and surrounding the riot. Coordinated the writing of the Inquiry Team Final Report ("Riot at Max") and managed extensive media contacts for the Inquiry Team.

Michigan DOC, Hawaii DOC, Alaska DOC: Initiated state-wide training programs in each state on institutional crisis intervention. All three State DOC's continued to provide this training to all or almost all institution staff for many years.

Pennsylvania DOC: After Camp Hill riots, conducted assessment of Department's emergency response capacity, developed plan to increase preparedness including recommendations for specialized equipment, staff, etc. Conducted administrative policy seminar, tailored emergency training curriculum to department's needs, trained cadre of mid-managers to deliver emergency preparedness training at all 16 institutions to both management and line/supervisory staff and developed format for new institutional emergency plans.

Nebraska, Iowa, Wyoming, Oregon, Kentucky, North Carolina, Missouri, Kansas, Florida, Delaware, North Dakota, Hawaii, Nevada, Arkansas, Vermont and New Hampshire DOC's, the Omaha, Jacksonville, Greenville and Boise jail systems: Emergency Preparedness. Typically began with security analysis and evaluation of existing emergency plans and procedures, review of emergency policies, leading to adaptation of LETRA's detailed, comprehensive and generic ("all risk") emergency system. Provided Emergency Preparedness training for all staff at all institutions on new emergency system by training and certifying department instructors.

Hawaii DOC: Created new Use of Force policy, then developed curriculum to train all staff to new policy. Prepared Department staff as instructors so Department would be self-sufficient. Achieved substantial reduction in allegations of improper use of force. Similarly adapted LETRA's model use of force policy and training for state DOC's in Oregon, New Mexico, Shelby Co. Jail.

Correctional Services of Canada: Crisis Intervention and Conflict Resolution work at Stony Mountain Penitentiary following riot and murder of two staff members. Developed Conflict Resolution program (in English and French) for all Regions of Penitentiary Service. Revised and expanded emergency policies governing crisis management at all Federal institutions in Canada.

POLICE CONSULTATION EXPERIENCE (representative sample)

FBI National Academy, Quantico, Virginia: Presented two seminars on Domestic Crisis Intervention to police executives from largest 50 police departments in U.S. LETRA was the first outside group (non-FBI) to be invited to present an entire course at the FBI Academy.

Richmond, California, Police Department: Developed new 40-hour training program for generalist patrol officers on child and juvenile issues. Course ranged from gangs to drug abuse to battered and neglected children. All uniformed officers and detective trained within one calendar year.

Sacramento, California, Police Department and Sheriff's Office: Long-term project to train trainers in Crisis Intervention. Over 1500 patrol officers trained in LETRA's Domestic Crisis Intervention during an 18 month period. Evaluation showed 40% reduction of officer injuries, reduction in time spent on disputes. Similar projects in Rochester, NY; San Jose, CA; and other police agencies.

COLLEGE/UNIVERSITY TEACHING EXPERIENCE

Denver University, San Francisco State University, San Jose City College, University of California at Santa Cruz, Guest Lecturer at Stanford Law School. Psychology courses taught: Learning, Theory of Measurement, Educational Psychology, Introductory Statistics. Criminal justice courses: Correctional Management, Police Supervisory Training, Training for Trainers, etc.

EXPERT WITNESS (Plaintiff and defense-side experience)

Use of Force (Police and Corrections); Operation of Correctional Facilities; Failure to Protect (Staff Sexual Misconduct with Offenders; Suicide; etc.); Emergency Preparedness and Emergency Response (Prisons and Jails); Crisis Intervention (Police, Probation, Parole, Jails and Prisons)

Currently a Federal Court Monitor On a Los Angeles Jails class action consent decree on use of force; also Federal Court Monitor, use of force consent decree, San Bernardino County Jails.

Class Action and related cases: Corrections expert in class action by Southern Poverty Law Center and Special Litigation Section of DOJ resulting in 2013 Consent Decree against New Orleans Jails; Corrections expert for Manhattan U.S. Attorney's Office in CRIPA investigation of adolescent conditions, Rikers Island; Invited testimony before Citizens' Commission on Jail Violence (CCJV), Los Angeles Jails; Federal Court security expert, consent decree on conditions, Virgin Islands Jails;

CRITICAL INCIDENT REVIEWS ("after-action reports")

Camp Hill (PA) riots; Hurricanes Katrina and Rita and the LA DOC; Hostage taking at Delaware Correctional Center; "Riot at Max" at Montana State Prism; Wyoming Penitentiary carbon monoxide poisonings; Southern Ohio Correctional Facility (Lucasville) riot.

AWARDS, PUBLICATIONS AND INVITED ADDRESSES

NDEA Fellow in Graduate Psychology. Presented invited addresses at ACA, APPA, AJA, CPPCA, IACP meetings, State Correctional Associations. Published numerous articles and chapters on corrections, research methodology, police science and psychology. Authored or co-authored more than 15 training texts, three book length NIC publications early NIC programmed learning course.

PROFESSIONAL ORGANIZATIONS (current and former)

American Correctional Association; American Probation and Parole Association; American Jail Association; California Probation, Parole and Corrections Association; American Psychological Association; International Association of Chiefs of Police

COMMUNITY INVOLVEMENT

Elected Trustee, West Valley-Mission Community College District, three terms. Served as President of Governing Board 1984-85 and 2005-2006. The District serves over 25,000 students, with more than 1000 employees and a budget of over $100 million dollars per year.

Member, Bd. of Directors, former President of large homeowners' association in Saratoga, CA.

Vice Chair, Board of Directors (1988 - 1995), Women's Housing Connection, which was the only homeless shelter in Santa Clara County exclusively for women and women with young children.

Co-founder and Director (1986-2009), Visa Technologies (later Momar Industries), a computer supply and flexible packaging company with over $10M in sales, annually.

Volunteer Mediator, Child Find, Inc., A national organization that attempts to locate missing children, reconcile run-away children and juveniles with their families, and prevent child abduction.

ADDITIONAL SKILLS AND EXPERIENCE

Budget and Personnel Management: As President of a College Board of Trustees, oversaw a budget in excess of $100M/year with approximately 1000 professional and support staff. Oversaw private corporate budget (Visa Technologies) in excess of $10M/year with 65 employees. Extensive experience teaching leadership development, personnel administration, budget and fiscal control and other management topics to criminal justice managers.

Media Relations and Public Speaking: Extensive media experience in community activities as well as with criminal justice work. Frequent public speaking in a wide variety of contexts.

Legislative Liaison and Policy Analysis: Substantial experience working with local legislative delegations, testifying before legislation bodies, analyzing and drafting policy and regulations.

Special Consultant to the California Assembly: (1) Investigation and hearings leading to resignation of Insurance Commissioner Charles Quackenbush. (2) Investigation and hearings on the state of California contract for Oracle software.

APPENDIX B

Jeffrey A. Schwartz, Ph.D.

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LIST OF CASES (May 28, 2019)

Case Name & Number	Court	Retained By	Summary of Case	Disposition	Participation
Piszker v. Wackenhut Corrections and Raymond Andrews Case No. 97-16397	Court of Common Pleas Delaware County Civil Trial Division	Defense Sean Halpin @ Reed Smith Shaw & McClay 2500 One Liberty Plaza 1650 Market St. Philadelphia, PA 19103 Office: 215-851-8100	Couple sued private corporation running Delaware County Jail for injuries received from an inmate who had escaped from the jail.	Case settled.	Wrote report.
Mahar v. City of Reed City, et al. Case No. 1:98CV178	U.S. District Court Western District of Michigan, Southern Division	Plaintiffs Diane Goller Dilley, Murkowski & Goller, PLLC 1000 Trust Building 40 Pearl Street, NW Grand Rapids, MI 49503 Office: 616-4598383	Resident sued Reed City Police Department for unlawful arrest resulting in injuries. Arrest was made pursuant to a littering citation.	Case settled.	Wrote report, deposed.
Gonzalez v. New Mexico Department of Corrections, et al.	13th Judicial District Court, County of Valencia, New Mexico	Defense Timothy S. Hale Riley, Shane & Hale 4101 Indian School Rd. NE Albuquerque, NM 87110 Office: 505-883-5030	Correctional officer sued State Department of Corrections for injuries resulting from his participation in an emergency preparedness drill.	Ruling for Defense.	Wrote report.
Jeffers v. James Gomez, et al. Case No. CIV S-97-1335	U.S. District Court Eastern District	Plaintiff John Houston Scott The Scott Law Firm 1375 Sutter Suite 222 San Francisco, Ca 94109 Office: 415-561-9600	Inmate shot during disturbance at new Folsom Prison, CA DOC.	Case settled.	Wrote report.
Leitner v. Santa Clara County		Defense Doug Allen	Personnel Board disciplinary action against staff over death of mentally disturbed inmate in County Jail.	Judgment for Defense.	Reviewed records and videotapes, consulted with Defense attorneys, wrote report.

Case Name & Number	Court	Retained By	Summary of Case	Disposition	Participation
White v. City of Big Rapids, MI, et al. Case No. 1:94-CV-296	U.S. District Court Western District of Michigan, Southern Division	Plaintiffs Dianne Goller Dilley, Murkwski & Goller, PLLC 1000 Trust Building 40 Pearl St. NW Grand Rapids, MI 49503 Office: 616-459-8383	Plaintiffs sued City of Big Rapids MI, a public safety director and two police officers for unlawful arrest, excessive force and civil rights violations because of a broken arm and other injuries that plaintiff sustained pursuant to a police traffic stop.	Case settled.	Wrote report, deposed.
Sandoval v. Terhune, et al. Case No. C99-20027	U.S. District Court Northern Division	Plaintiffs Lawrence Knapp 215 Dorris Plaza Stockton, CA 95204 Office: 209-946-4440	Inmate shot by CA Department of Corrections officer during an altercation among inmates in recreation yard.	Case settled.	Review of documents.
Ford v. Terhune, et al. Case No. CIVS991234	U.S. District Court Eastern District	Plaintiff John Houston Scott The Scott Law Firm 1375 Sutter Suite 222 San Francisco, CA 94109 Office: 415-561-9600	Gay inmate attacked and killed by cellmate in maximum security mental health unit.	Case settled.	Reviewed documents, wrote report.
Klink v. City of Newman, et al. Case No. F-99-6360	U.S. District Court Eastern District Fresno Division	Plaintiff Jeff Klink 9976 Falcon Meadow Dr. Elk Grove, CA 95624 Office: 916-686-1488	Mentally disturbed individual, on amphetamines, shot and killed by Newman policy officer while threatening officer with a shovel.	Case settled.	Reviewed documents, wrote report.
Perez v. Terhune, et al. Case No. C99-20117	U.S. District Court Eastern District San Jose Division	Plaintiff John Houston Scott The Scott Law Firm 1375 Sutter Suite 222 San Francisco, CA 94109 Office: 415-561-9600	Inmate shot by correctional officer during fight with another inmate on Administrative Segregation exercise yard at Salinas Valley State Prison, CA.	Case settled.	Reviewed documents, wrote report.
Little v. Shelby County. Case No. 96-252-M1A	U.S. Federal District Court. Western District	Defense Shelby County (Memphis) Kathleen Spruill Shelby County Attorney's Office Donnie Wilson, Chief County Attorney	1983 conditions of confinement case focusing on inmate on inmate violence in county jail. Consent decree entered 1997, county found in contempt 12/00.	Defendants released from court supervision in 2005.	Hired 03/01 as consultant to assist county in improving jail conditions, meeting terms of consent decree. Testified in court as expert for county. Then served as Court expert.

Case Name & Number	Court	Retained By	Summary of Case	Disposition	Participation
Torrez v. Terhune Case No. 02AS00716	Superior Court of the State of California IN and for County of Sacramento	Plaintiff Roger Naghash 4400 Mac Arthur Blvd. Suite 900 Newport Beach, CA 92660 Office: 9499955-1000	Shooting death of inmate Torrez during a fight between Hispanic and Asian inmates at High Desert State Prison.	Case settled	Reviewed documents, wrote report.
Mack v. Oakland PD Case No. C-00-4599-CAL	U.S. District Court Northern District of California	Plaintiff Rodney Mack, et al. John Burris, Esq. 1212 Broadway Street, Suite 1200 Oakland, CA 94612 Office: 5510-839-5200	Allegations of police misconduct. Over 100 criminal defendants wrongly sentenced.	Stipulated settlement agreement approved by court.	Review documents, drafted consent decree, wrote report (Referred to as "The Riders" case.
Xavier v. San Francisco Police Department	U.S. District Court Northern District of California	Plaintiff Harriet Ross, Esq. One Sansome Street Suite 2000 San Francisco, CA	Allegations of excessive force while incarcerated in San Francisco jail.	Judgment in favor of defendant.	Wrote report, deposed, testified.
Duran v. State of California Case No. GIC 753709	California Superior Court County of San Diego	Plaintiff John Houston Scott The Scott Law Firm 1375 Sutter Suite 222 San Francisco, CA 94109 Office: 415-561-9600	Inmate stabbed in kitchen of CDC prison.	Case settled.	Reviewed documents.
Karr v. Roseville PD		Plaintiff Jeff Klink 9976 Falcon Meadow Dr. Elk Grove, CA 95624 Office: 916-686-1488	Wrongful death claim for the shooting of mentally disturbed man living in a storage unit.	Case settled.	Reviewed documents, wrote report.
Fernandez v. San Francisco Police Department		Plaintiff Andrew Schwartz Casper, Meadows & Schwartz 2121 N. California Blvd. Ste. 1020 Walnut Creek, Ca 94560 Office: 925-947-1147	Plaintiff was inmate in County jail. Deputy had sexual relationship with Plaintiff in jail.	Judgment for defense.	Reviewed documents, prepared declaration.

Case Name & Number	Court	Retained By	Summary of Case	Disposition	Participation
Sheppard v. San Francisco Police Department Case No. C 01-3424-PJH	United States District Court Northern District of California	Plaintiff Harriet Ross One Embarcadero Center Ste. 500 San Francisco, CA 94111	Excessive force claim pursuant to arrest.	Judgment for Defense.	Reviewed documents, wrote report.
ILWU v. OPD Crowd Control Case		Plaintiff James Chanin 3050 Shattuck Ave. Berkeley, CA 94705 Office: 510-848-4752	Claim against Oakland PD for shooting people with multiple baton rounds, sting ball grenades, etc. during anti-war demonstration.	$4.5 million dollar settlement to Plaintiff Scott Olsen.	Assisting in preparation of model crowd control policy pursuant to seeking a consent decree.
Agredano v. County of San Bernardino SCVSS 098984	San Bernardino Superior Court	Plaintiff David Martinez, Esq. Robins, Kaplan, Miller & Ciresi, LLP 2049 Century Park E., Ste 3400 Los Angeles, CA 90067 Office: 310-552-0130 Fax: 310-229-5800	Inmate with long mental health and suicidal history hung himself from the top bunk. Inmate's family sued for failure to provide adequate medical care.	Case settled.	Reviewed documents.
Watson v. Livermore PD Case No. C-02-2830-WHA	United States District Court Northern District of California	Defense John L. Burris, Esq./State Bar #69888 Law Offices of John L. Burris 7677 Oakport St. Ste 1120 Oakland, CA 94621 Office: 510-839-5200	Claim of racial profiling by African American couple driving through Livermore.	Case settled.	Wrote curriculum for policy training regarding "minority issues with policy", per settlement agreement.
White v. Brown Case No. CIV F-02-5939 OWW SMS	United States District Court Eastern District of California	Plaintiff Stephen Horvath, Esq. 200 East Del Mar Blvd. Ste 202 Pasadena, Ca 91105	Civil rights case brought by family of inmate who died after a staff use of force against him at Corcoran State Prison in California.	Case settled.	
Adam Burke v. Garfield County Sheriff's Department, et al. Case No. 08-cv-00140	U.S. District Court District of Colorado	Plaintiff Andrea L. Blanscet Irwin & Boesen, PC 501 S. Cherry St. Ste 500 Denver, CO 80246 Office: 303-322-2531	Mr. Burke sued alleging that while he was in the Garfield County Jail, he was subject to excessive force including being shot in the testicles with a pepper ball gun, placed in a restraint chair and injured permanently.		Reviewed documents, wrote report.

Anditon v. Priest & Lamarque Case No. C02-3703 MMC	U.S. District Court Northern District of California	Plaintiff Bill Orrick, Esq. Coblentz, Patch, Duffy & Bass 2049 1 Ferry Bldg, Ste 200 San Francisco, Ca 94111 Office: 415-752-6809 Office: 415-772-5712	Mental health inmate at California's Salinas Valley State Prison sued for excessive force after he was sprayed with OC and then injured by baton strikes from officers.	Case settled.	Reviewed documents, wrote report.
Freeman v. Alameda County Case No. C04-1698 SI	U.S. District Court Northern District of California	Plaintiff Frank S. Moore 1374 Pacific Ave San Francisco, Ca 94109 Office: 415-292-6091	Suit alleged deliberate indifferences and failure to protect after homeless, mental health inmate was beaten to death by his cellmate in the Santa Rita (Alameda Co.) CA, jail.	Case settled.	Reviewed documents and consulted.
Cingle, Guardian for Luethke v. Nebraska Case No. BC295053	District Court of Lancaster County, Nebraska	Defense Assistant Attorney General Stephanie Caldwell 2115 State Capitol Lincoln, NE 68509 Office: 402-471-2862	Inmate was beaten to death in a multiple occupancy cell at Diagnostic and Reception Facility in Nebraska.	Judgment for defense.	Wrote report, deposed; testified at trial.
Gavira v. LA County Sheriff Case No. BC2955053	LASC – Central District	Defense Timothy J. Kral Manning & Marder, Kass, Ellrod, Ramirez, LA California Office: 213-624-6900 Fax: 213-624-6999	Family members sued for negligence, deliberate indifference in the failure to provide medical/mental health treatment and for excessive force in the suicide by hanging of a jail inmate.	Settled.	Reviewed documents.
Porras & Grigsby, et al. v. Los Angeles County Case No. CV04-1229 ABC	USDC CV04-1229 RGK (RNBX)	Defense Timothy J. Kral Manning & Marder, Kass, Ellrod, Ramires 801 S. Figueroa Ste. 15 Los Angeles, Ca 90017 Office: 213-624-6900 Fax: 213-624-6999	1983 class action suit; deliberate indifference providing medical services; general failure to provide inmates access to adequate medical services and 14th and 18th amendment violations regarding health care, sanitation and access to council.	Settled.	Reviewed documents.
Ferrel v. City of Santa Rosa Case No. SCV 237557	Superior Court of the State of California	Plaintiff Eric G. Young 141 Stony Circle Ste. 202 Santa Rosa, Ca 95401 Office: 707-575-5005	Plaintiff alleges excessive and unnecessary force by Santa Rosa Police Department.	Case settled.	Reviewed documents, deposed.

Baker v. State of Nebraska Docket No. 1044 545	District Court of Douglas County, Nebraska	Defense Ms. Maureen Hannon, Ms. Stephanie A. Caldwell, Assistant Attorneys General 2115 State Capitol Lincoln, NE 68509	Couple sued state for negligence after inmate escaped and invaded their home, injured them.	Case settled in 2008.	Wrote report.
Harris v. Grams, et al. Case No. 07-CV-678	United States District Court for the Western District of Wisconsin	Plaintiff Pamela McGillivray and Carlos Pabellon Garvey, McNeil & McGillivray, S.C. 634 W. Main St. Ste 101 Madison, WI 53703 Office: 608-256-1003	Inmate sued for deliberate indifference in denying medical treatment and for retaliation.	Settled.	Reviewed documents, wrote report, deposed.
Trina S. Garcia v. Zavares, et al. Case No. 1:08-CV-02780	U.S. District Court, District of Colorado	Plaintiff Andrea L. Blanscet Irwin & Boesen 501 S. Cherry St. Ste 500 Denver, CO 80246 Office: 303-322-2531	Ms. Garcia was an inmate in the CO DOC who was coerced into sex by a male staff member who was supervising her and was also having sex with at lease three other female inmates.		Reviewed documents, wrote report.
David Ramirez v. County of Los Angeles, et al. Case No. CV-08-2813	U.S. District Court Central District of California, Western Division	Plaintiff Navid Sulimani & Adam J. Rottenberg Proskauer Rose, LLP 2049 Century Park East Ste. 3200 Los Angeles, CA 90067 Office: 310-284-4541	Mr. Ramirez was an inmate at Men's Central Jail and sued for injuries as a result of "serial extraction" of segregation unit.	Verdict for Defense.	Reviewed documents; wrote report; deposed; testified at trial.
Troy Short v. AJ Trujillo, et al. Case No. 08-CV-02209	U.S. District Court, District of Colorado	Plaintiff Jared B. Briant & Spencer B. Ross Faegre & Benson, LLP 1700 Lincoln St. Ste 3200 Denver, CO 80203 Office: 303-607-3500	Mr. Short was an inmate in the CO DOC and was harassed, threatened and beaten by gang related inmates. He sued for failure to protect him.	Case settled.	Reviewed documents, wrote report, deposed.
Shannon Bastedenbeck v. Zavaras, et al. Case No. 08-CV001841	U.S. District Court District of Colorado	Plaintiff Andrea L. Blanscet Irwin & Boesen 501 S. Cherry St. Ste 500 Denver, CO 80246 Office: 303-322-2531	Ms. Bastedenbeck was an inmate in the CO DOC and was coerced into sexual relation by a Lieutenant. She sued Department Administrators and Supervisors for damages.		Reviewed documents, wrote report.
Oscar Garay, Jr., by Kelly Sue Garay v. Hamblen County Tennessee Case No. 2:11-CV-00128	U.S. District Court Eastern District of Tennessee	Plaintiff Robert Bates Law Offices of Tony Seaton 118 E. Watauga Ave. Johnson City, TN 37601 Office: 423-282-1041	Mr. Garay died as a result of a seizure while in a restraint chair in the Hamblen County Jail. His estate sued for failure to provide medication, medical treatment and for other causes.	Case settled.	Reviewed documents, wrote initial and supplemental report, deposed.

Jeffrey Marshall v. Deputy Castro, et al. Case No. S:04-1657	U.S. District Court Eastern District of California	Plaintiff Scotia J. Hicks, Yelitza V. Dunham & Craig Crockett Winston & Strawn, LLP 101 California St. San Francisco, CA 94111 Office: 415-591-1000	Mr. Marshall sued for unnecessary and excessive force on the part of Deputies in the Solano County, Ca Jail.	Case settled.	Reviewed documents, wrote initial and supplemental report, deposed.
Laura Lobozzo v. Colorado Department of Corrections, et al. Case No. 08-CV-01829	U.S. District Court Western District of Michigan, Southern Division	Plaintiff Andrea L. Blanscet Irwin & Boesen 501 S. Cherry St. Ste 500 Denver, CO 80246 Office: 303-322-2531	Laura Lobozzo was threatened and coerced into a sexual relationship by a male correctional officer while she was an inmate in the CO DOC. She sued for damages.		Reviewed documents, wrote report.
Estate of John Ketchapaw v. County of Ottawa, et al. Case No. 1:10-cv-320	U.S. District Court Western District of Michigan, Southern Division	Plaintiff Neal J. Wilensky Kaechele & Wilensky, PC 6500 Centurion, Ste 230 Lansing, MI 48917 Office: 517-853-1940	John Ketchapaw committed suicide. Plaintiff sued for damages based on Defendants alleged failure to appropriately screen Mr. Ketchapaw for suicide risk and to take appropriate preventative actions.	Case settled.	Reviewed documents, wrote report.
Don Antoine v. County of Sacramento Case No. 2:06-CV-01349	U.S. District Court Eastern District of California	Plaintiff John Houston Scott The Scott Law Firm 1375 Sutter St. Ste 222 San Francisco, CA 94109 Office: 415-561-9600	Mr. Antoine sued for damages alleging that several deputies had entered his cell, used excessive force, seriously injured him and then chained his handcuffs and leg shackles to the toilet drain grate in the cell floor and left him.	On appeal.	Wrote report; deposed; testified at trial.
Anthony Ferrel, et al. v. City of Santa Rosa, et al. Case No. SCV-237557	Superior Court State of California County of Sonoma	Plaintiff	Plaintiff and family members sued alleging that City of Santa Rosa police officers used excessive force in tasering, beating and pointing firearms at Mr. Ferrel and family members.	Case settled.	Reviewed documents, wrote report, deposed.
Krenn v. County of Santa Clara, et al. Case No. C07-2295	U.S. District Court Northern District of California	Defense David Sheuerman of Sheuerman, Martini & Tabari, PC 1033 Willow St. San Jose, CA 95125 Office: 408-288-9700	Andrew Martinez, a frequent mental health inmate in the Santa Clara County Jail, committed suicide in the jail in May 2006. His mother subsequently sued for failure to prevent the suicide.	Case settled.	Reviewed documents, wrote report.

Snyder & Santoro v. City and County of San Francisco Case No. 03-04927	U.S. District Court Northern District of California	Plaintiff John Houston Scott The Scott Law Firm 1375 Sutter St. Ste 222 San Francisco, CA 94109 Office: 415-561-9600	Mr. Snyder and Mr. Santoro alleged that they were walking out of a restaurant when two off duty SF police officers savagely beat them because they were gay. (Case referred to in SF as "Fajita – gate".)	Case settled.	Provided declaration on police Early Warning Systems, Progressive Discipline Systems, Effective Police Supervision, etc.
Daniel Duran v. State of California, et al. Case No. GIC753709	State of California San Diego Superior Court	Plaintiff Suzie Moore Law Offices of Suzie Moore 1901 First Ave. Ste 227 San Diego, CA 92101 Office: 619-231-9490	Mr. Duran sued after he was attacked and stabbed repeatedly by several other inmates at Centinela State Prison.	Case settled.	Reviewed documents, wrote report, deposed.
Lynette Frary (Carmignani) v. County of Marin (City of Novato) Case No. C-12-3928-MEJ	United States District Court Northern District of California	Plaintiff David L. Fiol, Attorney at Law Brent, Fiol, & Nolan LLP Two Embarcadero Center, 18th Floor San Francisco, CA 94111	Inmate died in custody from opiate overdose resulting from ingesting morphine pills prior to booking.	Settled	Received documents
Lawrence Carty v. John Dejongh (US Virgin Islands) Case No. 94-78	District Court of the Virgin Islands Division of St. Thomas and St. John	Appointed by Federal Court as the Court's Security Expert. The Honorable Judge Stanley S. Brotman.	Long-standing consent decree over conditions of confinement at two jails on St. Thomas, USVI.	Consent Decree ongoing	Conducted security audit, wrote report, testified on two occasions at Federal Court hearings in USVI.
LaShawn Jones, et al., v. Marlins Gusman, Sheriff, Orleans Parish, et al. Case No. 2:12-cv-00859	United States District Court Eastern District of Louisiana	Plaintiff Katie Schwartzman Director, Louisiana Office Southern Poverty Law Center 1055 St. Charles Ave., Suite 505 New Orleans, LA 70130	Class action suit over conditions of confinement in the New Orleans jails, jointly litigated by Southern Poverty Law Center and Special Litigation Section of Civil Rights Division of US DOJ.	Consent decree entered.	Conducted security audit of New Orleans jail facilities, wrote report, testified at hearing over consent decree.
Nathaniel L. Jackson v. Perry Phelps Case No. 10-919-SLR	United States District Court District of Delaware	Plaintiff Erika Caesar Young Conawa Stargatt & Taylor, LLP Rodney Square 1000 North King Street Wilmington, DE 19801	Inmate alleges cruel and unusual punishment for being placed in full restraints, left in cell for 24 hours in underpants as punishment for flooding cell.	Settled	Wrote report, deposed.

Ronald E. Johnson v. Douglas Weber Case No. CIV-12-4084	United States District Court District of South Dakota Southern Division	Plaintiff John Burke Thomas Braun Bernard & Burke, LLP 4200 Beach Drive Suite 1 Rapid City, SD 57702	Civil Rights suit by wife of Correctional Officer who was beaten to death in an escape attempt by two inmates at South Dakota state prison.	Dismissed pursuant to Defense motion.	Wrote report, deposed.
Aleshia Cyrese Henderson v. Stanley Glanz, Sheriff Case No. 12-cv-68-TCK-FHm	United States District Court Northern District of Oklahoma	Defense Guy Fortney, Esq. Corbin Brewster, Esq. Law Offices of Brewster & DeAngelis, P.L.L.C. 2617 East 21st Street Tulsa, OK 74114	Female inmate sues Sheriff for damages after she alleged rape by male inmate in medical area of jail.	Settled	Wrote report, deposed.
LaDona Poore v. Stanley Glanz, Sheriff Case No. 11-cv-797-CVE-TLW	United States District Court Northern District of Oklahoma	Defense Guy Fortney, Esq. Corbin Brewster, Esq. Law Offices of Brewster & DeAngelis, P.L.L.C. 2617 East 21st Street Tulsa, OK 74114	Former adolescent female inmate sues Sheriff alleging rape and other sexual assaults by male correctional officer.	$25,000 verdict for Plaintiff. On appeal.	Wrote report, deposed.
Linsey Dawn Shaver v. Stanley Glanz, Sheriff Case No. 12-Cv-234-CVE-PJC	United States District Court Northern District of Oklahoma	Defense Guy Fortney, Esq. Corbin Brewster, Esq. Law Offices of Brewster & DeAngelis, P.L.L.C. 2617 East 21st Street Tulsa, OK 74114	Female adolescent inmate sues Sheriff alleging sexual misconduct by male correctional officer in medical area of jail.	Pending	Wrote report.
Jeffrey Trevillion v. Stanley Glanz, Sheriff Case No. 12-CV-146-JHP-TLW	United States District Court Northern District of Oklahoma	Defense Guy Fortney, Esq. Corbin Brewster, Esq. Law Offices of Brewster & DeAngelis, P.L.L.C. 2617 East 21st Street Tulsa, OK 74114	Male inmate sues Sheriff over failure to provide wheel chair, excessive use of force and failure to provide medications.	Settled	Reviewed documents
CRIPA Investigation of Violence Issues Effecting Male Adolescent Inmates on Rikers Island Case No. 11-Cv-5845	United States District Court Southern District of New York	Plaintiff Emily A. Daughtry Jeffrey K. Powell Assistant United States Attorneys US Department of Justice Southern District of New York 86 Chambers St. New York, NY 10007	CRIPA investigation of staff use of force and inmate-on-inmate violence involving male adolescent inmates on Rikers Island.	Formal agreement reached under Federal Court Supervision	Reported to US Attorney's Office following assessment of condition for juveniles on Rikers. Participated in drafting/negotiating consent decree.
Marvin Hunter v. Jerome Wilen, Case No.	United States District Court Western District of Washington at Tacoma	Plaintiff Fred Diamondstone 1218 Third Ave., Suite 1000 Seattle, WA 98101	Inmate in Washington DOC has filed suits in State and Federal Court alleging he was assaulted by prison gang because Department wrongfully published information that he was a confidential informant then refused him protective custody or transfer.	Settled	Wrote report, deposed.

Michael Miceli v. Marlin Gusman, Sheriff Case No. 09-8078	United States District Court Eastern District of Louisiana	Plaintiff Mary E. Howell 316 S. Dorgenois St. New Orleans, LA 70119	Suicidal female inmate died in custody as a result of being placed in 5-point restraints on her back for 4 hours and staff using force to hold her down.	Settled	Received documents
Margaret Goetzee Nagle and John Eric Goetzee v. Marlin Gusman, Sheriff Case No. 12-1910	United States District Court Eastern District of Louisiana	Plaintiff Mary E. Howell 316 S. Dorgenois St. New Orleans, LA 70119	Widow of Coast Guard Commander sues Sheriff, Sheriff's employees, after her husband commits suicide on the tenth floor, mental health unit of the House of Detention.	Settled	Wrote report, deposed.
Jesse Goode v. County of Genesee Case No. 12-10340	United States District Court Eastern District of Michigan Southern Division	Plaintiff Neal Wilensky 6005 W. St. Joseph, Suite 303 Lansing, Michigan 48917	Inmate died as a result of opiate overdose ingested while in custody in the Genesee County Jail.	Settled	Wrote report, deposed.
Thomas Gould v. Board of County Commissioners of Major County Case No. CIV-11-290-M	United States District Court Western District of Oklahoma	Plaintiff Michael E. Grant Musser, Kouri, Bentwood & Grant 114 E. Sheridan, Suite 102 Oklahoma City, OK 73104	Wife arrested for possession when went to visit her husband in jail. Wife subsequently committed suicide by hanging in jail.	Dismissed pursuant to Defense motion.	Wrote report, deposed.
Phillip Morris, Jr. v. R. A. White, et al. Case No. CV-08-02823-DOC (SSx)	United States District Court Central District of California	Plaintiff Katherine A. Rykken Latham & Watkins, LLP 355 South Grand Ave Los Angeles, CA 90071	Inmate in California Department of Corrections sued alleging excessive force by staff after inmate ran from two officers and across exercise yard.	Settled	Wrote report.
Cook County Case No. 13 CV 8752	United States District Court Northern District of Illinois	Plaintiff Sheila Bedi, Esq. David Shapiro, Esq.' McCarther Justice Center, Northwestern University Law School	A class action suit against the Cook County Jails focusing on staff use of force and inmate-on-inmate violence.	Case dismissed on motion by circuit court.	Wrote report; deposed testified at hearing.
Pickens v Management Training Corp	In The United States District Court For the Southern District of Mississippi Northern Division	Plaintiff Yancy B. Burns Burns & Associates, PLLC P.O. Box 16409 Jackson, MS 39236	Inmate lost one eye after stabbed and beaten in riot/gang war at private prison is MS.	Settled	Wrote report
Rosales v State of Nebraska Case No. CI 13-717	District Court of Lancaster County, Nebraska	Defense Bijan Koohmaraie Assistant Attorney General Nebraska Department of Justice 2115 State Capitol Lincoln, Nebraska 68509	Plaintiff suffered brain damage as result of assault by another inmate. Plaintiff sued state for failure to protect.	Verdict for Defense	Testified at trial.
Christopher Shapard v. John Attea, et al. Case No. 08-CV-6146 (CJS)	United States District Court Western District of New York	Plaintiff Luke X. Flynn-Fitzsimmons	Plaintiff was inmate at Wende Correctional Facility in N.Y. DOC. Plaintiff alleges that three correctional	Verdict for Defense	Wrote report; deposed.

		Paul, Weiss, Rifkind, Wharton & Garrison, LLP 1285 Avenue of the Americas New York, NY 10019	officers beat him as retaliation.		
Anthony Josta v. Woodbury County Case No. 13-97-0060	In The United States Disctrist Court Northern District of Iowa Western Division	Plaintiff John f. Carroll, RN, JD Attorney 2809 S. 160th Street, Suite 409 Omaha, NE 68130	Plaintiff died due to alcohol withdrawal while he was in the Woodbury County, Iowa, Jail.	Settled	Wrote report.
Anita Arrington-Bey, Administration of the Estate of Omar K. Arrington-Bey v. City of Bedford Heights, et al. Case No. 1:14-CV-02514	Court of Common Pleas Cuyahoga County, Ohio	Plaintiff Jacqueline Green Friedman & Gilbert 55 Public Square, Suite 1055 Cleveland, OH 44113	Plaintiff died in custody in the Bedford Heights, Ohio, jail following his placement in a restraint chair after he assaulted two officers in the jail.	Settled	Wrote report, deposed.
Kelly Conrad Green v. Corizon Health, Inc. Case No. 42 USC 1983	United States District Court for the District of Oregon Eugene Division	Plaintiff Elden M. Rosenthal 121 S.W. Salmon St, Suite 1090 Portland, OR 97204	Plaintiff sued for failure to protect and failure to provide adequate medical services after he sustained permanent injuries.	Settled	Reviewed documents.
Farris v. Island County Case No. 15-I05352	Case settled before filing	Plaintiff Rebecca J. Roe Schroeter Goldmark Bender 810 Third Avenue, Suite 500 Seattle, WA 98104	Inmate died of dehydration and malnutrition while in custody for 11days in the Island County, WA Jail.	Settled	Reviewed documents.
Meirs v. Ottawa County Case No. 1:15-cv-00866	United States District Court Western District of Michigan	Plaintiff Steven T. Budaj Goodman & Hurwitz, PC. 1394 E. Jefferson Ave. Detroit, MI 48207	Inmate committed suicide while in custody in Ottawa County, MI, jail.	Verdict for defense	Wrote report; deposed; testified at trial.
Brian Otero v. Thomas J. Dart, Sheriff of Cook County Case No. 1:12-dv-03148	United States District Court for the Northern District of Illinois – Eastern Division	Plaintiff Jacie Zolna, Esq. Myron M. Cherry & Associates, LLC 30 North La Salle St., Suite 2300 Chicago, Illinois 60602	Class action suit alleging male prisoners in Cook County Jail held unnecessarily, endangered and treated differently than female prisoners after "not guilty" verdict.	Settled	Wrote report; deposed.
Glover v. Jayson Vest, et al. Case No. CIV-14-936-F	In the United States District Court for the Western District of Oklahoma	Plaintiff Rachel S. Fields Atkinson, Haskins, Nellis, Brittingham, Gladd & Fiasco, P.C. 525 South Main Tulsa, OK 74103	Staff sexual misconduct. Rape of female inmate in Harmon Co., OK jail by Deputy Chief of Police of Hollis, OK Police Department.	Jury award of 6.5 million dollars to Plaintiff	

Wilmer Catalan-Ramirez v. Ricardo Wong, Field Office Director, Chicago, U.S. Immigration and Customs Enforcement, et al.	District Court for the Northern District of Illinois Easter Division	Plaintiff Sheila Bedi, Esq. David Shapiro, Esq.' McCarther Justice Center, Northwestern University Law School	Handicapped Plaintiff was being transported in restraints without a seatbelt.		Testified by phone at Preliminary hearing
Donnie Ray Brown, et al. v. Conmed Healthcare Management, Inc., et al. Case No. 6:14-cv-01620-TC	United States District Court District of Oregon Eugene Division	Plaintiffs Benjamin W. Haile Attorney at Law P.O. Box 2581 Portland, OR 97208	Failure to provide medical treatment. Inmate in Coos Bay County, OR, jail died after failure to treat him for a perforated ulcer and peritonitis.	Settled	Wrote report and supplemental report.
Matthew Allen v. State of Oregon, et al., Case No. 3:11-CV-0218-PK	United States District Court District Court of Oregon Portland Division	Plaintiffs Benjamin W. Haile Attorney at Law P.O. Box 2581 Portland, OR 97208	Failure to protect (inmate-on-inmate gangs). Inmate in OR State Prison beaten by former gang after requesting protection.	Settled after state stipulated to liability on all three counts.	Reviewed documents.
Case Name & Number	**Court**	**Retained By**	**Summary of Case**	**Disposition**	**Participation**
Chris Blevins, et al. v. Marlin N. Gusman and Orleans Parish Sheriff's Office Case No. 2013-04979	Civil District for the Parish of Orleans State of Louisiana	Plaintiff Suzette Bagneris The Bagneris Firm, LLC 4919 Canal Street, Suite 104 New Orleans, Louisiana 70119	Failure to protect (inmate-on-inmate gangs). Male inmate stabbed to death in New Orleans Parish jails.	Settled	Reviewed documents.
Hamilton v. Correctional Health Care Management, Inc, et.al. Case No. CIV-09-544-M	In the United States District Court for the Western District of Oklahoma	Plaintiff Venessa Brentwood Durbin, Larimore & Bialick 920 N. Harvey Oklahoma City, OK 73102	Failure to provide medical treatment. Inmate died after staff use of force, lengthy time in restraint chair at the Oklahoma County Detention Center	Settled.	Wrote report; deposed.
The Estate of Joice Howard v. County of Genesee, et al. Case No. 14-12350	**Cannot find Complaint**	Plaintiff Neal Wilensky 6005 W. St. Joseph, Suite 303 Lansing, Michigan 48917	Failure to provide medical treatment. Female inmate in Genessee Co., MI, jail had high blood pressure and gran malseizures. Got no medication and died.	Settled	Wrote report.
Katka v. State of Montana, el. al. Case No. BDV-2009-1163	Montana First Judicial District Court Lewis and Clark County	Plaintiff Andree Larose Morrison, Motl & Sherwood, PLLP 401 N. Last Chance Gulch Helena, MT 59601	Juvenile held in high security at Montana State Prison. Conditions of confinement, failure to provide treatment.	Settled	Wrote report.
James Joshua Mayfield, et al. v. Orozco et al.	United States District Court Eastern District of California,	Plaintiff Josh Piovia-Scott Hadsell Stormer Renick, LLP	Failure to protect (suicide attempt).	Settled.	Wrote report.

Case No. 2:13-CV-02499-JAM-AC	Sacramento Division	128 North Fair Oaks Avenue Pasadena, CA 91103			
James Merchant v. Woodbury County, et al. Case No. 7C16-CV-4111		Plaintiff John F. Carroll Watson & Carroll PC LLO 2809 S. 160th Street, Suite 409 Omaha, NE 68130-1755	Failure to provide medical treatment at the Woodbury Co., IA, jail. Inmate's stroke-like symptoms disregarded, inmate suffered permanent and profound impairment.	Settled	Wrote report.
Glenda Millington v. Corrections Corporation of American, et.al. Case No. 10-CIV-650-L	The United States District Court for the Western District of Oklahoma	Plaintiff Steven J. Terrill Bryan & Terrill Law, PLLC 401 S. Boston, Suite 2201 Tulsa, OK 74103	Failure to protect inmate-on-inmate gangs. Inmate at Cinnarron, private prison in Oklahoma, badly beaten in gang incident. Permanent, serious brain damage.	Settled	Wrote report and declaration; deposed.
Williams v. Williams, et al. Case No. CV08-7958-JVS	In the United States District Court for the Central District of California	Plaintiff Leila Azari Latham & Watkins, LLP 355 South Grand Ave Los Angeles, CA 90071	Inmate in L.A. Co. jails, at IRC, was in wheel chair and alleged unnecessary staff use of force	Settled.	Wrote report; deposed; retained as rebuttal witness.
People of the State of New York v. Anthony Criscuolo Case No. 2055-2013	Supreme Court of the State of New York County of Bronx	Plaintiff Steven A. Metcalf II, Esq. The Metcalf Law Firm, PLLC 11 Broadway, Suite 615 New York, New York 10004	Motion to set aside. Guilty plea as a result of pre-trial conditions.		Took case pro bono; provided declaration.
Jon Watson v. Cumberland County, et al. Case No. 1:16-cv-06578-JHR-AMD	In the United States District Court for the District of New Jersey Camden Vicinage	Plaintiff Law Offices of Conrad Benedetto *Conrad Benedetto* 323 East Front Street Media, Pa. 19063	Suicide in the Cumberland County New Jersey Jail	Pending	Wrote report; deposed.
David Hennis v. Cumberland County, et al. Case No. 1:16-cv-04216	In the United States District Court for the District of New Jersey Camden Vicinage	Plaintiff Law Offices of Conrad Benedetto *Conrad Benedetto* 323 East Front Street Media, Pa. 19063	Suicide in the Cumberland County New Jersey Jail	Pending	Wrote report
Alissa Allen v. Cumberland County, et al. Case No. 1:15-CV-06273-JBS-AMD	In the United States District Court for the District of New Jersey Camden Vicinage	Plaintiff Law Offices of Conrad Benedetto *Conrad Benedetto* 323 East Front Street Media, Pa. 19063	Suicide in the Cumberland County New Jersey Jail	Pending	Wrote report.

Estate of Megan Moore, et al, v. Cumberland County Case No. 17-cv-2839-RBK-KMW	In the United States District Court for the District of New Jersey Camden Vicinage	Plaintiff Law Offices of Conrad Benedetto *Conrad Benedetto* 323 East Front Street Media, Pa. 19063	Suicide in the Cumberland County New Jersey Jail	Pending	Reviewed documents.
Estate of David Conroy et al, v. Cumberland County Case No. 1:17-cv-07183-RBK-AMD	In the United States District Court for the District of New Jersey Camden Vicinage	Plaintiff Law Offices of Conrad Benedetto *Conrad Benedetto* 323 East Front Street Media, Pa. 19063	Suicide in the Cumberland County New Jersey Jail	Pending	Reviewed documents.
(Johnson, Lamar) Adrienne Lewis, by and on behalf of the minor child Liya Alexandria Johnson v. East Baton Rouge Parish, et al. Case No. 16-352-JWD-RLB	United States District Court Middle District of Louisiana	Plaintiff The Claiborne Firm, P.C. David J. Utter, Esq. 410 E. Bay Street Savannah, GA 31401	Suicide in the East Baton Rouge Parish Jail	Settled	Wrote report.
Jonathan Fano v. East Baton Rouge Parish, et al. Case No. 3:17-cv-00656-SDD-EWD	United States District Court Middle District of Louisiana	Plaintiff The Claiborne Firm, P.C. David J. Utter, Esq. 410 E. Bay Street Savannah, GA 31401	Suicide in the East Baton Rouge Parish Jail by mentally ill male inmate.	Pending	Reviewed documents.
Frazier, Tayo Case No. 16-cv-2364	United States District Court for the Central District of Illinois Urbana Division	Plaintiff Shayla Maatuka Dodd & Maatuka 303 S. Mattis Ave, Suite 201 Champaign, IL 61821	Failure to provide medical services to female inmate going through withdrawal in Champaign Co. Jail. Inmate died.	Pending	Wrote report; deposed.
Cordell Johnson v. Correctional Corporation of America, et al. Case No. CIV-16-1061-R	In the United States District Court for the Western District of Oklahoma	Plaintiff Bryan & Terrill Spencer Bryan Steven Terrill 9 East Fourth Street, Suite 307 Tulsa, Oklahoma 74103	Failure to protect Inmate-on-inmate gang fight/riot in Cimmaron CCA operated private prison in OK. Inmate stabbed and permanent injuries.	Settled	Wrote report
Steve Tiffee, as Special Administrator for the Estate of Kyle Tiffee v. Corrections Corporation of America, et al. Case No. CJ-2016-378	In the District Court for Payne County State of Oklahoma	Plaintiff Bryan & Terrill Spencer Bryan Steven Terrill 9 East Fourth Street, Suite 307 Tulsa, Oklahoma 74103	Failure to protect. Inmate stabbed seriously injured in riot/gang war at Cimarron CCA operated prison in OK.	Pending	Reviewed documents.
Tyson Christian v. Willamette Community Health Solutions Case No. 6:17-cv-00885-AA	United States District Court For the District of Oregon Eugene Division	Plaintiff Patrick D. Angel Angel Law PC 6960 SW Varns Street, Suite 110 Portland, OR 97223 John T. Devlin Devlin Law, P.C.	Failure to protect alcoholic inmate found unresponsive on floor of jail cell; died.	Settled	Reviewed documents.

		1212 SE Spokane Street Portland, OR 97202			
Jacob Parenti v. County of Monterey; Sheriff Scott Miller Case No. 5:14-cv-05481	United States District Court Northern District of California	Plaintiff Joshua Piovia-Scott, Esq. Hadsell Stormer & Renick, LLP 128 North Fair Oaks Avenue Pasadena, CA 91103	Failure to provide medical care, negligence and wrongful death	Settled	Wrote report; deposed.
Estate of Laura Semprevivo, et al, v. Cumberland County Case No. 17-cv-2839-RBK-KMW	In the United States District Court for the District of New Jersey Camden Vicinage	Plaintiff Conrad Benedetto Attorney at Law Law Offices of Conrad J. Benedetto 1615 S. Broad Street Philadelphia, PA 19148	Suicide in the Cumberland County, New Jersey Jail	Pending	
Madaline Pitkin v. Corizon Health, Inc. Case No. 3:16-cv-02235-AA	United States District Court District of Oregon – Portland Division	Plaintiff John Coletti Paulson Coletti 1022 NW Marshal, Ste. 450 Portland, OR 97209	Failure to provide appropriate medical care to young female inmate undergoing withdrawal in the Washington County Oregon Jail	Settled for 10 million dollars.	Wrote reports.
Rocky Stewart v. Coos County Jail	Complaint not yet filed.	John T. Devlin Devlin Law, P.C. 1212 SE Spokane Street Portland, OR 97202	Failure to provide appropriate medical care		Reviewed documents
Abdiwali Musse v. William Hayes, et al. Case No. C18-1736-JCC	United States District Court Western District of Washington at Seattle	Plaintiff Jay Krulewitch 2611 N.E. 113th Street, Suite 300 Seattle, WA 98125	Inmate in King Co. Jail attacked and seriously injured while he slept in congregate cell.	Pending	
Markist Webb v. Management & Training Corporation Case No. 15-CV-029-LE-C	In the Circuit Court of Leake County, Mississippi	Plaintiff S. Todd Jeffreys, Esq. Povall & Jeffreys, P.A. P.O. Box 1199 215 North Pearman Ave. Cleveland, MS 38732	Inmate seriously injured in riot/gang war at privately run proson (Walnut Grove) in MS.	Settled	Reviewed documents.
Christopher Thomas Woolverton v. Barry Martin, et al. Case No. 2:15-cv-00314-J	United States District Court for the Northern District of Texas Amarillo Division	Plaintiff Ben Haile Attorney at Law P.O. Box 2581 Portland, OR 97208	Fatal abuse of seriously mentally ill inmate who also suffered from medical significant problems, in a Texas State Prison.	Pending	Wrote report; provided declaration.
Anthony Huff v. Garfield County Sheriff's Office		David Donchin, Esq. Durbin, Larimod & Bialick, PC Oklahoma City, Oklahoma			
Robert W. Lewis v. Cumberland County, et al. Case No. 1:16-cv-03503	In the United States District Court for the District of New Jersey Camden Vicinage	Plaintiff Law Offices of Conrad Benedetto *Conrad Benedetto* 323 East Front Street Media, Pa. 19063	Suicide in the Cumberland County New Jersey Jail	Pending	Wrote report; deposed.

APPENDIX C

Jeffrey A. Schwartz, Ph.D.
1610 La Pradera Drive
Campbell, California 95008

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jasletra@aol.com

Expert Witness Fee Schedule (9/10/18)

1. Document review and other case preparation: $325 per hour

2. Testimony at deposition or trial: $425 per hour (Minimum charge $1,700 or 4 hours)

3. Airfare, car rental, meals and incidentals on travel status, and other case expenses: Cost reimbursable

4. Retainer: Agreed to on case by case basis, typically $2,500

5. Initial case review, typically up to 4 hours: No charge if not retained or if case declined. Charged at case preparation rate if retained and case accepted.

APPENDIX D

Recent Publications
Jeffrey A. Schwartz

1. A note on "Verbal and Non-verbal Indicators to Assault"; Corrections.com; May, 2009.
2. "Planning for the Last Disaster; Correctional Facilities and Emergency Preparedness; Journal of Emergency Management; Volume 7, #1; January/February, 2009.
3. Reducing Exposure in Use of Force Litigation; Corrections Today; June, 2009.
4. "The Force Continuum: Is It Worth Keeping? Part 1; Bill Collins, Jeffrey A. Schwartz and Donald Leach; Correctional Law Reporter; December/January, 2011.
5. "The Force Continuum: Is It Worth Keeping? Part II"; Bill Collins, Jeffrey A. Schwartz and Donald Leach; Correctional Law Reporter; April/May, 2011.
6. "Come and Get Me! The Best and Worst in Cell Extractions"; American Jails; July/August, 2009.
7. Turn Around in a Good Jail; Gary Raney and Jeffrey A. Schwartz; American Jails; January/February, 2008.
8. "Fixing Use of Force Problems"; American Jails, January/February, 2010.
9. "A Guide to Preparing for and Responding to Jail Emergencies"; Jeffrey A. Schwartz, Ph.D. and Cynthia Barry, Ph.D.; a book-length monograph published by the National Institute of Corrections; 2009.
10. "A Guide to Preparing for and Responding to Prison Emergencies;" Jeffrey A. Schwartz, Ph.D. and Cynthia Barry, Ph.D.; June, 2005; a book length monograph published by the National Institute of Corrections.

APPENDIX E

DESCRIPTION OF DOCUMENTS UPLOADED TO SHAREFILE FOR JEFFREY SCHWARTZ BY ROSEN BIEN GALVAN & GRUNFELD LLP, as of June 2, 2020
Defendants' March 13, 2020 Verified Response to Plaintiffs' Special Interrogatories
Excerpts from CDCR Department Operations Manual (DOM), updated through 2020
Plaintiffs' February 28, 2020 RJD Motion and Supporting Documents and Exhibits, Proposed Order
Index of Appeals and Institution-Level Inquiries into Staff Misconduct at RJD, as of 03/31/20
Index of Appeals and Institution-Level Inquiries into Staff Misconduct at RJD, as of 04/17/20
Index of Appeals and Institution-Level Inquiries into Staff Misconduct at RJD, as of 04/20/20
Index of OIA-Level Investigations into Staff Misconduct at RJD, as of 03/31/20
Index of OIA-Level Investigations into Staff Misconduct at RJD, as of 04/01/20
Index of OIA-Level Investigations into Staff Misconduct at RJD, as of 06/01/20
December 10, 2018 Memorandum from Associate Warden Bishop to Associate Director Seibel
December 2015 Office of Inspector General Report re High Desert State Prison (HDSP)
January 2019 Office of Inspector General Report re Staff Complaints at Salinas Valley State Prison (SVSP)
March 25, 2020 CDCR Emergency Rules, Office of Administrative Law Mater No. 2020-0309-01
2019 CCPOA-CDCR Bargaining Agreement
April 4, 2018 Letter from Don Specter to CDCR Secretary Scott Kernan
May 5, 2020 Letter from Penny Godbold to Tamiya Davis and Joanna Hood, Defendants' Counsel
AIMS Flowchart (produced at Bates No. DOJ00093720) and AIMS UOF Flowchart (produced at Bates No. DOJ00093721)
Exhibits 89 and 90 to Freedman RJD Declaration (video media)
Exhibit 11 to February 4, 2020 Deposition of Tricia Ramos
Documents produced in *Armstrong v. Newsom* relating to OIA investigations and local inquiries into allegations of staff misconduct at RJD involving *Armstrong* class members, at beginning Bates Nos.: • [redacted] File – DOJ00017312, DOJ00059503 • [redacted] File – DOJ00018042, DOJ00059511 • [redacted] File – DOJ00018506, DOJ00059477 • [redacted] File – DOJ00003238, DOJ00079077, DOJ00065484 • [redacted] File – DOJ00056575 • [redacted] File – DOJ00017408, DOJ00012683, DOJ00017612, DOJ00012753, DOJ00020158, DOJ00017000, DOJ00016518, DOJ00016522, DOJ00016526,

DESCRIPTION OF DOCUMENTS UPLOADED TO SHAREFILE FOR JEFFREY SCHWARTZ BY ROSEN BIEN GALVAN & GRUNFELD LLP, as of June 2, 2020

DOJ00016528, DOJ00016524, DOJ00016540, DOJ00016531, DOJ00016538, DOJ00016534, DOJ00016546, DOJ00016530, DOJ00020158, DOJ00076199, DOJ00065146, DOJ00076203, DOJ00047738

- [redacted] File – DOJ00018479, DOJ00048246, DOJ00065664, DOJ00091038, DOJ00091070
- [redacted] File – DOJ00052714, DOJ00018158, DOJ00052918, DOJ00020109, DOJ00047983, DOJ00047986, DOJ00047989, DOJ00047991, DOJ00047994, DOJ00047985, DOJ47988, DOJ00047993, DOJ00059440, DOJ00090954, DOJ00090956, DOJ00071742, DOJ00065571
- [redacted] File – DOJ00017244, DOJ00056124, DOJ00019999, DOJ00056065, DOJ00076250, DOJ00076251, DOJ00076252, DOJ00076253, DOJ00078554
- [redacted] File – DOJ00017220, DOJ00052424, DOJ00052470, DOJ00055435, DOJ00055999, DOJ00055516, DOJ00091030, DOJ00091046
- [redacted] File – DOJ00052393, DOJ00016446, DOJ00052306, DOJ00071589, DOJ00078473, DOJ00078471, DOJ00078475
- Officer [redacted] File – DOJ00059495, DOJ67845
- [redacted] File – DOJ00078287, DOJ00059484
- [redacted] File – DOJ00068553
- [redacted] File – DOJ00073287, DOJ00073416, DOJ00057650, DOJ00017731, DOJ00065372, DOJ00073281, DOJ00073283, DOJ00017498, DOJ00017496, DOJ00073279, DOJ00093343, DOJ00093344
- [redacted] File – DOJ00077170, DOJ77596, DOJ00077698, DOJ00051777, DOJ00077786, DOJ00077575, DOJ00057659, DOJ0077788, DOJ00076238, DOJ00076240, DOJ00076883, DOJ00076885, DOJ00076879, DOJ00076887, DOJ00077164, DOJ00077169, DOJ00076241, DOJ00076243, DOJ00077558, DOJ00077281, DOJ00077276, DOJ00077283, DOJ00077560, DOJ00077277, DOJ00077166, DOJ00076244, DOJ00077801, DOJ00077802, DOJ00077804, DOJ00077795, DOJ00077806, DOJ00077796, DOJ00077798
- [redacted] File – DOJ00048330, DOJ00074940, DOJ00072818, DOJ00072876, DOJ00018850, DOJ00018851, DOJ00090793, DOJ00072817, DOJ00091014, DOJ00091032, DOJ00091080, DOJ00093503
- [redacted] File – DOJ00091615, DOJ00092687, DOJ00096290, DOJ00079165, DOJ00091997, DOJ00091797, DOJ00092036, DOJ00091879, DOJ00092837, DOJ00091830, DOJ00091838, DOJ00092808, DOJ00091727, DOJ00092261, DOJ00091676, DOJ00092382, DOJ00092154, DOJ00020076, DOJ00092447, DOJ00092647, DOJ00092056, DOJ00090750, DOJ00090783, DOJ00092148, DOJ00090756, DOJ00079056, DOJ00079162, DOJ00079576, DOJ00079137, DOJ00079053, DOJ00092835, DOJ00093554, DOJ00093676, DOJ00093673, DOJ00093637, DOJ00093697

DESCRIPTION OF DOCUMENTS UPLOADED TO SHAREFILE FOR JEFFREY SCHWARTZ BY ROSEN BIEN GALVAN & GRUNFELD LLP, as of June 2, 2020

- [redacted] File – DOJ00093145, DOJ00049693, DOJ00090650
- [redacted] File – DOJ00090053, DOJ00050070, DOJ00090224, DOJ00090136, DOJ00090051, DOJ00049805, DOJ00093709, DOJ00093706, DOJ00093704, DOJ00093712
- [redacted] File – DOJ00076342, DOJ00076621, DOJ00076860, DOJ00076256, DOJ00090788, DOJ00091180, DOJ00091391, DOJ00076254, DOJ00076616, DOJ00076428, DOJ00090786, DOJ00091593, DOJ00091606, DOJ00093536, DOJ0009333
- [redacted] File – DOJ00002945, DOJ00078561, DOJ00078555, DOJ00059461, DOJ00068260
- [redacted] File – DOJ00093627, DOJ00093543, DOJ00018431, DOJ00078167, DOJ00078202, DOJ00078086, DOJ00078093
- [redacted] File – DOJ00016330, DOJ00062548, DOJ00061399
- [redacted] File – DOJ00006717, DOJ00006735
- [redacted] File – DOJ0001281
- [redacted] File – DOJ00064188, DOJ00063554
- [redacted] File – DOJ00015111, DOJ00015125, DOJ00015174, DOJ00015203
- Audit Inquiry File – DOJ00004803
- [redacted] File – DOJ00010628, DOJ00010640
- [redacted] File – DOJ00006831, DOJ00006838
- [redacted] File 2 – DOJ00006821, DOJ00006828
- [redacted] File – DOJ00006926, DOJ00006923
- [redacted] File 2 – DOJ00006758, DOJ00006785, DOJ00006769
- [redacted] File – DOJ000006786, DOJ00006794
- [redacted] File – DOJ00002404, DOJ00006942, DOJ00047562, DOJ00002513, DOJ00013863
- [redacted] File – DOJ00002236
- [redacted] File – DOJ00061874, DOJ00060462
- [redacted] File – DOJ00062057, DOJ00060811
- [redacted] File – DOJ00062002, DOJ00060685
- [redacted] File – DOJ00012821
- [redacted] File – DOJ00015227
- [redacted] File – DOJ00010120, DOJ00010124, DOJ000101249

Declarations of *Armstrong* and *Coleman* class members in support of Plaintiffs' RJD Motion related to investigations and inquiries into staff misconduct at RJD:

- [redacted]
- [redacted]
- [redacted]

DESCRIPTION OF DOCUMENTS UPLOADED TO SHAREFILE FOR JEFFREY SCHWARTZ BY ROSEN BIEN GALVAN & GRUNFELD LLP, as of June 2, 2020
• [redacted] • [redacted] • [redacted] • [redacted] • [redacted]