Exhibit TT

DIVISION OF HEALTH CARE SERVICES
STATEWIDE MENTAL HEALTH PROGRAM
P.O. Box 588500
Elk Grove, California 95758

July 9, 2019

Matthew A. Lopes, Jr. Esquire
Office of the Special Master
Pannone Lopes Devereaux & O'Gara LLC
Northwoods Office Park
1301 Atwood Avenue, Suite 215 N
Johnston, RI 02919

via: Elise Owens Thorn, Esquire
Deputy Attorney General
Department of Justice
1300 I Street, Suite 125
P.O. Box 944255
Sacramento, CA 94244-2550

RE: *COLEMAN* MONTHLY REPORT OF INFORMATION REQUESTED AND RESPONSE TO JANUARY 19, 1999, COURT ORDER REGARDING STAFF VACANCIES

Dear Mr. Lopes:

Enclosed is the *Coleman* Monthly Report reflective of May, 2019, data (or as otherwise noted). The following is the list of enclosures:

1. California Department of Corrections and Rehabilitation (CDCR) Staffing Report.
   a. Mental Health Executive Summary.
   b. Mental Institution Vacancy by Classification.
   c. Mental Institution Vacancies Summary by Classification.
   d. Mental Health Month to Month Registry Usage.
   e. Mental Health Six-Month Vacancy Summary.
   f. Mental Health Program Institution Vacancies-Summary by Classification.
   g. Statewide Mental Health Program Compliance Summary Report.
   h. Enhanced Outpatient Administrative Segregation Unit (EOP ASU) Case Manager Positions and Vacancies.
   i. Mental Health Hiring Progress Report.
   j. Mental Health Statewide Hire Tracking Summary -- Clinical Positions Only.
   k. Mental Health Telepsych Allocated and Filled Positions Report.
   l. Psychiatric Inpatient Program (PIP) Staffing Data.
   m. Department of State Hospitals (DSH) Staffing Data.

2. Reception Center Monthly Reports.
   a. Reception Center Mental Health Screening Report.
   b. Reception Center Transfer Timelines Report.

3. Continuous Length of Stay Counts for Mental Health Services Delivery Systems (MHSDS) ASU, Secured Housing Unit (SHU), and Psychiatric Services Unit (PSU) report.

4. EOP Inmates Waiting Transfers to PSU.

5. EOP ASU Hub Trends.

6. Population and Census Reports.
   a. Health Care Placement Oversight Program (HCPOP) Information Report, Summary of Mental Health Population by Institution and Level of Care (H-1).
   b. MHSDS Management Information Summary (MIS).
   c. Weekly EOP/Outpatient Psychiatric Program Report.

7. Mental Health Crisis Bed (MHCB) Reports.
   a. MHCB Referrals report.
   b. MHCB Stays report.
   c. MHCB Wait List.

8. DSH and Inpatient Program Referral Reports.
   a. Referrals for Transfer to Inpatient Programs Report.
   b. DSH Monthly Report of CDCR Patients in DSH Hospitals, Summary of PC 2684s Report.

9. Milestone Credits Report.

10. Work Assignments Report.

11. Out of Level Housing Report.

If you have any questions, please contact me at (916) 691-0296.

Sincerely,

Katie Tebrock

KATHERINE TEBROCK, ESQUIRE
Deputy Director, Statewide Mental Health Program
California Department of Corrections and Rehabilitation

Enclosures

cc: Mohamedu F., Jones, Esq., *Coleman* Deputy Special Master
Kerry F. Walsh, Esq., *Coleman* Deputy Special Master
Jeffrey L. Metzner, M.D., *Coleman* Expert
Kerry C. Hughes, M.D., *Coleman* Expert

Mary Perrien, Ph.D., *Coleman* Expert
Henry A. Dlugacz, Esq., *Coleman* Expert
Patricia Williams, Esq., *Coleman* Monitor
Patrick McKinney, Esq., Office of Legal Affairs, CDCR
Nicholas Weber, Esq, Office of Legal Affairs, CDCR
Michael Bien, Esq., Rosen, Bien and Galvan
Donald Specter, Esq., Prison Law Office
Steve Fama, Esq., Prison Law Office
Brittany Brizendine, Psy.D, Assistant Deputy Director, Statewide Mental Health Program, Division of Healthcare Services (DHCS)
Angela Ponciano, Associate Director, Statewide Mental Health Program, DHCS
Laura Ceballos, Ph.D., Mental Health Administrator, Inpatient Facilities and Quality Improvement, Statewide Mental Health Program, DHCS
Wendy Worrell, Psy.D, Chief Psychologist, Quality Management and Informatics (A), Statewide Mental Health Program, DHCS
Teresa Owens, Health Program Specialist I, Quality Management, Statewide Mental Health Program, DHCS

MENTAL HEALTH SERVICES DELIVERY SYSTEM (MHSDS)
MANAGEMENT INFORMATION SUMMARY (MIS) REPORT

Level of Care	Housing Program	MALES			FEMALES		
		Capacity	Census[1]	Awaiting Placement[2]	Capacity	Census[1]	Awaiting Placement[2]
Correctional Clinical Case Management System (CCCMS)		**27,000**	**25,646**		**2,250**	**2,236**	
CCCMS	Reception Center (RC)		2,388			217	
	General Population (GP)		21,302			1,859	
	Enhanced Outpatient Program (EOP)		85			0	
	Mental Health Crisis Bed (MHCB)		6			0	
	Psychiatric Inpatient Program (PIP)		2			0	
	Specialized Medical Beds Housing		543			22	
	Administrative Segregation Unit (ASU)		259			84	
	Condemned		149			14	
	Long Term Restricted Housing Unit (LTRH)	130	118			0	
	Non-Disciplinary Segregation (NDS)		3			0	
	Psychiatric Services Unit (PSU)		61			0	
	Security Housing Unit (SHU)		5			40	
	Short Term Restricted Housing Unit (STRH)	1,125	725			0	
Enhanced Outpatient Program (EOP)		**7,385**	**6,285**		**225**	**158**	
EOP	Reception Center (RC)		166			0	
	General Population (GP)		76			36	
	Enhanced Outpatient Program (EOP)	6,564	5,212		195	108	
	Mental Health Crisis Bed (MHCB)		20			0	
	Psychiatric Inpatient Program (PIP)		18			0	
	Specialized Medical Beds Housing		188			5	
	Administrative Segregation Unit (ASU)	585	399	47	20	5	0
	Condemned		35			0	
	Long Term Restricted Housing Unit (LTRH)		0			0	
	Non-Disciplinary Segregation (NDS)		0			0	
	Psychiatric Services Unit (PSU)	236	141	19	10	4	0
	Security Housing Unit (SHU)		0			0	
	Short Term Restricted Housing Unit (STRH)		30			0	

Level of Care	Capacity	Census[1]	Awaiting Placement[2]	Capacity	Census[1]	Awaiting Placement[2]
Mental Health Crisis Bed (MHCB)	**434**	**287**	**12**	**41**	**30**	**3**
Psychiatric Inpatient Programs: Intermediate Care Facility (ICF)	**1,136**	**859**	**72**			
Low Custody	390	243	29			
Atascadero State Hospital (ASH)	256	133	19			
Coalinga State Hospital (CSH)	50	38	0			
California Medical Facility (CMF)	84	72	10			
High Custody	746	616	43			
California Health Care Facility (CHCF)	300	280	2			
CMF Single Cells	130	118	4			
CMF Multi Cells	70	49	14			
SVPP Single Cells	202	136	14			
Salinas Valley Psychiatric Program (SVPP) Multi Cells	44	33	9			
Acute Psychiatric Program (APP)	**396**	**330**	**22**			
ASH	0	0	0			
CHCF	214	189	11			
CMF	182	141	11			
Psychiatric Inpatient Program (PIP)	**33**	**26**	**0**	**75**	**46**	**1**
California Institution for Women (CIW)				45	37	0
Patton State Hospital (PSH)				30	9	1
San Quentin (SQ)	33	26	0			
Penal Code 2974s (Parolees)[5]		**3**				
Metro State Hospital (MSH)		0				
Napa State Hospital (NSH)		3				
Patton State Hospital (PSH)		0				
TOTALS (excluding Parolees)	**36,384**	**33,433**	**172**	**2,591**	**2,470**	**4**

	Total Capacity	Total Census[1]	Total Awaiting Placement[2]	Total Over Timeframes[3]	CENSUS PERCENTAGES	
					% MHSDS	% CDCR[4]
CCCMS	29,250	27,882			77.66%	22.17%
EOP	6,759	5,894			16.42%	4.69%
EOP-ASU & NDS	605	404	47	2	1.13%	0.32%
PSU	246	145	19	1	0.40%	0.12%
MHCB	475	317	15	0	0.88%	0.25%
PSYCHIATRIC INPATIENT	1,640	1,261	95	2	3.51%	1.00%
GRAND TOTAL	**38,975**	**35,903**	**176**	**5**	**100.00%**	**28.55%**

[1] Census sources: HCODS for CCCMS, EOP; HEART for MHCB; RIPA reports for ICF, APP, and PIP programs.

[2] Awaiting Placement = The sum of inmates waiting to be placed in a bed at a specific level of care. Those awaiting placement to ICF, APP, and PIP include referrals that have been custodially reviewed by HCPOP and are awaiting bed availability, inpatient program acceptance, or transfer to the inpatient program as of the reporting date (based on the Referrals to Inpatient Programs Application (RIPA)).

[3] Total Over Timeframes = The number of referrals that are beyond Mental Health Program Guide transfer timeframes: EOP-ASU includes cases in non-hubs waiting > 30 days, PSU includes cases with an original CSR endorsement date > 60 days, MHCB includes referrals > 24 hours, Psychiatric Inpatient includes Intermediate referrals > 30 days and Acute referrals > 10 days.

[4] CDCR pop as of 6/12/19 (OISB). Based on Total In-State Institution Population and Out of State (COCF).

[5] Census numbers are tracked and updated by Department of State Hospital (DSH).

Exhibit UU

OFFICE OF LEGAL AFFAIRS
Jennifer Neill
General Counsel
P.O. Box 942883
Sacramento, CA 94283-0001

June 7, 2019

Lisa Ells (LElls@rbgg.com)
Rosen Bien Galvan & Grunfeld LLP
101 Mission Street, Sixth Floor
San Francisco, CA 94105

VIA ELECTRONIC MAIL ONLY

Lisa,

I write to provide you with the requested Enhanced Outpatient Program (EOP) segregation data, which Defendants agreed to produce in Nick Weber's March 20, 2017 letter. Enclosed you will find a report showing the mean and median lengths of stay of class members in segregation, as well as a report on EOP patients and EOP patients on modified programs in segregation refusing more than fifty percent of their groups in the past month.

As of June 5, 2019, the Psychiatric Services Unit (PSU) at California State Prison, Sacramento, houses 199 PSU inmates. One hundred and twenty-five PSU inmates are currently placed in the Behavior Incentive Program as follows:

Step	Number of Inmates
Step 4	7
Step 3	17
Step 2	38
Step 1	63

The remaining PSU inmates have either finished their segregated housing term, are awaiting their initial IDTT, or have been placed in a lower or higher level of care and are awaiting transfer.

Finally, as of June 5, 2019, 3.68%, or 2,892 of the 78,673 non-class members housed in the California Department of Corrections and Rehabilitation, not counting contract beds, were in segregation.

Sincerely,

/s/ Melissa C. Bentz

Melissa C. Bentz
Attorney
Office of Legal Affairs

Exhibit VV

From:	Michael W. Bien
To:	Coleman Team - RBG Only
Subject:	FW: Coleman: PG Departures Update Stipulation [IWOV-DMS.FID6429]
Date:	Monday, July 13, 2020 4:11:30 PM
Attachments:	Shower and Yard in Segregation Compliance for June 2020.pdf Tier Report 07062020 - 07102020.pdf TMHU Patient List 0706-07102020.pdf June 2020 TMHU 114-A Tracking Logs.xlsx

From: Weber, Nicholas@CDCR
Sent: Monday, July 13, 2020 4:10:57 PM (UTC-08:00) Pacific Time (US & Canada)
To: Marc Shinn-Krantz; Melissa Bentz
Cc: Adriano Hrvatin; Damon McClain; Elise Thorn; Kyle Lewis; Lucas Hennes; Tyler Heath; Jessica Winter; Michael W. Bien; Lisa Ells; Matt Lopes; Kerry F. Walsh
Subject: RE: Coleman: PG Departures Update Stipulation [IWOV-DMS.FID6429]

All,

Attached are the following reports:

1) Shower and Yard in Segregation Compliance for June 2020
2) Tier Report (7/6 – 7/10/20)
3) TMHU/TIP Roster (7/6 – 7/10/20)
4) TMHU 114-A Tracing Log June 2020

CDCR will begin preparing redacted forms of these and prior reports referenced in the draft stipulation for inclusion in the Wednesday filing.

Nick Weber
Attorney
Department of Corrections & Rehabilitation
1515 S Street, Suite 314S
Sacramento, CA 95811-7243
(916) 323-3202

Region	Institution	Last Name	First Name	CDCR#	Housing Location	Level of Care	Date of Arrival	Date of Release	Level of Care When Released	TIP Housing (Prior to Release)
I	CCC	[redacted]			Non-Max	MHCB	6/27/2020	Pending		
I	CCC				Non-Max	MHCB	7/2/2020	Pending		
I	FOL				Max	MHCB	7/7/2020	Pending		
I	MCSP				Non-Max	MHCB	7/3/2020	Pending		
I	MCSP				Non-Max	MHCB	7/1/2020	7/6/2020	MHCB	
I	MCSP				Max	MHCB	7/5/2020	7/8/2020	EOP	
I	MCSP				Non-Max	MHCB	7/2/2020	7/6/2020	MHCB	
I	MCSP				Non-Max	MHCB	7/2/2020	7/6/2020	MHCB	
I	MCSP				Non-Max	MHCB	7/1/2020	7/6/2020	MHCB	
I	MCSP				Non-Max	MHCB	7/7/2020	7/8/2020	MHCB	
I	MCSP				Non-Max	MHCB	7/8/2020	Pending		
I	MCSP				Non-Max	MHCB	7/9/2020	Pending		
I	SAC				Max	ICF	5/27/2020	Pending		
I	SAC				Max	MHCB	6/30/2020	7/6/2020	MHCB	
I	SAC				Non-Max	MHCB	7/6/2020	7/8/2020	MHCB	
I	SAC				Max	MHCB	6/30/2020	7/6/2020	MHCB	
I	SAC				Non-Max	MHCB	7/3/2020	Pending		
I	SAC				Max	MHCB	7/6/2020	7/8/2020	MHCB	
I	SAC				Non-Max	MHCB	6/29/2020	Pending		
I	SAC				Non-Max	MHCB	7/5/2020	Pending		
I	SAC				Max	ICF	4/24/2020	Pending		
I	SAC				Non-Max	MHCB	7/6/2020	Pending		
I	SAC				Max	MHCB	7/1/2020	7/8/2020	MHCB	
I	SAC				Non-Max	MHCB	6/30/2020	7/8/2020	EOP	
I	SAC				Max	MHCB	7/8/2020	Pending		
I	SAC				Max	MHCB	7/4/2020	Pending		
I	SAC				Non-Max	MHCB	6/30/2020	7/8/2020	MHCB	
I	SAC				Non-Max	MHCB	6/19/2020	7/8/2020	MHCB	
I	SAC				Non-Max	MHCB	7/5/2020	7/6/2020	EOP	
I	SAC				Max	MHCB	7/1/2020	7/6/2020	CCCMS	
I	SAC				Non-Max	MHCB	7/5/2020	Pending		
I	SAC				Non-Max	MHCB	6/29/2020	7/6/2020	EOP	
I	SAC				Non-Max	MHCB	6/28/2020	Pending		
I	SAC				Max	MHCB	7/5/2020	7/8/2020	MHCB	
I	SAC				Non-Max	MHCB	7/2/2020	7/6/2020	CCCMS	
I	SAC				Max	MHCB	6/30/2020	Pending		
I	SAC				Non-Max	MHCB	7/2/2020	Pending		
I	SAC				Max	MHCB	6/16/2020	Pending		
I	SOL				Non-Max	Acute	7/5/2020	7/8/2020	ACUTE	
II	CTF				Non-Max	MHCB	7/1/2020	7/7/2020	EOP	
II	CTF				Non-Max	MHCB	7/1/2020	7/7/2020	EOP	
II	CTF				Non-Max	MHCB	7/7/2020	Pending		
II	CTF				Non-Max	MHCB	7/7/2020	Pending		
II	CTF				Non-Max	MHCB	7/8/2020	Pending		
II	DVI				Non-Max	MHCB	7/3/2020	7/7/2020		
II	SCC				Non-Max	MHCB	7/1/2020	7/6/2020	CCCMS	
II	SCC				Non-Max	MHCB	7/3/2020	7/6/2020	CCCMS	

II	SCC	[redacted]	Non-Max	MHCB	6/21/2020	7/7/2020	Acute	
II	SVSP		Non-Max	MHCB	7/3/2020	7/6/2020	MHCB	
II	SVSP		Non-Max	MHCB	7/4/2020	Pending		
II	SVSP		Non-Max	MHCB	7/6/2020	7/9/2020	EOP	
II	SVSP		Max	ICF (as of	6/12/2020	7/9/2020	ICF	
II	SVSP		Non-Max	MHCB	7/4/2020	7/7/2020	CCCMS	
II	SVSP		Non-Max	MHCB	7/7/2020	Pending		
II	SVSP		Max	ICF (as of	6/22/2020	Pending		
II	SVSP		Non-Max	MHCB	6/26/2020	Pending		
II	SVSP		Non-Max	MHCB	7/3/2020	7/6/2020	EOP	
II	SVSP		Non-Max	MHCB	7/3/2020	7/6/2020	EOP	
II	SVSP		Non-Max	MHCB	7/3/2020	7/6/2020	EOP	
II	VSP		Non-Max	Acute	6/17/2020	Pending		
II	VSP		Non-Max	MHCB	7/2/2020	7/7/2020	EOP	
II	VSP		Non-Max	MHCB	7/8/2020	Pending		
II	VSP		Non-Max	MHCB	7/5/2020	7/7/2020	EOP	
II	VSP		Non-Max	MHCB	7/2/2020	Pending		
II	VSP		Non-Max	MHCB	7/9/2020	Pending		
II	VSP		Non-Max	MHCB	7/9/2020	Pending		
III	ASP		Treatment in Place	MHCB	6/11/2020	Pending		EOP
III	ASP		Treatment in Place	MHCB	6/28/2020	Pending		OHU
III	ASP		Treatment in Place	MHCB	6/28/2020	Pending		OHU
III	ASP		Treatment in Place	MHCB	6/29/2020	7/6/2020		NDPF
III	ASP		Treatment in Place	MHCB	7/5/2020	Pending		OHU
III	CCI		Non-Max	MHCB	7/3/2020	Pending		
III	CCI		Non-Max	MHCB	7/5/2020	7/8/2020	CCCMS	
III	COR		Non-Max	MHCB	7/5/2020	7/6/2020	MHCB	
III	LAC		Max	MHCB	6/22/2018	7/8/2020	ICF	
III	LAC		Max	MHCB	6/26/2020	7/6/2020	ICF	
III	LAC		Max	MHCB	6/29/2020	7/6/2020	MHCB	
III	LAC		Non-Max	MHCB	6/30/2020	7/9/2020	ICF	
III	LAC		Max	MHCB	7/2/2020	Pending		
III	LAC		Non-Max	APP	7/9/2020	Pending		
III	LAC		Non-Max	MHCB	7/9/2020	Pending		
IV	CAL		Non-Max	MHCB	6/30/2020	Pending		
IV	CAL		Non-Max	MHCB	6/30/2020	Pending		
IV	CAL		Non-Max	MHCB	7/2/2020	7/7/2020	MHCB	
IV	ISP		Treatment in Place	MHCB	7/3/2020	7/7/2020	CCCMS	OHU
IV	RJD		Treatment in Place	ICF	3/11/2020	Pending		EOP
IV	RJD		Non-Max	MHCB	7/2/2020	7/9/2020	EOP	
IV	RJD		Non-Max	MHCB	7/7/2020	Pending		
IV	RJD		Treatment in Place	ICF	7/7/2020	7/9/2020	EOP	EOP
IV	RJD		Treatment in Place	MHCB	7/7/2020	7/8/2020	MHCB	ASU EOP
IV	RJD		Treatment in Place	ICF	4/30/2020	Pending		EOP
IV	RJD		Treatment in Place	ICF	3/27/2020	Pending		EOP
IV	RJD		Non-Max	MHCB	7/3/2020	7/9/2020	EOP	
IV	RJD		Non-Max	MHCB	7/8/2020	Pending		
IV	RJD		Non-Max	MHCB	7/3/2020	Pending		
IV	RJD		Treatment in Place	MHCB	6/24/2020	Pending		EOP

Exhibit WW

Date	Region	Institution	Patient Code	Program	Sub Program	MHI	Referral Date Time	Clinical LOS	TMHU Placement Date	TMHU Enddate	TMHU LOS	PC Contact	PC Contact Conf	MHMD Contact	MHMD Contact Conf	IDTT	RT Contact	Group Attended	Group Refused	Group Offered	Total Offered	Conf Hour	Non Conf Hour	Cell Front	1st Rounding	2nd Rounding
7/7/2020	Region I	FSP	Patient 1	ASU	ASU	MHCB	7/7/2020 14:03	6.83	7/7/2020 15:40	7/13/2020 14:00	5.93					09:00:00	Standard Con	0	0	0	0					
7/8/2020	Region I	FSP	Patient 1	ASU	ASU	MHCB	7/7/2020 14:03	6.83	7/7/2020 15:40	7/13/2020 14:00	5.93	10:12:00 C	NonCof					0	0	0	0.2		0.2	0.2		
7/9/2020	Region I	FSP	Patient 1	ASU	ASU	MHCB	7/7/2020 14:03	6.83	7/7/2020 15:40	7/13/2020 14:00	5.93	11:41:00 C	NonCof					0	0	0	0.07		0.07	0.07		
7/10/2020	Region I	FSP	Patient 1	ASU	ASU	MHCB	7/7/2020 14:03	6.83	7/7/2020 15:40	7/13/2020 14:00	5.93	08:46:00 C	NonCof					0	0	0	0.08		0.08	0.08		
7/11/2020	Region I	FSP	Patient 1	ASU	ASU	MHCB	7/7/2020 14:03	6.83	7/7/2020 15:40	7/13/2020 14:00	5.93			13:15:00 Ci	NonCof			0	0	0	0.25		0.25	0.25		
7/12/2020	Region I	FSP	Patient 1	ASU	ASU	MHCB	7/7/2020 14:03	6.83	7/7/2020 15:40	7/13/2020 14:00	5.93			11:15:00 Ci	NonCof			0	0	0	0.25		0.25	0.25		
7/13/2020	Region I	FSP	Patient 1	ASU	ASU	MHCB	7/7/2020 14:03	6.83	7/7/2020 15:40	7/13/2020 14:00	5.93	11:20:00 C	NonCof					0	0	0	0.08		0.08	0.08		
7/6/2020	Region I	MCSP	Patient 2	ASU	ASUHub	MHCB	7/5/2020 4:40	3.27	7/5/2020 5:20		9.2	08:00:00 C	NonCof					0	0	0	0.08		0.08	0.08		
7/7/2020	Region I	MCSP	Patient 2	ASU	ASUHub	MHCB	7/5/2020 4:40	3.27	7/5/2020 5:20		9.2	08:25:00 C	NonCof	11:11:00 Ci	NonCof			0	0	0	0.22		0.22	0.22		
7/8/2020	Region I	MCSP	Patient 2	ASU	ASUHub	MHCB	7/5/2020 4:40	3.27	7/5/2020 5:20		9.2	09:05:00 C	NonCof			10:00:00	Standard Con	0	0	0	0.25		0.25	0.25		
7/6/2020	Region I	SAC	Patient 3	ASU	NDS	ACUTE	7/2/2020 14:58	11.8	5/27/2020 20:37		47.56							0	0	0	0					
7/7/2020	Region I	SAC	Patient 3	ASU	NDS	ACUTE	7/2/2020 14:58	11.8	5/27/2020 20:37		47.56							0	0	0	0					
7/8/2020	Region I	SAC	Patient 3	ASU	NDS	ACUTE	7/2/2020 14:58	11.8	5/27/2020 20:37		47.56			07:51:00 Ci	NonCof			0	0	0	0.07		0.07	0.07		
7/9/2020	Region I	SAC	Patient 3	ASU	NDS	ACUTE	7/2/2020 14:58	11.8	5/27/2020 20:37		47.56	11:00:00 C	NonCof					0	0	0	0.17		0.17	0.17		
7/10/2020	Region I	SAC	Patient 3	ASU	NDS	ACUTE	7/2/2020 14:58	11.8	5/27/2020 20:37		47.56							0	0	0	0					
7/11/2020	Region I	SAC	Patient 3	ASU	NDS	ACUTE	7/2/2020 14:58	11.8	5/27/2020 20:37		47.56	10:15:00 C	NonCof					0	0	0	0.25		0.25	0.25		
7/12/2020	Region I	SAC	Patient 3	ASU	NDS	ACUTE	7/2/2020 14:58	11.8	5/27/2020 20:37		47.56	09:45:00 C	NonCof					0	0	0	1.25		1.25	1.25		
7/13/2020	Region I	SAC	Patient 3	ASU	NDS	ACUTE	7/2/2020 14:58	11.8	5/27/2020 20:37		47.56							0	0	0	0					
7/6/2020	Region I	SAC	Patient 4	MHCB	MCB	MHCB	6/30/2020 23:38	6.48	7/1/2020 2:30	7/6/2020 12:51	5.43	10:20:00 C	NonCof					0	0	0	0.17		0.17	0.17		
7/6/2020	Region I	SAC	Patient 5	ASU	NDS	MHCB	6/30/2020 15:32	13.77	6/30/2020 19:52	7/6/2020 13:03	5.72	10:50:00 C	NonCof					0	0	0	0.17		0.17	0.17		
7/6/2020	Region I	SAC	Patient 6	ASU	ASUHub	MHCB	7/6/2020 9:17	8.03	7/6/2020 11:01	7/8/2020 15:52	2.2	08:45:00 C	NonCof					0	0	0	0.5		0.5	0.5		
7/7/2020	Region I	SAC	Patient 6	PSU	PSU	MHCB	7/6/2020 9:17	8.03	7/6/2020 11:01	7/8/2020 15:52	2.2			10:00:00 Ci	NonCof			0	0	0	0.83		0.83	0.83		
7/8/2020	Region I	SAC	Patient 6	PSU	PSU	MHCB	7/6/2020 9:17	8.03	7/6/2020 11:01	7/8/2020 15:52	2.2			07:30:00 Ci	NonCof			0	0	0	0.5		0.5	0.5		
7/6/2020	Region I	SAC	Patient 7	ASU	NDS	ICF	5/1/2020 15:37	73.77	6/16/2020 20:43		27.56							0	0	0	0					
7/7/2020	Region I	SAC	Patient 7	PSU	PSU	ICF	5/1/2020 15:37	73.77	6/16/2020 20:43		27.56	11:20:00 C	NonCof					0	0	0	0.17		0.17	0.17		
7/8/2020	Region I	SAC	Patient 7	ASU	NDS	ICF	5/1/2020 15:37	73.77	6/16/2020 20:43		27.56			07:46:00 Ci	NonCof			0	0	0	0.07		0.07	0.07		
7/9/2020	Region I	SAC	Patient 7	ASU	NDS	ICF	5/1/2020 15:37	73.77	6/16/2020 20:43		27.56	10:40:00 C	NonCof					0	0	0	0.17		0.17	0.17		
7/10/2020	Region I	SAC	Patient 7	ASU	NDS	ICF	5/1/2020 15:37	73.77	6/16/2020 20:43		27.56							0	0	0	0					
7/11/2020	Region I	SAC	Patient 7	ASU	NDS	ICF	5/1/2020 15:37	73.77	6/16/2020 20:43		27.56	10:00:00 C	NonCof					0	0	0	0.25		0.25	0.25		
7/12/2020	Region I	SAC	Patient 7	ASU	NDS	ICF	5/1/2020 15:37	73.77	6/16/2020 20:43		27.56	09:30:00 C	NonCof					0	0	0	0.25		0.25	0.25		
7/13/2020	Region I	SAC	Patient 7	ASU	NDS	ICF	5/1/2020 15:37	73.77	6/16/2020 20:43		27.56							0	0	0	0					
7/9/2020	Region I	SAC	Patient 8	ASU	ASU	MHCB	7/8/2020 22:34	5.48	7/9/2020 0:30		5.4			08:30:00 Ci	NonCof			0	0	0	0.75		0.75	0.75		
7/10/2020	Region I	SAC	Patient 8	ASU	NDS	MHCB	7/8/2020 22:34	5.48	7/9/2020 0:30		5.4	09:15:00 C	NonCof					0	0	0	1		1	1		
7/11/2020	Region I	SAC	Patient 8	ASU	NDS	MHCB	7/8/2020 22:34	5.48	7/9/2020 0:30		5.4	09:45:00 C	NonCof					0	0	0	0.42		0.42	0.42		
7/12/2020	Region I	SAC	Patient 8	ASU	NDS	MHCB	7/8/2020 22:34	5.48	7/9/2020 0:30		5.4			11:15:00 Ci	NonCof			0	0	0	0.42		0.42	0.42		
7/13/2020	Region I	SAC	Patient 8	ASU	NDS	MHCB	7/8/2020 22:34	5.48	7/9/2020 0:30		5.4	07:25:00 C	NonCof					0	0	0	0.08		0.08	0.08		
7/6/2020	Region I	SAC	Patient 9	ASU	NDS	MHCB	7/5/2020 3:10	9.29	7/5/2020 3:50		9.26	11:20:00 C	NonCof					0	0	0	0.17		0.17	0.17		
7/7/2020	Region I	SAC	Patient 9	ASU	NDS	MHCB	7/5/2020 3:10	9.29	7/5/2020 3:50		9.26	11:50:00 C	NonCof			12:00:00	Standard Con	0	0	0	0.17		0.17	0.17		
7/8/2020	Region I	SAC	Patient 9	ASU	NDS	MHCB	7/5/2020 3:10	9.29	7/5/2020 3:50		9.26	10:30:00 C	NonCof	08:01:00 Ci	NonCof			0	0	0	0.32		0.32	0.32		
7/9/2020	Region I	SAC	Patient 9	ASU	NDS	MHCB	7/5/2020 3:10	9.29	7/5/2020 3:50		9.26			10:05:00 Ci	NonCof			0	0	0	0.33		0.33	0.33		
7/10/2020	Region I	SAC	Patient 9	ASU	NDS	MHCB	7/5/2020 3:10	9.29	7/5/2020 3:50		9.26	10:45:00 C	NonCof					0	0	0	0.25		0.25	0.25		
7/11/2020	Region I	SAC	Patient 9	ASU	NDS	MHCB	7/5/2020 3:10	9.29	7/5/2020 3:50		9.26	10:10:00 C	NonCof					0	0	0	0.17		0.17	0.17		
7/12/2020	Region I	SAC	Patient 9	ASU	NDS	MHCB	7/5/2020 3:10	9.29	7/5/2020 3:50		9.26	11:15:00 C	NonCof					0	0	0	0.25		0.25	0.25		
7/13/2020	Region I	SAC	Patient 9	ASU	NDS	MHCB	7/5/2020 3:10	9.29	7/5/2020 3:50		9.26			11:30:00 Ci	NonCof			0	0	0	0.25		0.25	0.25		
7/6/2020	Region I	SAC	Patient 10	ASU	NDS	MHCB	7/1/2020 11:03	5.14	7/1/2020 12:55	7/6/2020 18:40	5.24	11:40:00 C	NonCof			12:00:00	Standard Con	0	0	0	0.17		0.17	0.17		
7/6/2020	Region I	SAC	Patient 11	PSU	PSU	MHCB	7/5/2020 11:11	8.95	7/5/2020 13:03	7/8/2020 15:39	3.11							0	0	0	0					
7/7/2020	Region I	SAC	Patient 11	PSU	PSU	MHCB	7/5/2020 11:11	8.95	7/5/2020 13:03	7/8/2020 15:39	3.11	11:10:00 C	NonCof			12:46:00	Standard Con	0	0	0	0.17		0.17	0.17		
7/8/2020	Region I	SAC	Patient 11	ASU	NDS	MHCB	7/5/2020 11:11	8.95	7/5/2020 13:03	7/8/2020 15:39	3.11							0	0	0	0					
7/6/2020	Region I	SAC	Patient 12	MHCB	MCB	MHCB	6/30/2020 20:20	8.69	6/30/2020 22:54		13.46	10:30:00 C	NonCof					0	0	0	0.17		0.17	0.17		
7/7/2020	Region I	SAC	Patient 12	MHCB	MCB	MHCB	6/30/2020 20:20	8.69	6/30/2020 22:54		13.46	11:40:00 C	NonCof					0	0	0	0.17		0.17	0.17		
7/8/2020	Region I	SAC	Patient 12	MHCB	MCB	MHCB	6/30/2020 20:20	8.69	6/30/2020 22:54		13.46			12:30:00 Ci	NonCof			0	0	0	0.67		0.67	0.67		
7/9/2020	Region I	SAC	Patient 12	MHCB	MCB	MHCB	6/30/2020 20:20	8.69	6/30/2020 22:54		13.46							0	0	0	0					
7/10/2020	Region I	SAC	Patient 12	ASU	NDS	ACUTE	7/9/2020 12:55	4.88	6/30/2020 22:54		13.46							0	0	0	0					
7/11/2020	Region I	SAC	Patient 12	ASU	NDS	ACUTE	7/9/2020 12:55	4.88	6/30/2020 22:54		13.46	09:15:00 C	NonCof					0	0	0	0.25		0.25	0.25		

Date	Region	Institution	Patient Code	Program	Sub Program	MHI	Referral Date Time	Clinical LOS	TMHU Placement Date	TMHU Enddate	TMHU LOS	PC Contact	PC Contact Conf	MHMD Contact	MHMD Contact Conf	IDTT	RT Contact	Group Attended	Group Refused	Group Offered	Total Offered	Conf Hour	Non Conf Hour	Cell Front	1st Rounding	2nd Rounding
7/12/2020	Region I	SAC	Patient 12	ASU	NDS	ACUTE	7/9/2020 12:55	4.88	6/30/2020 22:54		13.46							0	0	0	0					
7/13/2020	Region I	SAC	Patient 12	ASU	NDS	ACUTE	7/9/2020 12:55	4.88	6/30/2020 22:54		13.46							0	0	0	0					
7/6/2020	Region I	SAC	Patient 13	ASU	NDS	ACUTE	6/29/2020 13:22	14.86	6/16/2020 15:54		27.76							0	0	0	0					
7/7/2020	Region I	SAC	Patient 13	ASU	NDS	ACUTE	6/29/2020 13:22	14.86	6/16/2020 15:54		27.76	10:50:00 C	NonCof					0	0	0	0.17		0.17	0.17		
7/8/2020	Region I	SAC	Patient 13	ASU	NDS	ACUTE	6/29/2020 13:22	14.86	6/16/2020 15:54		27.76	10:15:00 C	NonCof	08:06:00 Ci	NonCof			0	0	0	0.32		0.32	0.32		
7/9/2020	Region I	SAC	Patient 13	ASU	NDS	ACUTE	6/29/2020 13:22	14.86	6/16/2020 15:54		27.76							0	0	0	0					
7/10/2020	Region I	SAC	Patient 13	ASU	NDS	ACUTE	6/29/2020 13:22	14.86	6/16/2020 15:54		27.76	08:45:00 C	NonCof					0	0	0	0.25		0.25	0.25		
7/11/2020	Region I	SAC	Patient 13	ASU	NDS	ACUTE	6/29/2020 13:22	14.86	6/16/2020 15:54		27.76	09:00:00 C	NonCof					0	0	0	0.25		0.25	0.25		
7/12/2020	Region I	SAC	Patient 13	ASU	NDS	ACUTE	6/29/2020 13:22	14.86	6/16/2020 15:54		27.76	11:00:00 C	NonCof					0	0	0	0.25		0.25	0.25		
7/13/2020	Region I	SAC	Patient 13	ASU	NDS	ACUTE	6/29/2020 13:22	14.86	6/16/2020 15:54		27.76			11:00:00 Ci	NonCof			0	0	0	0.25		0.25	0.25		
7/6/2020	Region II	SVSP	Patient 14	ML	SNY	ICF	6/22/2020 17:16	21.7	6/12/2020 13:19	7/9/2020 11:04	26.91	11:20:00 St	Conf			12:00:00	Standard Con	0	0	0	0.42	0.42				
7/7/2020	Region II	SVSP	Patient 14	ML	SNY	ICF	6/22/2020 17:16	21.7	6/12/2020 13:19	7/9/2020 11:04	26.91	10:20:00 C	NonCof					0	0	0	0.33		0.33	0.33		
7/8/2020	Region II	SVSP	Patient 14	ML	SNY	ICF	6/22/2020 17:16	21.7	6/12/2020 13:19	7/9/2020 11:04	26.91	16:08:00 C	NonCof					0	0	0	0.25		0.25	0.25	RT at 10:00	
7/9/2020	Region II	SVSP	Patient 14	ML	SNY	ICF	6/22/2020 17:16	21.7	6/12/2020 13:19	7/9/2020 11:04	26.91	08:03:00 C	NonCof	11:30:00 St	Conf			0	0	0	1.28	1	0.28	0.28		
7/6/2020	Region II	SVSP	Patient 15	ML	SNY	ICF	7/2/2020 13:18	11.86	6/12/2020 19:24	7/8/2020 18:04	25.94	08:30:00 C	NonCof					0	0	0	0.42		0.42	0.42		
7/7/2020	Region II	SVSP	Patient 15	ML	SNY	ICF	7/2/2020 13:18	11.86	6/12/2020 19:24	7/8/2020 18:04	25.94	15:10:00 St	Conf					0	0	0	1.33	1.33				
7/8/2020	Region II	SVSP	Patient 15	ML	SNY	ICF	7/2/2020 13:18	11.86	6/12/2020 19:24	7/8/2020 18:04	25.94	15:03:00 St	Conf					0	0	0	1.02	1.02			RT at 10:00	

Average Total Offered	0.27

Exhibit XX

Roy W. Wesley, Inspector General

Bryan B. Beyer, Chief Deputy Inspector General

OIG | OFFICE *of the* INSPECTOR GENERAL

Independent Prison Oversight

January 2019

Special Review of Salinas Valley State Prison's Processing of Inmate Allegations of Staff Misconduct

OIG | OFFICE of the INSPECTOR GENERAL

Roy W. Wesley, Inspector General
Bryan B. Beyer, Chief Deputy Inspector General

Independent Prison Oversight

Regional Offices

Sacramento
Bakersfield
Rancho Cucamonga

January 24, 2019

Dear Governor and Legislative Leaders:

Enclosed is the Office of the Inspector General's report titled *Special Review of Salinas Valley State Prison's Processing of Inmate Allegations of Staff Misconduct*. In January 2018, the secretary of the California Department of Corrections and Rehabilitation (the department) and attorneys from the Prison Law Office requested that the Office of the Inspector General assess Salinas Valley State Prison's (Salinas Valley) process for handling inmate allegations of staff misconduct, commonly referred to as *staff complaints*. The prison conducts staff complaint inquiries—a precursor to a formal investigation—to address such allegations. A staff complaint inquiry includes the gathering of evidence, through interviews and document collection, and can evolve into a formal investigation if the prison suspects staff misconduct serious enough to warrant disciplinary action. This special review encompassed two periods: a retrospective review of 61 staff complaint inquiries that the prison completed between December 1, 2017, and February 28, 2018, and an onsite monitoring review of 127 staff complaint inquiries that the prison initiated between March 1, 2018, and May 31, 2018.

In this report, we concluded that Salinas Valley's process for handling staff complaints was inadequate and may have resulted in decisions it cannot defend. The hiring authority—the person with the authority to hire and discipline staff—determined that subject staff had not violated policy in 183 of the 188 staff complaint inquiries we reviewed (97 percent of the inquiries) and concluded that only one of them warranted a formal investigation. However, we found that more than half of the staff complaint inquiries were inadequately performed because the staff complaint reviewers—supervisors the prison assigned to conduct the staff complaint inquiries—did not follow sound practices with respect to interviewing, collecting evidence, and writing reports. Notably, we found at least one significant deficiency (or inadequate rating) in 173 of the staff complaint inquiries included in this review (92 percent). We did not conclude whether the hiring authority's decisions were correct or incorrect, or whether an accused staff member was responsible for committing the alleged misconduct; rather, we concluded that the hiring authority often made decisions based on flawed investigative work.

The deficiencies we found may have resulted, in part, from a lack of training for the staff complaint reviewers. For instance, among the 61 individual reviewers, only 14 of them had received any training prior to conducting their first staff complaint inquiry-related interview, and that training component consisted of only a two-hour class providing them with a general overview of the process and acquainting them with filling out proper forms. Forty-two individuals received this training class sometime after conducting their first interview, and five individuals never received this training.

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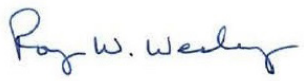
Nevertheless, none of the reviewers received meaningful training in how to conduct interviews, collect evidence, or write reports. Overall, this lack of training was evident in the quality of their staff complaint inquiries.

In addition, we concluded that inadequate staff complaint inquiries resulted not only from poor investigative skills, but also from the staff complaint reviewers' lack of independence. These reviewers were frequently peers or coworkers who worked in the same location as the accused staff—the same individuals the reviewers must rely upon if their physical safety were threatened. The reviewers also displayed signs of bias in favor of their fellow staff when conducting their staff complaint inquiries; they sometimes ignored corroborating evidence offered by inmate witnesses and often compromised the confidentiality of the process. As a result, we question whether Salinas Valley can effectively police itself utilizing the staff complaint process. Furthermore, an inadequately functioning staff complaint process that lacks independence fosters distrust among inmates and, in the cases we reviewed, the compromised confidentiality could have exposed inmates to retaliation for complaining about staff.

Moreover, although we determined Salinas Valley completed most staff complaint inquiries within the required time frame of 30 working days, it did not always notify inmates or its associate director when some staff complaint inquiries took longer to complete than required.

Finally, we also assessed nine other inquiries conducted by reviewers regarding inmate complaints concerning alleged staff misconduct that the Prison Law Office brought to the department. We found that the reviewers' work with respect to these inquiries suffered from the same general types of failures as those we identified during the two periods covered in this special review. We found the quality of seven of the nine inquiries to be inadequate.

Respectfully submitted,



Roy W. Wesley
Inspector General

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"Scales of Justice" (cover): Graphic image designed by the U.S. Department of Justice; sourced via the Internet.

Summary

In January 2018, the secretary of the California Department of Corrections and Rehabilitation (the department) and attorneys from the Prison Law Office requested that the Office of the Inspector General (the OIG) assess Salinas Valley State Prison's (Salinas Valley) process of handling inmate allegations of staff misconduct, commonly referred to as *staff complaints*. The department allows prisons to conduct what are known as *staff complaint inquiries*, a preliminary collection of evidence pertaining to an allegation, and to use local prison supervisors to conduct them. A staff complaint inquiry can evolve into a formal investigation if the hiring authority—the person responsible for hiring and disciplining staff—determines, as part of an inquiry, that staff misconduct may have occurred which warrants disciplinary action.

This special review included a retrospective paper review of 61 staff complaint inquiries the prison completed between December 1, 2017, and February 28, 2018, and an onsite monitoring review of 127 staff complaint inquiries the prison initiated between March 1, 2018, and May 31, 2018. In total, our review included 188 staff complaint inquiries. This special review also included our assessment of nine additional complaints submitted to the department by the Prison Law Office.

Any inmate who alleges staff misconduct may file an appeal, and the prison may handle this appeal as a staff complaint by conducting a staff complaint inquiry. A supervisor—typically a sergeant or a lieutenant—is assigned the staff complaint inquiry as an extra task, in addition to all other regular duties. That supervisor, who is referred to as a *reviewer* for the purposes of this process, collects evidence and conducts interviews of the inmate appellant, of inmate witnesses and staff witnesses, and of the staff member who is the subject of the complaint.

The reviewer then composes a report summarizing the evidence and the interviews, offers a recommendation, collects all evidence into a package, and sends that package to the hiring authority for a determination. If, at any time during this process, the reviewer suspects that serious misconduct possibly warranting adverse personnel action might have occurred, the reviewer must stop the staff complaint inquiry immediately and refer the matter to the hiring authority for further disposition. If the reviewer completes the staff complaint inquiry, the hiring authority then determines whether staff violated policy, and if so, takes appropriate action. If the hiring authority determines that staff did not violate policy, then generally no action is taken. The inmate is informed in writing of the hiring authority's determination of whether staff violated policy.

Staff Complaints … *By the Numbers*

3,218	Staff complaint appeals the department accepted statewide during the six-month period of December 1, 2017, through May 31, 2018.
298	Staff complaint appeals Salinas Valley accepted during the six-month period of December 1, 2017, through May 31, 2018. This number was significantly higher than the number accepted at all other prisons during this time frame and represented about 9 percent of the total.
188	Staff complaint inquiries included in this review. This number reflects the inquiries the prison completed during the three-month period of December 1, 2017, through February 28, 2018, and those it began during the three-month period of March 1, 2018, through May 31, 2018.
414	Interviews of inmates and staff that inquiry reviewers conducted beyond our presence while we were onsite. This included 373 staff witnesses and subjects, and 41 inmate appellants and witnesses. The department did not permit OIG staff to attend interviews of peace officers employed by the department, nor were we properly notified of some interviews conducted with the inmate appellants and witnesses.
218	Interviews of inmates and staff we observed while we were onsite. These included 10 staff witnesses and subjects (none of whom were peace officers), and 208 inmate appellants and witnesses.
183	Staff complaint inquiries for which the hiring authority determined staff acted within policy. In percentage terms, this equated to 97 percent of the staff complaint inquiries. In five instances, the hiring authority determined staff violated policy.
104	Staff complaint inquiries in which we determined the overall quality of the inquiry was inadequate. In percentage terms, this equated to 55 percent.

Special Review Highlights

The Process Salinas Valley Used to Review Allegations of Staff Misconduct Was Inadequate, and Staff Assigned to Conduct the Reviews Were Inadequately Trained

Of the 188 staff complaint inquiries we reviewed, the prison determined that its staff did not violate policy in 183 of them (97 percent). However, we found that the dependability of the staff complaint inquiries was significantly marred by inadequate investigative skills that reviewers demonstrated—notably, by their deficiencies in interviewing, collecting evidence, and writing reports. This resulted in final reports that were often incomplete or inaccurate, or both incomplete and inaccurate. Due to these overall procedural deficiencies, we determined that prison staff completed more than half of the staff complaint inquiries inadequately. This resulted in the hiring authority being deprived of adequate investigative results for making determinations. The hiring authority found that staff had violated policy in five cases and took corrective action in only four cases. The hiring authority determined corrective action was not possible in the fifth case. Furthermore, the hiring authority determined that one case warranted a formal investigation.

Our conclusions, however, are not meant to convey whether the hiring authority's decisions were correct or incorrect, or whether accused staff members were responsible for committing the alleged misconduct; rather, we point out that the hiring authority made decisions based on inadequate investigative work. Highlights of our findings in this section include the following:

- ✓ We found 104 of the 188 staff complaint inquiry reviews (55 percent) to be inadequate.
- ✓ We found at least one significant deficiency in 173 of the 188 staff complaint inquiries (92 percent).
- ✓ A reviewer's rank of service had little effect on the quality of the staff complaint inquiry; we found the work across all ranks to be lacking in quality.

Poor interviewing techniques:

- ✓ In 28 staff complaint inquiries (16 percent), a reviewer improperly interviewed a subject before interviewing the appellant, which was out of sequence.
- ✓ During the onsite review period, in 22 staff complaint inquiries (17 percent), reviewers failed to ask relevant questions or appropriate follow-up questions while interviewing the appellants and inmate witnesses.
- ✓ In the 158 staff complaint inquiries with a potential witness, reviewers failed to interview the witnesses or explain why they had not done so in 47 of those inquiries (30 percent).
- ✓ In 16 instances (9 percent), we found reviewers failed to interview all of the subjects whom they identified or reasonably should have identified.

Poor evidence collection techniques:

- ✓ Of the 150 staff complaint inquiries that could have had relevant evidence to collect, reviewers failed to do so in 90 instances (60 percent).

Poor report writing skills:

- ✓ Of the 188 staff complaint inquiry reports, 108 of them (57 percent) were incomplete or inaccurate, or both.
- ✓ We concluded that 101 of the 188 staff complaint inquiry reports were incomplete (54 percent).
- ✓ We concluded that 45 of the 188 staff complaint inquiry reports were inaccurate (24 percent).

In addition, we found that reviewers were inadequately trained in how to conduct staff complaint inquiries. The two-hour training component that reviewers received during our monitoring period focused on completing forms and observing legal requirements when dealing with peace officers. The training did not include instructions in best practices for framing interviews, planning questions or preparing follow-up questions, or deducing conclusions from evidence. We note the following deficiencies:

- ✓ Only 14 of the 61 reviewers (23 percent) had received any relevant training on the staff complaint inquiry process before conducting their first staff complaint inquiry-related interview.
- ✓ We found that 42 reviewers (69 percent) received training at some point after conducting their first interview. As of November 19, 2018, we found that five reviewers (8 percent) had no record of receiving any training in the staff complaint process.
- ✓ None of the 61 reviewers received meaningful training in techniques of interviewing, collecting evidence, or writing reports.

Staff Complaint Reviewers Were Not Independent: They Sometimes Displayed Bias in Favor of Their Fellow Staff Members, Sometimes Ignored Inmate Witness Testimony, and Often Compromised Confidentiality

Reviewers conducting staff complaint inquiries were supervisors—typically, sergeants and lieutenants—performing inquiries in addition to their regular duties; they were also frequently peers or coworkers of the staff members they were investigating, and were sometimes involved directly or peripherally with the incident under investigation. In a prison setting, these reviewers must always rely on fellow staff for their physical safety, which raises concerns over their ability to remain impartial. Reviewers demonstrated bias against inmates and in favor of staff, recording opinions as evidence, and basing conclusions on

those opinions. Reviewers also ignored corroborating evidence given by inmates in some instances and discounted or mischaracterized corroborating evidence in other instances. Moreover, reviewers frequently compromised the confidentiality of the staff complaint inquiry process, which, in the cases we reviewed, could have exposed the inmates to retaliation for raising concerns against staff. Selected highlights of this finding include the following:

- ✓ In 113 of the 188 staff complaint inquiries (60 percent), the prison assigned a reviewer who worked on the same yard and shift as the subject employee.
- ✓ In 11 instances (6 percent), the reviewer held the same rank or a lower one than the subject employee.
- ✓ In five instances (3 percent), the reviewer was actually involved in the incident giving rise to the staff complaint.
- ✓ During 34 appellant interviews and during 31 witness interviews, reviewers improperly compromised the confidentiality of the process.

Salinas Valley Completed Most of the Staff Complaint Inquiries Within Required Time Frames; However, the Prison Did Not Always Notify Inmates, as Required, When Inquiries Were Overdue

Although the prison completed most of the staff complaint reviews within a 30-working-day time frame, some staff complaint inquiries took longer without the reviewer seeking extensions or notifying the inmates involved that the staff complaint inquiry would be late. On average, the prison completed a staff complaint inquiry in 27 days. We include the following notable findings:

- ✓ Reviewers completed 133 of the 165 time-sensitive staff complaint inquiries (81 percent) within the 30-working-day requirement. Reviewers completed another 18 staff complaint inquiries after 30 working days had passed, but within their requested extension period.

- ✓ Reviewers did not complete 14 staff complaint inquiries (8 percent) on time, including those with a time extension granted.

- ✓ Reviewers failed to provide the inmates with the required notification in 24 of the 32 cases (75 percent) that took longer than 30 working days to complete, and failed to notify their associate director in 27 of the 32 cases (84 percent).

Salinas Valley Staff Worked More Thoroughly When Reviewing Complaints Submitted by Attorneys Who Represented Inmates, but They Still Did Not Complete High-Quality Inquiries

The OIG also assessed the department's inquiries conducted in connection with nine complaint letters submitted to Salinas Valley by the Prison Law Office. Although the inquiry reports for these cases were generally longer and more detailed than the staff complaint inquiry reports prepared in connection with the 188 cases the OIG reviewed during the paper review and the onsite review periods, these inquiries also suffered from the reviewers' general failures to interview subjects and relevant witnesses, the reviewers' not addressing all allegations, and the reviewers interviewing the inmate complainant after interviewing the subjects or other witnesses. We found the quality of seven of the nine inquiries to be inadequate. In addition, the reviewers at times relied upon the investigative work and findings in prior staff complaint inquiries conducted by Salinas Valley regarding these same complaints rather than conducting independent inquiries.

Definitions of Select Terms Used in This Report	
Adverse Action	A documented action, punitive in nature and intended to correct misconduct or poor performance or terminate employment. Examples of these actions include a letter of reprimand, pay reduction, suspension without pay, or termination.
Appeal	An inmate may appeal (or challenge) any policy, decision, action, condition, or omission by the department that has a material adverse effect upon his or her health, safety, or welfare. Toward that end, an inmate may use the form "CDCR Form 602" (commonly referred to as a "602") to file his or her appeal.
Appeals Coordinator	A prison employee who is responsible for processing appeals (receiving, logging, routing, and monitoring disposition), monitoring the system, preparing the quarterly appeals report, recommending corrective action where indicated, and working with the in-service training officer to ensure that training on the appeals process is carried out.
Appellant	The inmate who has submitted an appeal.
Confidential Supplement to Appeal or "Attachment C"	The template used by staff inquiry reviewers to document the results of their inquiries into the allegations in a staff complaint appeal. The template requires the name of accused staff, the allegation or allegations in question, statements of witnesses, findings, conclusion, and recommendation.
Corrective Action	A documented nonadverse action taken by a supervisor to assist an employee improve his or her work performance, behavior, or conduct. Examples of these actions include verbal counseling, in-service training, on-the-job training, written counseling, or a letter of instruction.
Hiring Authority	The individual who has the authority to hire and discipline staff under his or her signature authority. In this context, the hiring authority is the warden of Salinas Valley State Prison and also, in some delegated instances, the chief deputy warden. Throughout this report, we refer to the *hiring authority* with respect to various decisions. For the 188 inquiries we monitored, a total of six individuals were considered to be the hiring authority, two of whom were women and four, men. Thus, the pronouns we use throughout the report may alternate from time to time, depending upon the hiring authority's gender for the case under discussion.
Department Operations Manual	The department's operations manual. The full title is *California Department of Corrections and Rehabilitation Adult Institutions, Programs, and Parole Operations Manual*. It is commonly referred to as the DOM.
Investigative Services Unit	A unit staffed by prison employees who are trained to conduct administrative reviews and investigations.
Office of Internal Affairs	The office within the department authorized to investigate allegations of staff misconduct. This office works independently of the prison chain of command.
Reviewer	A supervising prison employee who is responsible for conducting the staff complaint inquiry. Typically, the reviewer is a sergeant or a lieutenant, but the reviewer must hold at least one rank above that of the accused staff member. This is not a dedicated position: reviewers must also complete their regular duties in addition to conducting staff complaint inquiries.
Staff Complaint	An inmate appeal alleging facts that would constitute prison employee misconduct.
Staff Misconduct	Staff behavior that violates a law, regulation, policy, procedure, or that violates an ethical or professional standard.
Subject	A prison employee who is alleged to have committed misconduct.

Definitions of Select Terms Used in This Report (continued)	
Types of Inquiries/Investigations	
Allegation Inquiry	The collection of preliminary information concerning an allegation of employee misconduct necessary to evaluate whether a matter shall be referred to the (Office of Internal Affairs) Central Intake Unit. Allegation inquiries shall be conducted at the direction of the hiring authority when there is an allegation of misconduct, which if true could lead to adverse action, and the subject(s), allegation(s), or both are not clearly defined or more information is necessary to determine if misconduct may have occurred. Prison employees assigned to the Investigative Services Unit or Office of Internal Affairs' special agents conduct allegation inquiries.
Appeal Inquiry	The department conducts a confidential staff complaint appeal inquiry upon receipt of an inmate complaint alleging staff misconduct when the nature of the allegation or the lack of evidence makes adverse action unlikely. The process involves gathering evidence, including documentary evidence and interviews with the appellant, any witnesses, and accused staff, that supports or refutes an allegation of misconduct. Employees at the prison conduct appeal inquiries in addition to carrying out their regular assigned duties. (For purposes of this OIG review, an appeal inquiry is synonymous with a staff complaint inquiry.)
Investigation	The collection of evidence that supports or refutes an allegation of misconduct, including criminal investigations, administrative investigations, retaliation investigations, or allegation inquiries. Office of Internal Affairs' special agents conduct investigations.
Decisions Made During the Appeals Process	
Accepted Appeal	A form 602 appeal that meets the proper criteria and is accepted for processing.
Canceled Appeal	An appeal the appeals coordinator or a manager at the department's headquarters has returned to the appellant without responding to the specific appeal issue and which is considered closed without the appellant having exhausted his or her administrative remedies.
Rejected Appeal	A form 602 appeal the appeals coordinator or a manager at the department's headquarters has returned to the appellant with instructions to correct a deficiency. In some cases, the hiring authority may order an administrative review even though the appeal was rejected.
Withdrawn Appeal	An appeal an inmate has withdrawn. An inmate may withdraw an appeal by requesting that the process be stopped at any point up to receiving a signed response. A withdrawn staff complaint (appeal) must be returned to the hiring authority to determine further administrative action.
Monitoring Periods in This Review	
Onsite Review Period	The three-month period of staff complaint inquiries the prison initiated between March 1, 2018, and May 31, 2018. During this period of the review process, we actively monitored the handling of complaints in real time, attending the interviews of inmates and nonpeace officer staff.
Paper Review Period	The three-month period of staff complaint inquiries the prison completed between December 1, 2017, and February 28, 2018. During this period of the review process, we performed a retrospective review of all written documents supporting the type of review the prison conducted.

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Introduction

Background

In January 2018, the secretary of the department and attorneys from the Prison Law Office requested that the OIG assess the process Salinas Valley used when handling inmate allegations concerning staff misconduct.[1] The department refers to these allegations as *staff complaints*.

An Overview of the Staff Complaint Inquiry Process

The department processes staff complaints in accordance with the regulatory requirements of Title 15, *California Code of Regulations*, and of its departmental operations manual.[2] The department established the staff complaint process as a result of previous negative attention received from the media, courts, and the legislature, who criticized the department for ignoring or condoning employee misconduct toward inmates.[3] To address these concerns, the department acknowledged that "its credibility depended upon its ability to demonstrate appropriate steps [would] be taken to identify and correct staff misconduct when it occur[red] or to refute allegations found to be false."[4]

The department also acknowledged that "the most effective approach would have been to investigate each and every complaint," but noted that "a process involving investigations for every complaint would have been cost[-]prohibitive and easily overwhelmed." The department instead created the confidential staff complaint inquiry process for staff accused of wrongdoing by inmates. The department provided some insight into its rationale on page 3 from its instructional handbook:

> Absent the court[']s approval of a confidential review process, plaintiff's counsel would have been able to litigate the legal sufficiency of each and every step of the process[,] however trivial the

[1] The Prison Law Office is a nonprofit public interest law firm that provides free legal services to adult and juvenile offenders to improve their conditions of confinement.

[2] Title 15, *California Code of Regulations*, Section 3084–3984.9. *California Department of Corrections and Rehabilitation Adult Institutions, Programs, and Parole Operations Manual* (State of California: Department of Corrections and Rehabilitation, 2018). Commonly known as the DOM. Sections 54100.25–54100.25.2.

[3] *Instructional Handbook for Preparers of Staff Complaint Appeal Templates* (California Department of Corrections and Rehabilitation, Division of Adult Institutions, Office of Appeals, February 1, 2016). Hereafter referred to as "departmental instructional handbook."

[4] Ibid, p. 3.

> complaint. The *process*, instead of the complaint[,] would be on trial. This means that every allegation would require a long and costly investigation irrespective of its merit or importance in order to ensure every action was legally defensible. The courts understood this would inevitably result in large backlogs and defeat the main purpose of the staff complaint process which is to ensure timely resolution of complaints.

The department also noted that inmate allegations of staff misconduct may reflect inmates' attempts to manipulate or retaliate against staff, and that staff members' rights to due process must therefore be protected. The staff complaint inquiry review process also functions to "exonerate staff who have been falsely accused,"[5] with this departmental publication offering additional instruction on its opening page[6]:

> Staff complaints raise important issues with respect to how we manage our core responsibilities. Information developed through staff complaint inquiries can provide the Department [with] critical information regarding its effectiveness at managing the inmate population. If the allegations can be proven, the importance of this process is [self-evident]. But even untrue allegations can provide insight into the status of an inmate population. Since institutions are environments where allegations of misconduct may reflect attempts by inmates to manipulate or retaliate against staff, the right of staff to due process is critical to preserve the integrity of the system.

Initial Screening, Reviewing, and Processing of Staff Complaints

An inmate who alleges staff misconduct (i.e., staff behavior that violates law, regulation, policy, procedure, or that violates an ethical or professional standard) may fill out an appeal form (known as CDCR Form 602). On the appeal form, the appellant—the inmate who files an appeal—describes in detail what happened, including dates,

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[5] *Administrative Interview Process Training Module* (State of California: Department of Corrections and Rehabilitation), p. 1. Hereafter referred to as "departmental training module."

[6] Ibid.

times, places, and names of all people involved in the incident and all witnesses, if possible (see Appendix D).

The appellant submits the appeal form to the prison's appeals office, where its staff briefly screen the form to determine whether the complaint would be considered either a routine complaint or a staff complaint. A routine complaint would appear to not involve staff misconduct; for example, an inmate's complaint that his books did not arrive from the library could be one type of a routine complaint. In contrast, an inmate's complaint that a staff member stole his books would be a staff complaint.

Staff at the appeals office send the appeal, now a possible staff complaint, to the appeals coordinator for a second opinion to confirm that it is a staff complaint. The appeals coordinator further screens the appeal to determine whether the alleged misconduct would violate any policy if the allegations were true. While this level of screening duplicates the initial screening, it also provides a trail of additional paper documentation: the appeals coordinator checks a box on a separate form—which serves as a memorandum to the hiring authority—designating his or her judgment in the matter (see Appendix D). If the appeals coordinator concurs that the appeal contains a staff complaint, he or she forwards the appeal form along with the memorandum to the hiring authority.[7] At that point, after reviewing both the appeal and the recommendation from the appeals coordinator, the hiring authority makes the official determination of the staff complaint; this is effected by checking a box on the memorandum form, which offers the following options[8]:

- Refer to the Office of Internal Affairs (OIA) via CDCR Form 989 for Investigation/notification of direct adverse action (reasonable belief misconduct occurred and adverse action likely). *(This option is reserved for instances when the hiring authority reasonably believes that misconduct has occurred and that adverse action is likely.)*
- Refer to Institutional Services Unit (ISU) for Allegation Inquiry (additional information needed to establish

[7] The individual who has the authority to hire and discipline staff under his or her signature authority. In this context, the hiring authority is the warden of Salinas Valley State Prison and also, in some delegated instances, the chief deputy warden. Throughout this report, we refer to the hiring authority with respect to various decisions. For the 188 inquiries we monitored, a total of six individuals were considered to be the hiring authority, two of whom were women and four, men. Thus, the pronouns we use throughout the report may alternate from time to time, depending upon the hiring authority's gender for the case under discussion.

[8] Language in this listing is taken directly from departmental memoranda (see Appendix D, this report); language set in italics is our explanation of the options.

likelihood of adverse action per Department Operations Manual (DOM) Section 31140.14.[)] (*This option is reserved for instances when the hiring authority needs additional information to establish the likelihood of adverse action. The reference to ISU is to the prison's Investigative Services Unit.)*

- Refer to [ ] for an Appeal Inquiry to be conducted by appropriate supervisory staff (adverse action unlikely). The Original of the completed "Confidential Supplement to Appeal, Appeal Inquiry" (Attachment C) is to be forwarded to the Inmate Appeals Office for filing with the appeal. Inmates/Parolees will not be provided a copy of this confidential report. *(This option is reserved for instances when the hiring authority does not believe that adverse action is likely. The square brackets should include a location or area of assignment.)*

- Process as a routine appeal. Appeal does not meet criteria for assignment as a staff complaint (no misconduct identified, even if facts as alleged are assumed to be true)—accept, reject or cancel in accordance with CCR Title 15, Section 3084.5. *(This option is for when the hiring authority believes the appeal does not meet the criteria for assignment as a staff complaint because even if the facts are assumed to be true, as alleged, it would not constitute misconduct.)*

- Cancel/Reject with no Investigation/Inquiry.

- Cancel. Assign for review outside Appeal Process via an Inquiry or Investigation (Offender will *not* be notified. Attachment E is not used). (*For these last two bullet points, the hiring authority could cancel or reject the appeal, but still assign the matter for an inquiry or investigation outside of the appeals process.)*

Steps of a Staff Complaint Inquiry: Interviewing, Collecting Evidence, Writing Reports

When the hiring authority determines that an allegation warrants a staff complaint inquiry (which would be demonstrated by him or her checking off the third bullet point on the outline of the memorandum form listed above), the appeals coordinator forwards the staff complaint to a manager within a particular yard. That manager then assigns the staff complaint inquiry to a reviewer, a supervisor who holds a rank at least one level above that of the accused staff member. In general, the prison must complete the staff complaint inquiry within 30 working days of receiving it. The reviewer first assesses all information contained in the staff complaint and collects any other necessary documentation relevant to the allegations. Next, the reviewer conducts interviews

with the appellant, with all pertinent witnesses, and finally with the subject to obtain relevant testimonial evidence. When conducting a staff complaint inquiry, the reviewer is not compelled to interview all witnesses if he or she can demonstrate that the witness testimony would not be relevant or is not needed because the testimony would be cumulative. If the reviewer believes a witness is not credible, he or she must present facts that support such a conclusion. Reviewers cannot decline to interview witnesses "or reject their testimony 'because they are an inmate'" (departmental training module, p. 3).

If, at any point during the course of the staff complaint inquiry, the reviewer discovers information indicating that serious misconduct (conduct that would likely lead to adverse action) may have occurred, the reviewer must cease interviewing any staff or inmate regarding the matter. The reviewer must immediately bring this information to the hiring authority's attention for further review. The hiring authority must then determine whether to instruct the reviewer to continue the staff complaint inquiry, assign the matter to the prison's Investigative Services Unit, or refer the matter to the Office of Internal Affairs for consideration of an investigation.

Outcomes Following a Staff Complaint Inquiry

When a hiring authority receives a completed staff complaint inquiry report package (the Confidential Supplement to Appeal or Attachment C and related supporting documents), he or she must weigh a number of options. The hiring authority may conclude no policy violation occurred and take no further action. Alternatively, the hiring authority may conclude a policy violation did occur and may impose corrective action, such as on-the-job training or counseling, for minor infractions.

Conversely, if the hiring authority reasonably believes that the policy violation would likely require adverse action, such as a reprimand, pay reduction, suspension, or dismissal, he or she must first refer the matter to the Office of Internal Affairs for consideration of an investigation or for permission to take adverse action without any additional investigation. If the Office of Internal Affairs conducts an investigation, that office would subsequently return its final investigative report to the hiring authority for final disposition. The Office of Internal Affairs' investigative reports do not contain any conclusions or recommendations concerning whether the misconduct occurred; the reports only contain factual evidence uncovered during the investigation. Ultimately, the hiring authority determines all disciplinary and corrective actions against his or her employees. Following the hiring authority's final determination, he or

she must inform the appellant in writing whether or not subject staff violated policy.

Differences Between an Inquiry and an Investigation

Investigative entities often interchangeably use the words *inquiry* and *investigation* to mean an examination or the attempt to determine the facts of an event or situation. In fact, the definitions of *investigation* or *to investigate* incorporate the word *inquiry*, such as in the following example: "The activity of trying to find out the truth about something, such as a crime, accident, or historical issue; especially, either an authoritative inquiry into certain facts, as by a legislative committee, or a systematic examination of some intellectual problem or empirical question, as by mathematical treatment or use of the scientific method."[9] Furthermore, a thesaurus we reviewed identified the word *inquiry* as a synonym for an *investigation*.[10]

Despite these generally accepted meanings, the department does not use the words interchangeably and posits a distinction between inquiries and investigations. The department views an inquiry as either the first step of an investigation or part of the larger process of its investigations. Section 31140.14 of the department's operations manual sets forth that "allegation inquiries shall be conducted at the direction of the Hiring Authority when there is an allegation of misconduct, which if true could lead to adverse action, and the subject(s), allegation(s), or both are not clearly defined or more information is necessary to determine if misconduct may have occurred." If, during the course of an inquiry, the individual conducting the inquiry obtains sufficient information to warrant an internal investigation, then the hiring authority is directed to forward a request for investigation or for authorization to take direct action regarding the allegation(s) to the department's Office of Internal Affairs. Furthermore, in terms of its appeal inquiries, the department notes that "the current appeals review process is designed to complement the larger and more formal investigative process … by providing **an initial review of less serious allegations**" (emphasis added; departmental instructional handbook, p. 3).

Although the department attempts to make a distinction between an inquiry and an investigation, in reality, both processes encompass several and, in some cases, identical core steps in the examination of an event or situation. In its inquiries and investigations, department staff

[9] *Black's Law Dictionary*, ed. B. Garner, 10th ed. (Thomson Reuters, 2014). Entry: "investigation."

[10] *Merriam-Webster's Thesaurus*, online: **https://www.merriam-webster.com/thesaurus/inquiry**.

(the reviewer at the prison or a special agent at the Office of Internal Affairs) conduct interviews with various individuals, including inmates and other prison staff; gather and examine relevant documentary evidence; and draft a report.

However, even though the department's core activities for inquiries and investigations mirror each other, the department uses the term *investigation* to refer to the work conducted by its statewide Office of Internal Affairs, reserving the term *inquiry* primarily for the work conducted by reviewers (or investigators) at the prisons. Ironically, even though the department characterizes the work conducted by special agents with the Office of Internal Affairs as investigations, the special agents advise the accused employees they investigate that the employees are the subjects of an *inquiry* being conducted by the Office of Internal Affairs. Also, the department's own definition of *investigation* includes "allegation inquiries."[11]

Furthermore, investigations conducted by the Office of Internal Affairs are generally more robust, and benefit from the background of those assigned to conduct them and the additional investigative tools and techniques at the disposal of those investigators. The prisons assign *reviewers* at the institutions to conduct inquiries. A reviewer is typically a sergeant or a lieutenant, most of whom have had very little or no investigative training or on-the-job experience conducting investigations. Even when trained in the investigative process, these reviewers tend to possess only rudimentary training in conducting interviews and collecting evidence. In contrast, the Office of Internal Affairs employs special agents to conduct its investigations. These special agents undergo many hours of advanced, specialized, and on-the-job training in conducting investigations.

In addition to the differing backgrounds between those whom the department assigns to conduct inquiries and those it assigns to perform investigations, different tools are generally available to those conducting inquiries versus those performing investigations. Reviewers at the prisons generally have at their disposal basic documentation regarding the misconduct allegation, such as the inmate's written complaint, staff reports, time sheets, and documentation regarding the inmate's housing assignment, disciplinary history, and complaint history. In contrast, special agents have more sophisticated investigative techniques and tools available to them, including the ability to obtain forensic examinations of email messages and other computer-related information; the option to perform surveillance; the ability to conduct

[11] From the DOM, Section 31140.3: "The collection of evidence that supports or refutes an allegation of misconduct, including criminal investigations, administrative investigations, retaliation investigations, or allegation inquiries."

undercover and sting operations; the ability to obtain wiretap evidence; the option to obtain and execute search warrants; and the ability to audio-record interviews. Such techniques are typically unavailable to reviewers at the prisons.

The ability of reviewers and special agents to audio-record interviews is markedly different and illustrates the limitations under which prison reviewers operate in contradistinction to the conditions under which special agents perform their investigations. Reviewers at the prison conducting appeal inquiries may audio-record interviews of employees accused of misconduct only in very limited circumstances. Pursuant to the department's operations manual, Section 54100.25.2, employees who are subjects of a staff complaint inquiry "may request to record the interview and will be allowed to retain their copy of the recording. However, under such circumstances, a concurrent separate recording shall be made by the Department and retained in the appeal office. ***Only the subject*** can initiate a request to record the interview" (emphasis added).

In contrast, Section 31140.33 of the department's operations manual states that during Office of Internal Affairs investigations, "all noticed employee interviews concerning matters that could lead to an adverse action shall be audiotape-recorded." Furthermore, an employee being interviewed as the subject or witness of an investigation may also request audio-recording of the interview.[12] Therefore, in performing investigations, a special agent must record subject and witness interviews. By being required to record such interviews, the special agent has the ability to later review those individuals' statements. This allows the special agent the ability to better familiarize him- or herself with the evidence in the case, and, thus, to conduct a more thorough investigation and prepare a more accurate written report. A special agent often uses information gleaned from reviews of recorded interviews to develop and pursue additional witnesses or evidence. The requirement to record and the ability to later review interviews is also particularly important to assist a special agent in conducting further interviews in an investigation and in being able to effectively confront a subject with information previously provided in interviews conducted at an earlier date. Conversely, due to the recording limitations imposed upon him or her, a reviewer at the prison is deprived of these investigative techniques.

Lastly, another key distinction between these two processes exists when a reviewer uncovers any indication that the matter is serious enough

[12] DOM Section 31140.33, and the *Agreement Between the State of California and California Correctional Peace Officers Association (CCPOA) Covering Bargaining Unit 6 Corrections* (Effective July 3, 2018, Through July 2, 2019, Section 9.09 (j.)).

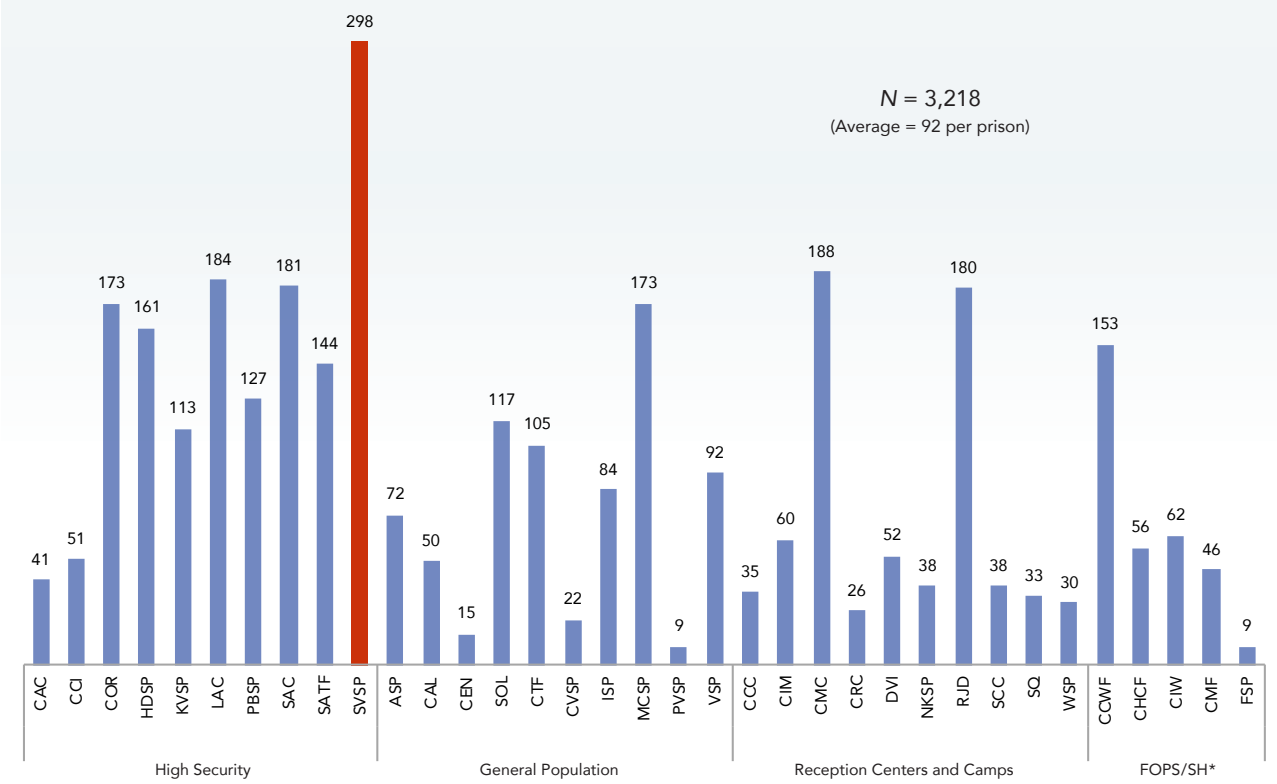
to lead to adverse action. In such cases, the reviewer must immediately stop the inquiry process and return the matter to the hiring authority, who may in turn request that the Office of Internal Affairs conduct an investigation. This procedural stop-mechanism does not occur during an investigation conducted by the Office of Internal Affairs. As we describe in more detail in the body of this report, reviewers completed all but one of the staff complaint inquiries they undertook during our six-month review period, presumably because the one staff complaint inquiry met the department's conditions warranting an additional level of review and, thus, warranting an investigation. Table 1 below lists a comparison of activities associated with the two processes.

Table 1. Comparison of Activities Associated With Inquiry and Investigation Processes

Action	Inquiry	Investigation
Conduct Interviews	✓	✓
Collect and Review Documentary Evidence	✓	✓
Prepare Report	✓	✓
Conducted by Individual With Extensive Training in Investigations		✓
Conducted by Prison Staff With Minimal Training in Investigations	✓	
Forensic Examination of Evidence (optional)		✓
Surveillance (optional)		✓
Undercover / Sting Operations (optional)		✓
Wiretap Evidence (optional)		✓
Search Warrant (optional)		✓
Audio-record Interviews		✓

Source: Analysis of the two processes by the Office of the Inspector General.

Figure 1. Number of Staff Complaints Accepted by the Department, December 1, 2017, Through May 31, 2018



* FOPS/SH is the department's abbreviation that stands for Female Offender Programs and Services/Special Housing.

Source: Data from the California Department of Corrections and Rehabilitation's *Inmate/Parolee Appeals Tracking System*.

Volume and Nature of Staff Complaints

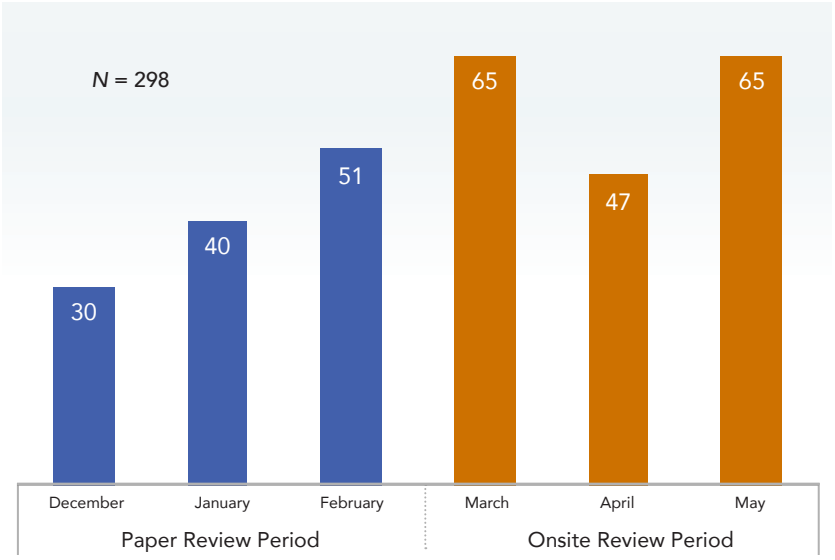
During the six-month period that began December 1, 2017, through May 31, 2018, the department accepted 3,218 staff complaint appeals statewide, ranging from nine to 298 staff complaints among the prisons (see Figure 1, above). This translated into an average acceptance rate of about 92 staff complaints per prison. The department's High Security Mission, which contains 10 institutions, accounted for the largest share of accepted staff complaints, with 1,473 (46 percent).[13] Among those

[13] The department groups the institutions into one of four mission-based disciplines: (1) high security, (2) general population, (3) reception centers and camps, and 4) female offender programs and services/special housing.

10 institutions, Salinas Valley stood out, having accepted 298 staff complaints, 110 more than the prison with the next-highest number of staff complaints and more than three times as many as the average rate per prison. We acknowledge that inmates' awareness of our review could have exerted some influence over these numbers if inmates filed staff complaints in anticipation of our visit during the last three months in this period.

Figure 2 below illustrates the volume of staff complaints accepted by Salinas Valley by month over the six-month review period ending May 2018. From December 2017 through February 2018, Salinas Valley accepted 121 staff complaints, and from March 2018 through May 2018, the prison accepted 177 staff complaints, an increase of 56 staff complaints (46 percent). Again, it is possible the increase is partly due to inmates' anticipation of our review.

Figure 2. Number of Staff Complaints Accepted at Salinas Valley, December 1, 2017, Through May 31, 2018



Source: Data from the California Department of Corrections and Rehabilitation's *Inmate/Parolee Appeals Tracking System*.

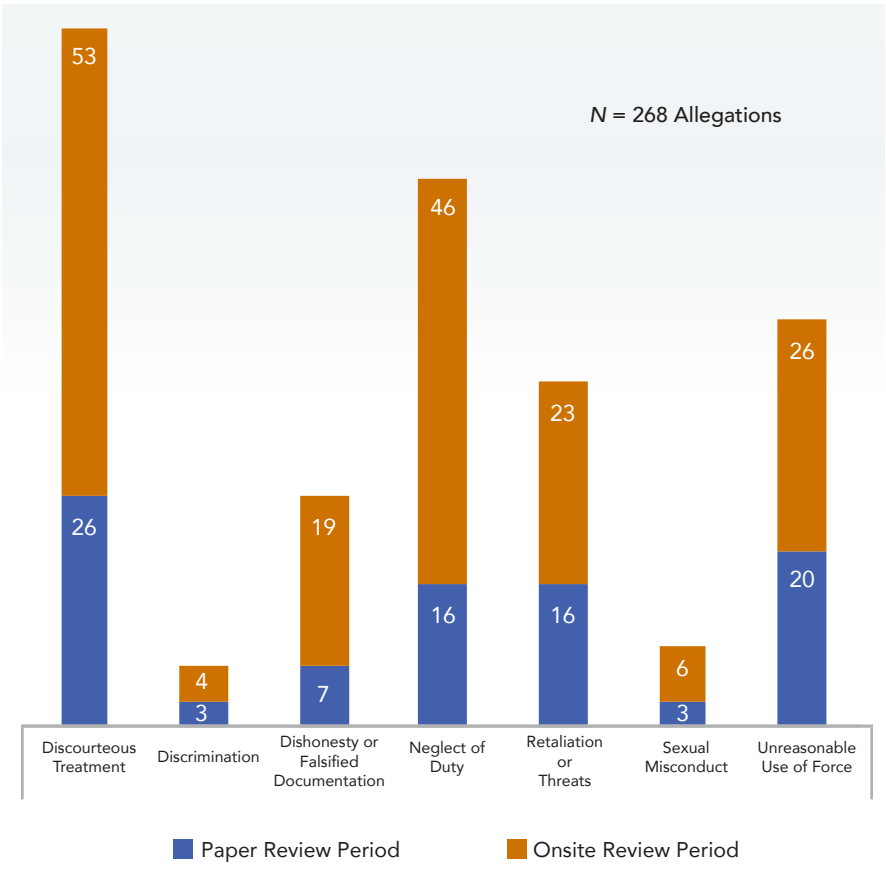
Our review focused on the 61 staff complaint inquiries the prison *completed* between December 1, 2017, and February 28, 2018, and the 127 staff complaint inquiries the prison *initiated* between March 1, 2018, and May 31, 2018. The total number of complaints we reviewed for which the prison completed a staff complaint inquiry during these two periods was 188 (the combination of 61 and 127).[14] We organized these 188 complaints into seven general categories:

- Discourteous Treatment
- Discrimination
- Dishonesty or Falsified Documentation
- Neglect of Duty
- Retaliation or Threats
- Sexual Misconduct
- Unreasonable Use of Force

Of the 188 staff complaint inquiries we reviewed, allegations included a variety of topics, and many staff complaint inquiries included more than one type of allegation (totaling 268 allegations). Figure 3 on the following page shows the most prevalent allegation type included some form of alleged discourteous treatment: in 79 instances (42 percent), inmates complained about their treatment by staff. The second most prevalent complaint involved staff's neglect of duty, for which we reviewed 62 instances (33 percent). The next most prevalent was the use of force: in 46 instances (24 percent), inmates alleged that officers used unnecessary or excessive force against them. Next followed 39 complaints (21 percent) alleging retaliation or threats. This type was followed by 26 complaints (14 percent) alleging some form of dishonesty, nine allegations (5 percent) concerning various types of sexual misconduct, and seven allegations (4 percent) of discrimination.

[14] Not all of the inmate complaints accepted by the prison resulted in a staff complaint inquiry; some were withdrawn, canceled, or referred to the Office of Internal Affairs before they could become inquiries. Our methodology for selecting inquiries for the paper review period included only those for which the prison *completed* an inquiry between December 1, 2017, and February 28, 2018. Therefore, this included some cases that the prison accepted before December 1, 2017, and excluded some cases the prison accepted, but did not complete an inquiry by February 28, 2018. During the onsite review period, we reviewed the inmate appeals reviewed and accepted as staff complaints between March 1, 2018, and May 31, 2018. Some of the onsite review period cases closed, but some did not during the time we completed our review. This accounts for the difference between the 298 staff complaints accepted by the prison during the six-month period and the 188 staff complaint inquiries we reviewed during the same time frame.

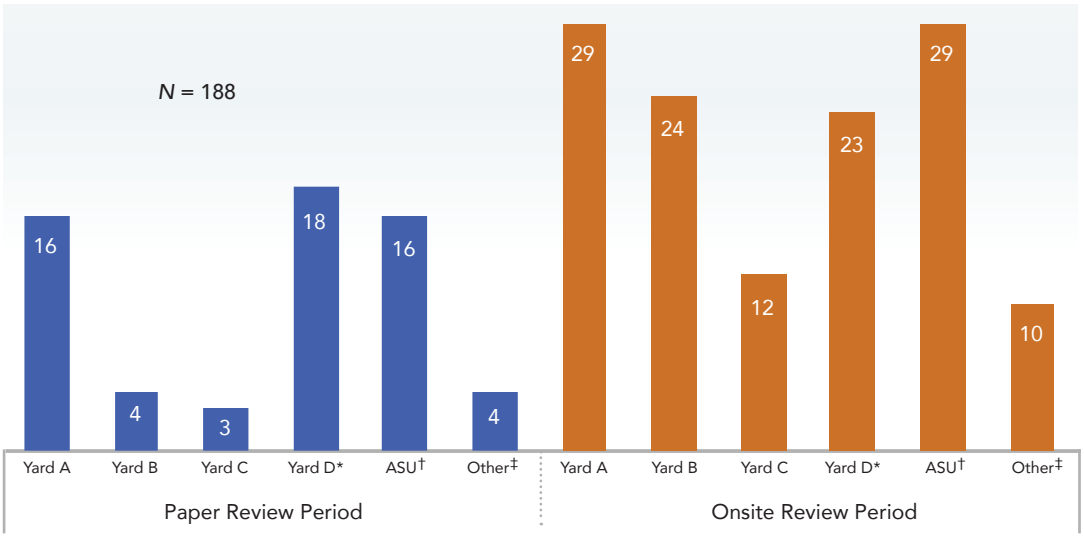
Figure 3. Number and Type of Allegations Included in the 188 Staff Complaint Inquiries We Reviewed



Source: Allegations categorized by the Office of the Inspector General.

To provide a frame of reference, we also organized the 188 complaints we reviewed by the inmate's location at the time the person submitted the complaint (see Figure 4, following page). During the first three months of this period, the highest number of complaints originated from inmates housed on yard "D," which was followed by those housed on yard "A" and in the administrative segregation unit. However, over the second three-month period of our review, the highest numbers of complaints originated from yard "A" and in the administrative segregation unit, followed by those on yards "B" and "D."

Figure 4. Number of Staff Complaints for Which the Prison Completed a Staff Complaint Inquiry, by Appellant Housing Location at the Time of Submission, December 1, 2017, Through May 31, 2018



* Yard D includes housing units D2–D8.

† The Administrative Segregation Unit (ASU) includes D1 and Z9 housing units.

‡ Other includes Central Health, Minimum Support Facility, and other institutions.

Source: Data collected by the Office of the Inspector General.

The Department Is Considering New Options for Handling Staff Complaints

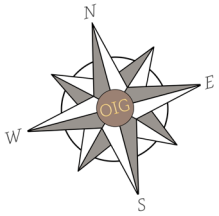
In October 2017, the department set forth an issue paper addressing the findings and recommendations of a wardens' advisory group (wardens' group) that the department convened to consider reforming the appeals process[15] departmentwide. This wardens' group reviewed the department's current appeals processes and procedures, as well as those of other jurisdictions and states, and proposed a series of adjustments it believed would improve efficiency and cost effectiveness while reducing the likelihood of litigation against the department. Proposed changes included implementing an optional informal process that the warden's group surmised could promote inmates' or parolees' direct interaction with departmental staff and help to realize an efficient resolution of complaints, and consolidating levels of review to streamline the appeals process.

[15] In this section, our reference to the department's "appeals process" includes the department's handling of staff complaints.

The issue paper included analyses of the costs and benefits associated with each proposed change to the department's appeals process. Regarding one major area of proposed change, the prison level of review, the wardens' group proposed three distinct alternative plans, each consisting of a detailed process by which an appeal travels to and from various levels of review, including proposed staffing changes to accommodate the changed process. The department, however, did not choose a solution from among these alternatives.

In December 2018, the department provided us with a draft proposal, contemplating another option for restructuring the appeals process. In general terms, the draft proposal considers renaming appeals by calling them "grievances" and "appeals of grievances." Toward that end, grievances would be handled at the local level (prisons) and appeals of grievances would be handled at the headquarters level by the Division of Internal Oversight and Research (a division separate from the Division of Adult Institutions, which controls the prisons). If adopted, the department contends the new process would expedite grievances related to personal safety, institutional safety, or sexual misconduct. The draft proposal also modifies the number of reasons to five for canceling or rejecting appeals.

Figure 5. Salinas Valley State Prison: Site Plan



Key

A and **B**: Complex 1

C and **D**: Complex 2

MSF: Minimum Support Facility

Source of map data: Google Earth © 2018.

URL: https://earth.google.com/web/@36.47787827,-121.37716242,86.03962306a,801.12769569d,35y,130.20425371h,0t,0r (accessed November 20, 2018).

Scope and Methodology

In January 2018, the secretary of the department and attorneys from the Prison Law Office requested that the OIG assess the effectiveness of Salinas Valley's process of handling inmate complaints alleging staff misconduct (see Appendix A to review a copy of the engagement letter and the scope of our work).

This assessment comprised a *review*. We differentiate this term from the term *investigation* in two primary respects. First, a review focuses on the adequacy of a *process*, whereas an investigation focuses on the appropriateness of an individual's *behavior*. Second, a review's intended outcome is fundamentally different from that of an investigation: a review may result in recommendations regarding policies and procedures, whereas an investigation may result in disciplinary or criminal action against individuals due to their behavior, if warranted. Consequently, we present a number of recommendations that address process-related improvements. Our recommendations do not take into consideration the behavior of the individuals we observed throughout the monitoring period.

As a significant limitation to our scope, at the direction of the secretary, OIG monitors were not allowed to witness or attend the interviews of the prison's peace officers. Thus, the conclusions presented in this report reflect only the interviews we were able to witness and the documents we were able to review. At the direction of the federal receiver who oversees the prison health care system, we also limited our review to the staff complaint process under the control of the secretary of the department. Consequently, we did not review any staff complaints processed by California Correctional Health Care Services that were related to the delivery of medical care.

To accomplish our assessment, we reviewed the department's policies, procedures, and regulations regarding the handling of staff complaints. We reviewed both its 2016 instructional handbook and its training module. Both sources served—and continue to serve—as guides for employees involved with the staff complaint process. We also reviewed local operating procedures used specifically by Salinas Valley in connection with this process. Our assessment resulted in a qualitative conclusion of either *adequate* or *inadequate*, referring to the overall quality of the staff complaint inquiry. In this context, quality refers to our opinion of the reviewer's competence in performing various inquiry-related tasks, such as interviewing, collecting evidence, and writing reports. Collectively, we formed an opinion in connection with each staff complaint inquiry we reviewed. Since we were not permitted to observe key interviews of staff subjects and witnesses, our assessment is not

intended to convey validation or invalidation of the prison's conclusions regarding the alleged staff misconduct.

To gain an understanding of the staff complaint inquiry process from the employee's perspective, we spoke with several staff members who worked in the prison's appeals office as well as with various employees who were later assigned to conduct staff complaint inquiries. Several of the employees we spoke with told us they were interested in receiving more training and gaining more experience in performing the duties associated with this process.

To determine how the prison tracked and monitored staff complaints, we reviewed printed outputs generated by the inmate appeals tracking system. The department uses this system statewide to track and monitor staff complaints at all of its locations. However, for the purposes of this review, we did not audit the data or perform any data reliability tests to ensure the completeness and accuracy of the data stored in the system.

To determine whether staff had received training related to the staff complaint process, we reviewed training records for every employee who conducted staff complaint inquiries. We evaluated whether any of the training listed for those employees was sufficient for them to conduct effective staff complaint inquiries.

To determine whether the prison followed its policies when resolving staff complaints, we reviewed documentation for the 61 staff complaints the prison completed between December 1, 2017, and February 28, 2018. Throughout this report, we refer to this period as the *paper review period* since we were not present at the prison, and our review primarily consisted of a paper document review. In contrast, we monitored in person the 127 staff complaint inquiries initiated by the prison between March 1, 2018, and May 31, 2018. We refer to this period as the *onsite review period*. Throughout this report, we present several comparisons of the department's handling of staff complaints in each period. During our review period, the hiring authority referred four staff complaints originating from the appeals process to the Office of Internal Affairs, bypassing the prison's inquiry process. We did not monitor those cases as part of this review, and they are not counted among the 188 staff complaint inquiries. Following the investigation conducted by the Office of Internal Affairs, the hiring authority determined in two of the cases that staff had not violated policy; in the remaining two cases, the hiring authority disciplined staff, issuing a Letter of Reprimand to one employee and imposing a two-day suspension on another employee.

We observed a total of 218 interviews of inmates and noncustody staff, consisting of 118 appellant interviews, 90 inmate witness interviews, four witness interviews of noncustody staff, and six subject interviews

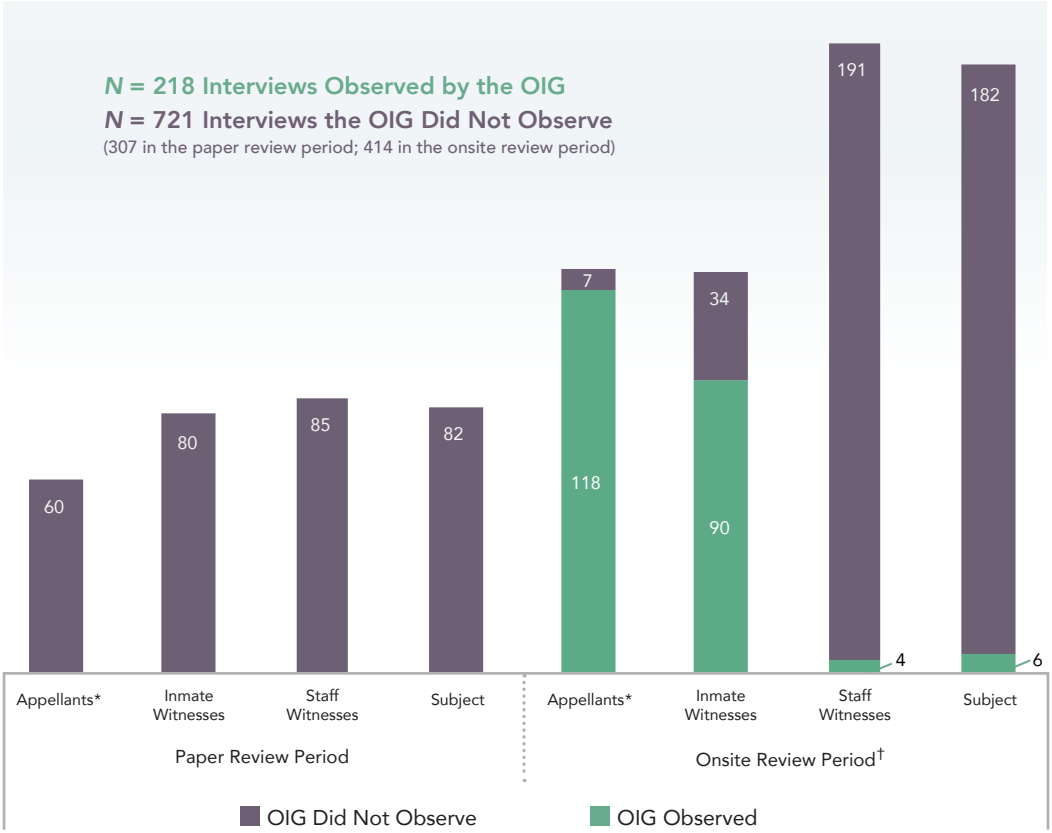
of noncustody staff. As previously noted, the secretary did not permit OIG monitors to attend interviews of peace officer subjects or peace officer witnesses who were named in the complaints. Significantly, during the onsite review period, reviewers conducted a total of 414 interviews outside of the presence of our monitors, consisting of seven appellant interviews, 34 inmate witness interviews, 191 staff witness interviews, and 182 staff subject interviews. Our scope was again limited when reviewers interviewed seven appellants and 34 inmate witnesses without notifying the respective OIG monitor. During the onsite review period, collectively, reviewers conducted 134 more interviews of staff than of inmates. Much of the information reviewers obtained during those interviews was unavailable to us due to the scope limitation; consequently, we could rely only upon the written summary of those interviews contained in the Confidential Supplement to Appeal (staff complaint inquiry report). On the following page, Figure 6 presents a summary of these data points.

To gain an understanding of the staff complaint inquiry process from an inmate's perspective, we interviewed 20 inmates at random who were previously involved with the process during each period. Many of the inmates commented that the staff complaint process was broken. Only three inmates stated that they believed the process was fair, and many said they felt reluctant to use it because they were either directly threatened or retaliated against for filing staff complaints. Comments from interviews ranged from inmates expressing feelings of negativity concerning how they were treated during the staff complaint process to their more serious feelings of being threatened in retaliation for filing a staff complaint.

For example, one inmate told us a reviewer was argumentative with him while he was being interviewed for his staff complaint. According to the inmate, the reviewer challenged the manner in which a subject officer had disrespected him, and the reviewer made the inmate feel "stupid and petty." The inmate told us that he believed the appeal process was a "joke." He made further comments, suggesting the process was "not fair," that "nothing happens with complaints," and "they get shot down." He finally commented that "it is [the inmate's] word versus the officer's word."

Another inmate more ominously described how he was approached by a sergeant three weeks after the inmate participated in a staff complaint inquiry interview. The inmate stated that the sergeant told him not to pursue the staff complaint any further and not to file any additional staff complaints or the inmate would end up in the administrative segregation unit. The inmate added during our discussion with him, "If you file a staff complaint in [the housing unit], they make your life a living hell. The floor officers will go into your cell and destroy it and

Figure 6. Number and Types of Interviews Conducted by the Prison, December 1, 2017, Through May 31, 2018



* One appellant in each of the review periods refused to be interviewed, and one appellant in the onsite period waived his right to be interviewed.

† We did not observe interviews with seven appellants and 34 inmate witnesses as well as with one staff witness and two staff subjects because Salinas Valley neglected to notify us of the interviews.

Source: Data collected by the Office of the Inspector General.

they will use excessive force." The inmate told us that he decided not to elevate his staff complaint to the third level following the sergeant's comments.

Finally, to assess the prison's handling of and response to nine specific complaints submitted to the department by the Prison Law Office between December 21, 2017, and January 23, 2018, we obtained and reviewed the relevant documentation related to each complaint. We present the results in summary form, beginning on page 69.

Special Review Results

Salinas Valley Inadequately Conducted Reviews of Allegations of Staff Misconduct

Salinas Valley's process of reviewing inmate complaints cleared the overwhelming majority of staff who were accused of misconduct. However, we found numerous problems with its process as demonstrated by staff's inadequate skills in gathering evidence through interviews and document collection, and by staff's inadequate report writing skills that rendered final reports that were often incomplete or inaccurate. Staff members who were tasked with conducting staff complaint inquiries received inadequate training in interviewing, gathering evidence, or writing reports, and were instead oriented to filling out basic forms. Further, we found that Salinas Valley did not consistently follow through on corrective actions for the few staff who were found to have violated policy.

An inmate who alleges that a staff member's behavior violated law, policy, or ethical or professional standards is permitted to file an appeal with Salinas Valley's management. The department refers to these types of employee misconduct appeals as *staff complaints* and internally reviews them by conducting a staff complaint inquiry, which is a local, less-formal version of an investigation. In the prison setting, an assigned supervisor (a reviewer) performs a staff complaint inquiry by conducting interviews, collecting relevant documentary evidence, and writing a report. Following a completed staff complaint inquiry, the hiring authority (an individual with the authority to hire and discipline staff) determines whether staff violated policy. We retrospectively reviewed 61 staff complaint inquiries the prison completed from December 1, 2017, through February 28, 2018 (labeled the paper review period), and monitored in person 127 staff complaint inquiries the prison initiated from March 1, 2018, through May 31, 2018 (labeled the onsite review period). Between the two periods, we reviewed a total of 188 staff complaint inquiries (the sum of 61 and 127).

Salinas Valley Rarely Found Misconduct From Its Staff Complaint Inquiries, and in the Few Cases Where It Determined That Staff Violated Policy, It Did Not Always Provide Corrective Action—Until We Asked About It

The hiring authority determined that subject staff did not violate policy in 183 of the 188 staff complaint inquiries we reviewed (97 percent). Although the hiring authority determined that at least six officers violated policy in the remaining five inquiries (3 percent), he or she

did not timely provide the corrective actions ordered for five of the six officers; the hiring authority concluded staff in the remaining staff complaint inquiry violated policy, but did not specifically identify any particular individuals (see Table 2, below). The prison provided a Letter of Instruction (a type of corrective action) to one officer shortly after the hiring authority identified the policy violation, but prison staff took an additional 240 days to provide training to three other officers and 411 days to provide training to two more officers. Unfortunately, too much time had elapsed between the dates the policy violations occurred and the officers' training, greatly diminishing the value of this training. Furthermore, the failure to train staff in a timely manner also suggests Salinas Valley did not take the violations seriously and failed to demonstrate the prison was committed to ensuring its staff make improvements in these areas of concern.

Table 2. Summary of Corrective Actions for the Six Employees Who Were Found to Have Violated Policy

Case ID	Employee	Allegation Type	Policy Violation	Description of Corrective Action	Date Ordered	Date Received*	Number of Days Between Ordered and Received
14	Officer 1	Unreasonable Force	Yes	Training	10/27/17	12/12/18	411
	Officer 2	Unreasonable Force	Yes	Training	10/27/17	12/12/18	411
65	Officer 3	Neglect of Duty	Yes	Training	4/3/18	11/29/18	240
	Officer 4	Neglect of Duty	Yes	Training	4/3/18	11/29/18	240
80	Officer 5	Unreasonable Force	Yes	Training	4/4/18	11/29/18	239
155	Unidentified Employee(s)	Neglect of Duty†	Yes	None	–	–	–
163	Officer 6	Discourteous Treatment	Yes	Letter of Instruction	6/18/18	7/10/18	22

* On November 29, 2018, we asked Salinas Valley to provide us with a status report of the corrective actions it took on the above cases. Based on this request, the prison provided training to three officers as a result of our query (see above, Cases 65 and 80). In addition, on December 12, 2018, Salinas Valley provided training to two officers as a result of our query (see above, Case 14).

† The original allegation in this case was related to discourteous treatment. The reviewer and hiring authority concluded, however, that unidentified staff violated policy when they failed to sign a search receipt. We categorized this as a neglect of duty.

Source: Analysis by the Office of the Inspector General.

The hiring authority determined in one of the staff complaint inquiries that an officer improperly confiscated an inmate's signal amplifier (used for his television) and timely issued the officer a Letter of Instruction, a form of corrective action, 22 days after it was ordered (Case 163). In a second staff complaint inquiry, the hiring authority found that an officer failed to document a use of force and ordered training. However, it took the prison 239 days to train the officer, and only because we asked to see documentation (since the date of the training was the same as the date we contacted the prison) (Case 80). In the third staff complaint inquiry, the hiring authority concluded that two officers had inappropriately refused to sign a form and recommended the officers receive training. As with the last example, the prison provided training to the two officers on the same day we asked for evidence that the training occurred, 240 days after the training was initially ordered (Case 65).

An inmate alleged in the fourth staff complaint that he was subjected to unreasonable force when officers slammed him to the ground. The hiring authority determined that two officers' actions violated policy with respect to their use of force. Based on a handwritten notation on the staff complaint inquiry report (dated December 2017), the hiring authority claimed that corrective action had been taken; however, when we asked in November 2018 to see documentation of the training it provided, the prison responded that it had yet to provide the training and that the action was still pending. On December 12, 2018, Salinas Valley provided us with copies of the training it had just given to the two employees, which took place 411 days after it was initially ordered (Case 14).

In the fifth, and perhaps most problematic, of these five staff complaint inquiries, the hiring authority did not find staff violated policy in any of the inmate's allegations; instead, the hiring authority found that a different policy had been violated when staff did not properly sign a form. Despite finding a violation of policy, the hiring authority did not identify the particular staff members who violated that policy. In this instance, the inmate alleged discourteous treatment and neglect of duty when he complained that upon returning to his bunk, he found that staff had discarded his dental prosthetics during a search of his living area in the dormitory. The inmate alleged that when he spoke to the sergeant about his dental prosthetics, the sergeant responded, "Tough shit[.] 602 it."

We were onsite for the reviewer's interview with this appellant, who commented to the reviewer that his dental prosthetics had been accidentally discarded and that he did not want his appeal to be a staff complaint; he was merely unhappy with the sergeant's response because the inmate wanted to get his missing prosthetics replaced as soon as

possible.[16] The inmate said he was "not looking to get anyone in trouble" and that too many officers had been present for him to be able to identify any one individual.

The reviewer did not obtain the sign-in sheet for staff or the logbook to identify potential staff witnesses, nor did the reviewer interview any witnesses. The reviewer did obtain the search receipt provided to the inmate, but it included only the inmate's name, number, and assigned bunk, and no staff member had signed the receipt. The reviewer also obtained the order requisition confirming the inmate had been issued dental prosthetics.

We were not permitted to observe the reviewer's interview of the named sergeant, but the completed staff complaint inquiry report packet noted that the reviewer asked the sergeant whether he recalled making the statement, "Tough shit[.] 602 it," and that the sergeant replied, "I spoke to several inmates that night and informed them that I was not involved with the searches, [and] that they would have to 602 the Supervisor who oversaw the searches and those conducting the searches."

The reviewer concluded that because the subject sergeant was not the sergeant in charge of the searches, the inmate had "misidentified the sergeant." In fact, the reviewer noted the name of the sergeant who was actually in charge of the searches—the one who should have been included as a subject—but did not interview him. The reviewer provided no explanation for not having done so. Furthermore, the reviewer dropped the allegation of discourteous treatment and focused instead on the neglect of duty for the unsigned search receipt. That unsigned receipt, the reviewer observed, was improper documentation, concluding:

> Staff violated policy when they failed to properly account for a search of the assigned area of the appellant thus causing the unnecessary loss of his upper and lower partial dental prosthetics. Therefore, the appellant's claims do not hold merit against [the interviewed sergeant], but his claims against staff due [*sic*] hold merit as they failed in their responsibilities to properly document a Cell/Bunk/Locker Search within Dorm 1.

[16] Based on our analysis of the six-month period of complaints we reviewed (December 1, 2017, through May 31, 2018), it took Salinas Valley, on average, 27 days to process a staff complaint, which was not soon enough.

The reviewer concluded staff violated policy for the unsigned search receipt, yet failed to connect the violation with any staff names. The reviewer also failed to address the alleged discourteous statement made by a sergeant to the appellant. We are puzzled that the hiring authority agreed with the reviewer's conclusions and signed off on the staff complaint inquiry. She also did not identify any staff names or request further attempts to identify them and also did not address the appellant's discourteous treatment allegation.

When we asked the prison about this staff complaint inquiry in November 2018, a lieutenant responded that he did not believe any further action was possible, unless prison staff were to complete a blanket-style training "on search form completion and/or removal of medical appliances." The hiring authority agreed with the lieutenant and indicated that she did not believe that another training was "warranted at this time." Consequently, no one was held accountable for potentially making a discourteous statement nor for improperly filling out a search form (Case 155).

Moreover, the prison referred six of the 188 staff complaints to the prison's Investigative Services Unit for an additional level of review. This additional review led to the hiring authority determining that staff had not violated policy. The prison also referred one of the 188 staff complaints to the department's Office of Internal Affairs. In this case, the appellant alleged that an officer improperly conducted an unclothed search. The Office of Internal Affairs conducted an interview with the subject and returned the case to the hiring authority for consideration of adverse action. Upon conclusion, the hiring authority did not sustain that allegation.

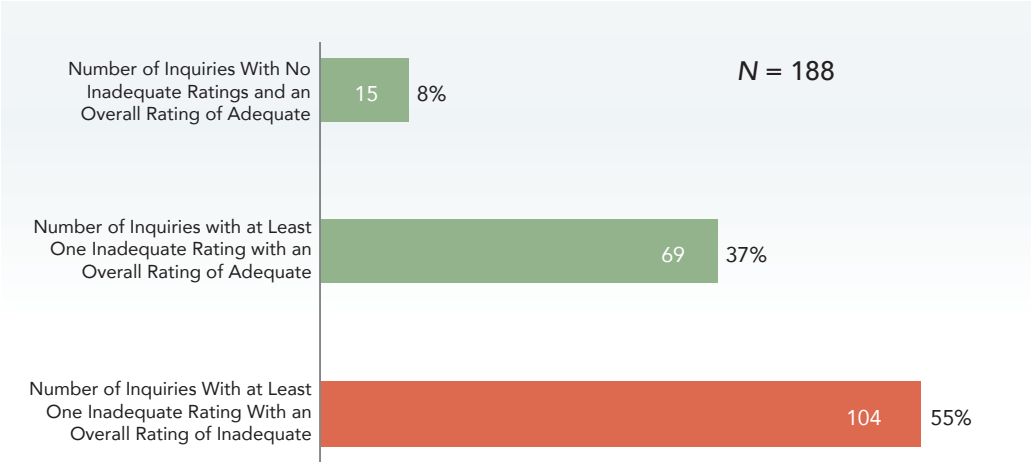
The Quality of More Than Half of the Staff Complaint Inquiries We Reviewed Was Inadequate

Our assessment revealed numerous weaknesses in reviewers' technical proficiencies in their capacities to perform these reviews: their skills in interviewing people, collecting evidence, and writing reports were broadly inadequate. We found, for example, that reviewers frequently interviewed individuals out of sequence and, in some cases, failed to ask relevant questions during interviews. We also found that reviewers sometimes failed to interview pertinent witnesses and subjects altogether and did not explain why they had not done so, as instructed. We also found that reviewers often failed to collect all relevant documentary evidence necessary for a complete staff complaint inquiry. Finally, we found a multitude of deficiencies in the reviewers' report writing skills, reflected regularly in reports that

were inaccurate or incomplete, or both inaccurate and incomplete. We found at least one significant deficiency (or inadequate rating) in 173 of the 188 staff complaint inquiries (92 percent). Overall, these deficiencies led us to conclude that the quality of 104 of the 188 staff complaint inquiries (55 percent) were inadequate (see Figure 7, bottom of this page). Consequently, we question whether the prison could ultimately defend its conclusions while basing them on inadequate staff complaint inquiries.

For the purpose of this review, we assessed *quality* subjectively, using our own professional experience with monitoring investigations and other departmental processes. We assessed the appropriateness of the reviewer's assignment; interviews conducted with the appellant, the witnesses, and the subject; the evidence collected; and the thoroughness of the staff complaint inquiry report. Our qualitative assessments, however, were not intended to reflect either validation or invalidation of the department's policy determinations. An adequate rating reflected our opinion that, overall, the staff complaint inquiry was performed using sound investigative practices. Our assessment was based on six questions, as depicted in Table 3 on the following page.

Figure 7. Overall Quality Ratings for the 188 Staff Complaint Inquiries We Reviewed



Source: Analysis by the Office of the Inspector General.

Table 3. Summary of the OIG's Assessment Questions

Assessment Question*	Relevant Period	
	Paper	Onsite
Question 1 Was the staff complaint inquiry assigned to an appropriate reviewer?	✓	✓
Question 2† Did the reviewer properly conduct an interview of the appellant?	(partial) ✓	✓
Question 3 Did the reviewer properly conduct an interview of the witnesses?	✗	✓
Question 4 Did the reviewer properly conduct an interview of the subjects?	✗	✓
Question 5 Did the reviewer collect all relevant documentary evidence?	✓	✓
Question 6 Did the reviewer prepare an adequate inquiry report?	✓	✓

* For a complete description of the criteria we used to assess these questions, please refer to Appendix C.

† During the paper review period, we only checked whether the appellant was interviewed in the proper order; we did not assess the quality of the interview.

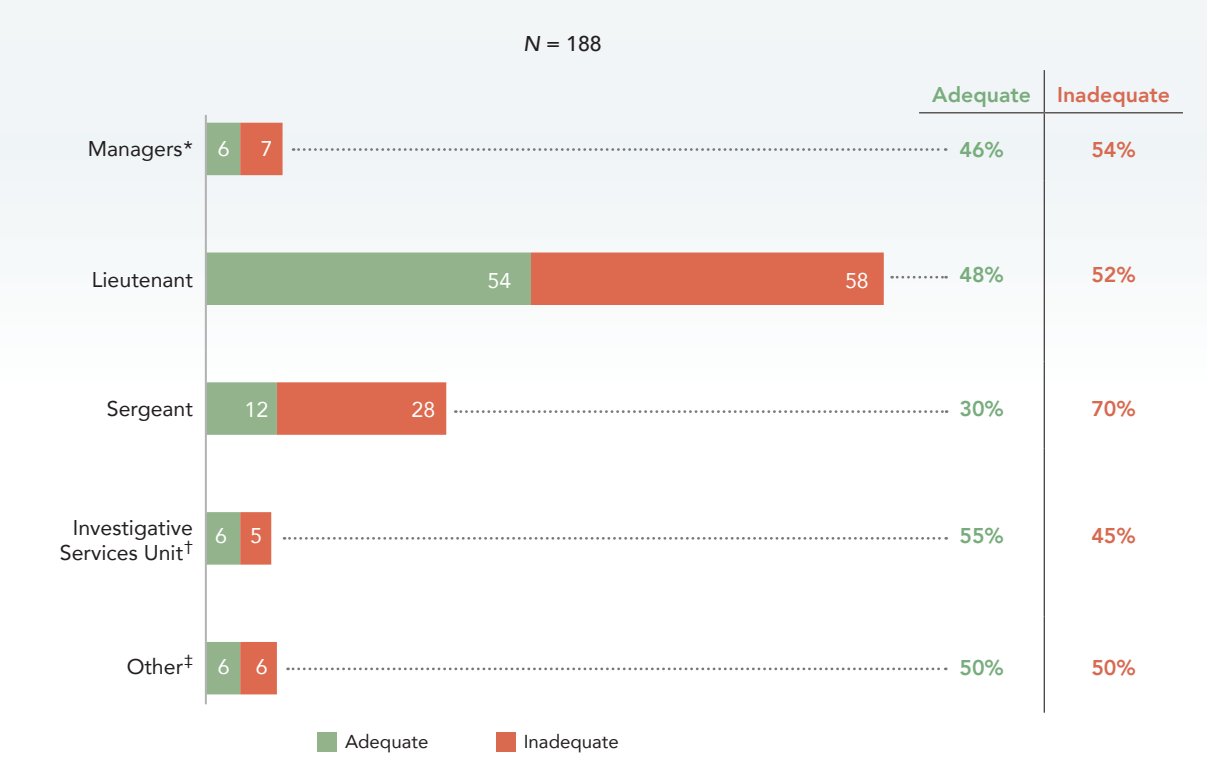
Source: The Office of the Inspector General.

For cases we found inadequate, we did not conclude that staff members alleged to have committed misconduct actually violated policy or were found responsible for the alleged misconduct. Rather, we found that the prison's handling of these cases was inadequate because it did not rely on an adequate process to fully support its conclusions.

We summarized each reviewer by rank or classification to discern whether any notable performance differences were evident; for example, whether more senior employees performed more effectively than less senior employees. On the following page, Figure 8 depicts the groupings by rank, including managers, lieutenants, sergeants, and all others. In addition, we separately grouped those staff complaint inquiries conducted by staff in the Investigative Services Unit. By frequency, out of the 188 staff complaint inquiries, lieutenants performed the majority of them at 112 (60 percent); followed by sergeants with 40 (21 percent). The remaining groups combined performed 36 staff complaint inquiries (19 percent).

The best performers, by rank, were included in the category "others," composed of correctional counselors and other nonsworn supervisors and managers. We found their work to be adequate in 50 percent of their staff complaint inquiries. Next were lieutenants, whom we found conducted adequate staff complaint inquiries in 48 percent of their cases. We found the performance of managers, consisting of associate wardens and captains, to be surprisingly subpar with only 46 percent of their staff complaint inquiries rated adequate. Finally, we found the performance of sergeants to be particularly weak, having rated the quality of their reviews adequate in only 30 percent of their staff complaint inquiries.

Figure 8. Overall Quality for the Staff Complaint Inquiries We Reviewed, by Reviewer Rank



* Managers include the classifications of Associate Warden and Captain.

† The Investigative Services Unit group consisted of inquiries performed by two Lieutenants and two Sergeants.

‡ Other includes the classifications of Correctional Food Manager I, Assistant Correctional Food Manager, Building Trades Supervisor, Prison Industry Manager, and other noncustody, supervisory positions. Also included in this category is the Correctional Counselor II classification, which is a custody position.

Source: Data collected by the Office of the Inspector General.

Similarly, we studied the performance of the staff working in the prison's Investigative Services Unit, who generally bring more experience to bear when conducting various types of investigative activities. We found their performance, however, to be only slightly better than that of those in the other groupings. Two sergeants and two lieutenants from this unit conducted 11 staff complaint inquiries; in six of those, we found the quality of their staff complaint inquiries to be adequate (55 percent).

We Observed Many Instances of Deficient Interviewing Skills

A key problem we found in our review was deficient interviewing skills. Examples of these deficiencies included interviewing subjects prior to interviewing appellants, failing to ask relevant questions during the interviews, neglecting to inquire about other witnesses, or failing to interview all of the pertinent witnesses and subjects. These deficiencies heavily contributed to our overall assessment.

An important aspect of interviewing is the sequence in which interviews are carried out. Both standard investigative practices and the departmental training module dictate that the reviewer interview the appellant first, followed next by interviewing all witnesses, leaving the subject interview for last. Interviewing the appellant first affords the reviewer a better opportunity to fully understand the nature of the complaint and gather information beyond any narrative the appellant is able to communicate in writing. This is especially crucial in the prison setting where inmates often have little formal education and may be less adept with handwriting or expressing their thoughts on paper. This interview sequence also allows the reviewer to develop a comprehensive understanding of the situation before finally questioning the subjects. The reviewer must also establish effective communication with the people he or she interviews, prepare and organize questions in advance of the interview, and recognize opportunities to identify additional potential witnesses as interviews are taking place. A strong proficiency also includes the ability to deviate from a script of interview questions as information is discovered during an interview.

We found that out of the 172 staff complaint inquiries in which reviewers interviewed the appellant and at least one subject, reviewers improperly interviewed at least one subject before they interviewed the appellant in 28 of the cases (16 percent). When this occurred, the reviewers lost the opportunity to question the subject about key issues that arose from speaking with the appellant first. In one case, during the interview of the appellant, the reviewer disclosed to the appellant that he had already spoken to the subject and witnesses and that they had all denied the allegations of misconduct. The appellant then informed the reviewer that he had two separate conversations with the subject: he stated

there were witnesses to the first conversation, but not to the second conversation. The appellant stated that it was the second interaction he was referring to in his complaint. The reviewer would have learned that fact had he interviewed the appellant first, but since he did not, he did not have a complete account of the allegations when he initially interviewed the subject. Of concern, the reviewer did not conduct a follow-up interview with the subject to address the issue of the second conversation (Case 132).

During the onsite review period, we observed numerous instances of reviewers asking ineffective questions or failing to ask appellants obvious follow-up questions when the situation warranted doing so. For example, in one case we monitored a telephone interview of an appellant who, for reasons unrelated to the complaint, had been transferred to another prison. According to the appellant, staff at Salinas Valley had subjected him to cruel and unusual punishment as part of a use-of-force incident. The inmate's appeal stated in its entirety:

> I would like to do a video interview for staff misconduct and for cruel and unusual punishment on 3-18-18. I thank you for your time.

After contacting the appellant by telephone and advising him that the call concerned his staff complaint at Salinas Valley, the reviewer asked the appellant only one question: "Do you have anything else?" The appellant responded by giving a lengthy statement about the incident, including the comment, "All the officers knew." Instead of inquiring about this statement, the reviewer simply repeated, "Do you have anything else?" The appellant made a few additional comments, after which the reviewer concluded the interview. The appellant had not identified any of the officers by name, and the reviewer failed to ask him obvious questions, such as whether the appellant could identify any of the officers by name. The reviewer also failed to ask follow-up questions, such as whether the inmate could clarify his statement or provide a general description of the officers involved in the incident. By asking only one general question and by failing to ask other more pertinent questions, the reviewer appeared disinterested and missed an opportunity to obtain evidence that could have aided in assessing the appellant's credibility or in supporting or refuting his allegations (Case 100).

In another example, an appellant claimed during his interview that a female officer harassed him, calling him a "bitch" and a "coward"; falsely accused him of misbehavior; and issued him an undeserved counseling memorandum. And yet, the male reviewer stated: "She is always professional with me." The appellant replied, in effect, that the

subject officer would naturally be professional with the reviewer because the reviewer held a higher rank and was a supervisor. The reviewer then responded: "Are you calling me a liar?" This reviewer's interviewing technique resulted in the inmate disengaging from the interview. Not only did we find this question to be ineffective, we also found it to be inappropriate and argumentative. Since this conversation took place in the presence of our monitor, it suggested that the reviewer did not care that his comments could be construed as being inappropriate or argumentative. In addition, the reviewer's remarks ignored the department's specific instruction from page 3 of its training module concerning secondhand evidence, as cited below (Case 77):

> When interviewing staff and inmates ask them to state the facts as they observed them. Unfounded, [secondhand] and conclusory statements such as, "he was professional" that do not speak to the allegations are not acceptable responses.

In yet another example, an appellant alleged that a supervising custodian, the subject of the staff complaint, threatened to have the appellant fired from his job if the appellant did not withdraw a prior appeal. The appellant claimed the supervising custodian stated to him "And you wonder why I won't allow you to get a raise to a higher pay slot … just so you know, if you keep this up, you might find yourself without a job." The appellant alleged that when he asked, "Keep what up?", the supervising custodian responded, "Writtin [*sic*] complaints on … staff."

We were present during the reviewer's interview with the appellant and observed a number of problems. The reviewer's first question was "What are you looking for?" The appellant responded, "Fairness." The reviewer then asked about the appellant's level of pay and stated that he would look at the appellant's current hourly wage and make any adjustments if he was not being paid according to policy. The reviewer then asked the appellant if he would consider withdrawing the appeal. The appellant agreed to withdraw his appeal on the condition that the reviewer "would look at … hiring practices." One concern we have with the reviewer's interview is that he neglected to ask any questions about the alleged misconduct, which was the threatening comments made by staff. The reviewer instead offered to address the appellant's pay rate. Although it was good for the reviewer to check the status of the appellant's pay rate, it was not the focus of the staff complaint inquiry. We also found it problematic that the reviewer asked the appellant to withdraw his appeal. The appellant's withdrawal of his appeal did not absolve the supervising custodian if he had made threatening comments (Case 93).

Furthermore, we found that reviewers did not always ask appellants if they could identify witnesses who could provide additional corroborating information. In 21 of the staff complaint inquiries we observed during the onsite review period, reviewers failed to ask whether the appellant had additional witnesses. In these cases, the reviewers missed an opportunity to gather evidence to better support or refute the allegations.

We also found that reviewers did not interview all pertinent witnesses who were identified. In 158 of the 188 staff complaint inquiries, at least one witness was, or reasonably should have been, identified, but reviewers did not interview one or more of them in 47 inquiries (30 percent). The reviewers also failed to provide an explanation, as they are supposed to do, per the departmental training module: "Interview requested witnesses unless it can be demonstrated that their testimony would not be relevant or is not needed as it would only restate information already available" (p. 3).

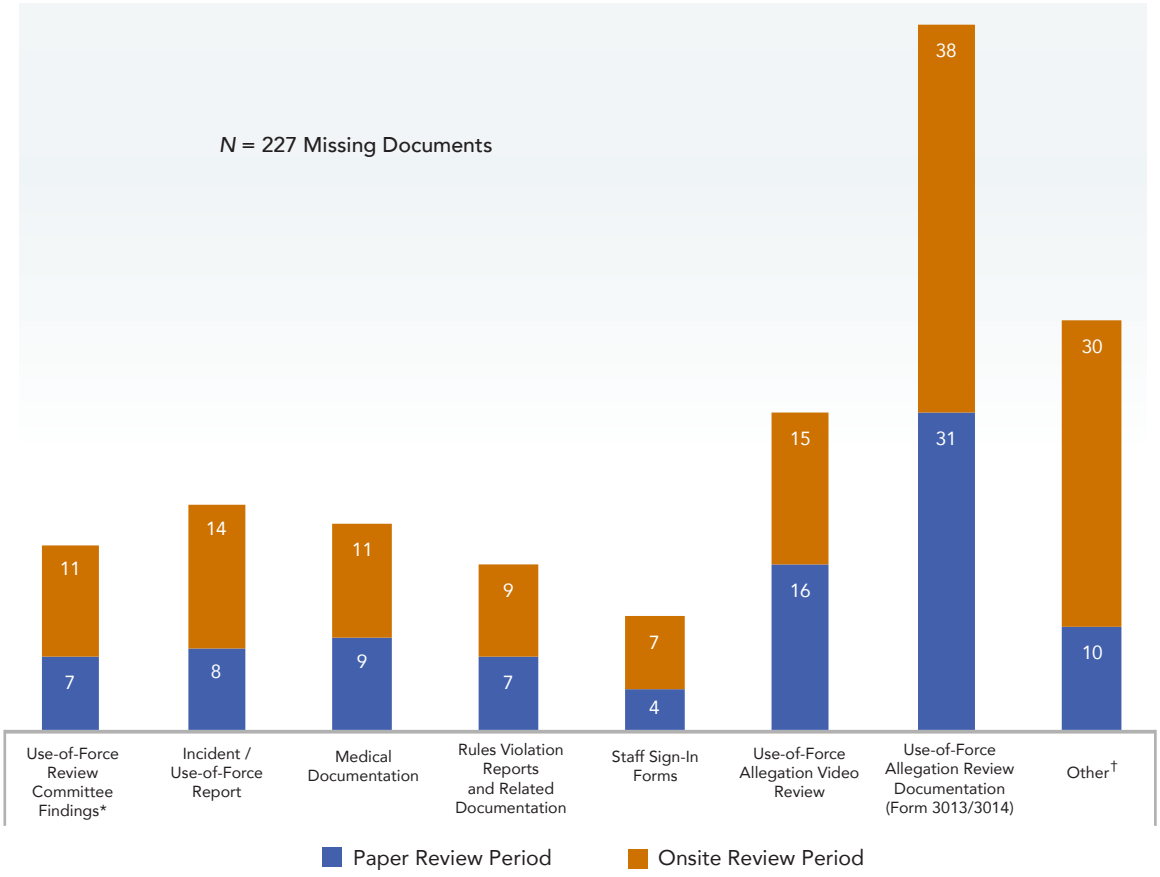
Moreover, we also found that in at least 16 staff complaint inquiries, reviewers failed to interview all the subjects whom they identified or reasonably should have identified. Again, as with the witnesses, the reviewers did not provide a rationale for not interviewing the subjects. In one case, we noted that an appellant named another subject he believed engaged in misconduct, but the reviewer did not interview the additional named subject or other staff. Without having comprehensive investigative results available, the hiring authority did not have enough information to make an informed decision (Case 151).

Staff Complaint Inquiry Reports We Reviewed Often Lacked Complete Documentary Evidence

Our review also revealed that reviewers did not collect or attach to the completed staff complaint inquiry report all necessary documentary evidence required to support or refute allegations of staff misconduct. In the absence of such documentation, reviewers also failed to document their attempts to validate the existence of the documents. Of the 150 staff complaint inquiries that we believe required the reviewer to collect or to attempt to collect some type of documentary evidence, reviewers failed to do so in 90 instances (60 percent). In these instances, we found that reviewers did not collect or try to validate the existence, or contents, of available reports related to other incidents, other interviews, medical visits, prior complaints or appeals, committee decisions regarding uses of force, or records documenting personnel

assignments and attendance, to name a few examples. Figure 9 below shows the number of documents that reviewers neglected to collect, validate, or attach to the completed staff complaint inquiry report. As the figure illustrates, this happened during both the paper review and onsite review periods with some regularity.

Figure 9. Number and Types of Relevant Documentation the OIG Found to Be Missing During the Staff Complaint Review Process



* During our review periods, Salinas Valley conducted 46 use-of-force-related staff complaint inquiries. Out of those 46 inquiries, in 17 cases, the use-of-force review committee made findings, which were available to the reviewer. In four of those cases, the reviewer obtained information regarding the findings, but did not attach findings documentation to the staff complaint inquiry report; and in 13 cases, the reviewer did not obtain information regarding the findings. In all 17 of these cases, the reviewer did not attach available findings documentation to the report. In one remaining case, there was no indication that the reviewer contacted the use-of-force review committee to learn whether there were any findings, and if so, obtain them.

† Other includes various types of documentation such as logs, classification records, prior appeals information, counseling records, and work assignment and pay records.

Source: Data collected by the Office of the Inspector General.

We noted that while some of the staff complaint inquiry reports contained a list of evidence the reviewer had examined, such as incident reports, medical assessments, time sheets, and sign-in logs, other reports did not. Staff complaint inquiry reports lacking these references led us to question whether the reviewer even considered this type of supporting evidence. For example, if an appellant stated that he was seen by medical staff after being subjected to a use of force, we would expect the reviewer to collect the related medical records. Similarly, we would expect a reviewer to collect documentary evidence to identify the names of employees when the appellant was unable to provide their names during the interview. For example, the reviewer could examine employee sign-in sheets or other employee rosters to identify staff members who worked on the date, time, and place in connection with the allegation.

A common omission in evidence collection was the prison's Institutional Executive Review Committee's (use-of-force review committee) findings regarding uses of force. The prison separately reviews use-of-force incidents to evaluate those actions in light of policy and training. Findings produced by this committee were sometimes available for the reviewer to include in the staff complaint inquiry report package and also to consider when recommending action to the hiring authority. In fact, the department's guidance on handling staff complaint inquiries even directs the reviewer to defer to the use-of-force review committee findings (departmental instructional handbook, p. 10). Despite the importance of this evidence, in 13 of the 17 cases in which use-of-force review committee findings were available, the reviewer did not obtain information regarding the findings or note in the staff complaint inquiry report that the committee findings were reviewed or considered.

In one of the cases monitored during the paper review period, an appellant alleged that two officers used unreasonable force on him by slamming him to the ground. The reviewer failed to collect a number of documents central to the allegation, namely, the use-of-force reports prepared by the staff involved in the incident, a previous interview with the appellant concerning this issue, and the findings of the prison's official use-of-force review committee (which had already determined that the use of force violated policy). The reviewer, however, independently determined that the force used was appropriate and indicated that no policy violation had occurred. The hiring authority caught the discrepancy when reviewing the staff complaint inquiry and made a notation on the final staff complaint inquiry report indicating that staff had, in fact, violated policy (Case 14).

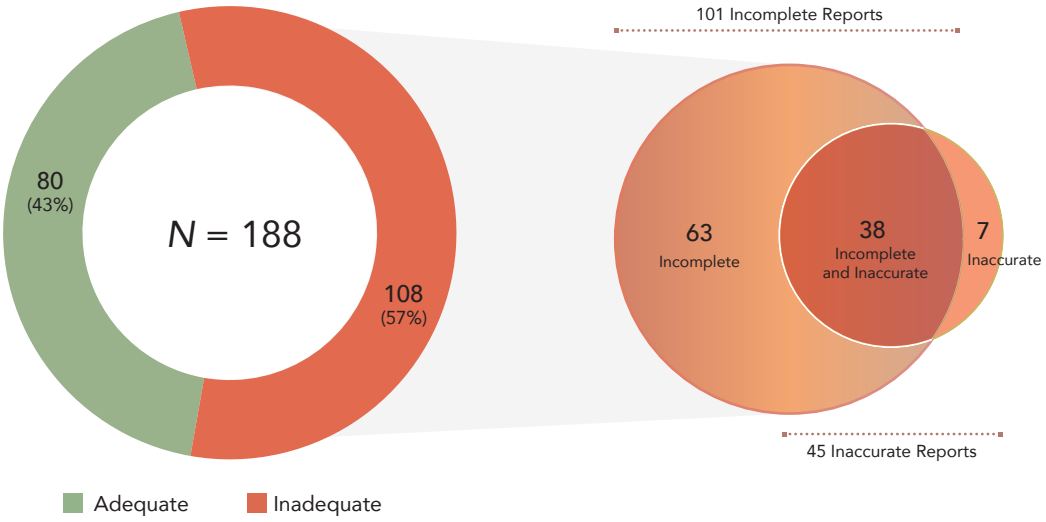
Another common type of documentary omission was related to the collection of relevant medical documentation. In one case, for example, an appellant alleged that an officer shut a food port on one of the appellant's hands while the appellant was attempting to retrieve a medication cup he dropped during medication pass. The appellant alleged that his hand remained stuck in the food port for 15 to 30 minutes, which caused one of his left fingers to be injured. Because we reviewed this case as part of the paper review period, we were not present for the interviews. Nevertheless, our review of the staff complaint inquiry report revealed the reviewer did not document any attempts to locate a medical assessment form that a psychiatric technician generated after evaluating the appellant. Notably, the staff complaint inquiry report included a summary by the psychiatric technician who stated he had not seen anything wrong with the appellant's finger. However, we independently gathered and reviewed a medical assessment form completed by the same psychiatric technician three days later, which documented a "split" to the appellant's left index finger. The reviewer's failure to collect the relevant documentary evidence precluded her from addressing this discrepancy (Case 51).

By not including the requisite documents or documenting any attempts to collect them, the reviewers in these instances neglected to provide the evidence needed to better support or refute staff misconduct allegations. The reviewers also undermined the hiring authority's final review, forcing him or her to rely only on the reviewer's written report without the inclusion of additional supporting evidence.

Staff Complaint Inquiry Reports We Reviewed Were Often Incomplete or Inaccurate; Some Were Both Incomplete and Inaccurate

We found many staff complaint inquiry reports seriously deficient because they were either incomplete or inaccurate, or both incomplete and inaccurate. This deficiency remained consistent throughout both the paper review and the onsite review periods. Since OIG monitors were present for many interviews conducted during the onsite review period, we were in a position to discover numerous discrepancies between what appellants or witnesses said during those interviews and what the reviewer ultimately reported in the summary. In other instances, we found discrepancies by reviewing the completed staff complaint inquiry reports. Figure 10 on the following page shows the distribution of deficiencies.

Figure 10. Quality of the Staff Complaint Inquiry Reports



Source: Data and analysis by the Office of the Inspector General.

The department requires reviewers to complete their staff complaint inquiry report using a specific template form, referred to as the "Confidential Supplement to Appeal" or "Attachment C" (see Appendix D, which offers a blank sample of this form). The template allows reviewers to enter a synopsis of the allegation, their findings, and their conclusion in a consistent format; it also allows the reviewer to include specific information concerning witnesses, including all witnesses he or she interviewed, as well as the identities of witnesses not interviewed and the reasons for not interviewing them. The findings section of this report must include "detailed statements from the inmate/parolee making the allegation, all pertinent witnesses, accused staff (if needed) and a detailed description of any other evidence reviewed" (departmental training module, p. 7). The training module directs the reviewer to "analyze the facts and any logical inference that can be drawn from those facts" and then to indicate on the form "whether any or all of the allegations were supported by the facts, whether the facts were insufficient to support any conclusion or whether the facts were sufficient to exonerate staff of the allegations" (departmental training module, p. 7).

We concluded that 101 of the 188 staff complaint inquiry reports were incomplete. In one particularly egregious instance, a reviewer who interviewed two inmate witnesses failed to include the witness statements in his completed report and thus failed to mention that the witnesses' statements actually corroborated an allegation of potential misconduct. In this case, the appellant alleged that an officer repeatedly called him a "coward" and a "bitch." The appellant also alleged that the officer wrote the word "bitch" on a piece of paper and placed it on his cell-front window, and that the officer had falsified a counseling memorandum issued for talking to other inmates through the cell doors. The appellant provided the reviewer with detailed information concerning his complaint, including names of both inmate and staff witnesses.

The OIG monitor was present during the interviews of the inmate witnesses. One inmate witness stated that he heard the officer scream at the appellant and heard her call the appellant a "coward." The second inmate witness stated that he heard a "heated exchange" between the appellant and the officer, and heard the officer call the appellant a "bitch." On the face of it, these statements directly support the appellant's allegations. Curiously, the reviewer failed to include these inmate witness statements in the staff complaint inquiry report, but he did summarize statements made by three officers whom he interviewed as witnesses outside of our presence. According to these statements, the three officers had not observed any conflicts between the subject officer and the appellant nor observed the subject officer behave in an unprofessional manner toward the appellant. Because he neither presented the information received from inmate witnesses in his report nor offered a credibility assessment of the inmates' statements, the reviewer did not provide the hiring authority with a complete staff complaint inquiry report. Based on the evidence provided, the hiring authority determined staff did not violate policy (Case 77).

In another case demonstrating an incomplete report, the appellant alleged that staff inappropriately housed him with a cellmate, which later resulted in a fight between the two inmates. The appellant did not know who made the decision to house him with another person, so the reviewer chose to name as the subject an officer who escorted the appellant to the administrative segregation unit after the fight. Based on the comments in the staff complaint inquiry report, the subject officer denied having had any part of the decision to house the appellant, resulting in the reviewer concluding that no policy violation occurred. However, if the reviewer had instead conducted even a perfunctory review of the appellant's housing chronology records in the department's computer system, he could have determined which staff member made the housing decision and then talked to that

person about his or her rationale.[17] By not doing so, the reviewer's report was incomplete (Case 5).

Not only did we find omissions that rendered a staff complaint inquiry report incomplete, we also found errors that rendered the staff complaint inquiry reports inaccurate. Of the reports we reviewed during the paper review period, 25 percent (15 of 61) contained errors affecting accuracy; this percentage was nearly the same, 24 percent (30 of 127), during the onsite review period. Errors ranged from incorrect interview dates to more serious inaccuracies.

For example, in one case, the reviewer's characterization of the evidence was inaccurate, and his conclusion was self-contradictory. In this case, the appellant alleged, among other things, that in 2017, three officers falsified monthly pay sheets indicating that he had worked as a porter for more days than he actually had worked. In his conclusion, the reviewer stated that there was no evidence to support allegations of staff misconduct and that witness testimony refuted the allegations. Our monitors, however, observed that an inmate witness did corroborate the appellant's allegations. The inmate witness stated that most officers in the building did not like the appellant and did not allow him out to work very often, and when he was let out to work, he was only allowed to work a couple of hours. Despite the reviewer's previous statement that there was no evidence to support the allegations, he continued, "I conclude that there might have been a violation of policy, and therefore this reviewer recommends administrative action." However, the hiring authority determined—based on an inaccurate staff complaint inquiry report—that no policy violation had occurred and took no further action (Case 82).

An appellant alleged in another case that an officer put the appellant's life in jeopardy when the officer inappropriately disclosed to other inmates the nature of the appellant's convictions. During his interview, we heard the appellant state that he feared for his safety if he were released to a particular yard, but not if he were housed in the administrative segregation unit. Yet the reviewer noted in his conclusion, in error, that the appellant stated he did *not* fear for his safety. Again, this significant error rendered the staff complaint inquiry report inaccurate (Case 160).

[17] We checked the department's computer system and, in a matter of minutes, were able to identify the staff member who made the housing decision.

Staff Were Not Adequately Trained to Conduct Staff Complaint Inquiries

During our interactions with reviewers during the onsite monitoring period, we found that staff assigned to conduct staff complaint inquiries were clearly and admittedly unaware of even the most basic investigative techniques, and were not well-versed in best practices in the investigative field. Training serves an essential role in ensuring that staff members have a full grasp of how to conduct a staff complaint inquiry, the standard steps required, and the department's expectations. Proper training also results in greater uniformity and comparability of the resultant work product.

Nevertheless, the reviewers assigned to complete staff complaint inquiries received only rudimentary training. In fact, among the 61 individual staff members who conducted staff complaint inquiries during our review, only 14 had undergone any training prior to conducting their first staff complaint inquiry-related interview, and that training had consisted of a two-hour course that provided only a general overview of the process and the official forms used when conducting staff complaint inquiries. Forty-two staff members received training at some point after conducting their first interview and, as of November 19, 2018, five had not received training at all. In some instances, reviewers received only a one-hour class because the primary instructor was unavailable, and a substitute instructor stepped in to teach the class. None of the reviewers, however, received substantive training in conducting interviews, collecting evidence, or preparing staff complaint inquiry reports.

During the onsite review period, Salinas Valley's appeals coordinator conducted multiple two-hour training courses that covered the staff complaint process. The course consisted of an overview covering two of the department's publications: its 2016 instructional handbook and its training module. The 17-page instructional handbook focuses primarily on introducing the official forms used to document staff complaint inquiries into allegations of staff misconduct and on the minutiae of completing those forms, rather than on the actual process of conducting a staff complaint inquiry, such as interviewing techniques, collecting evidence, and writing reports. The 15-page training module also focuses on instructions for completing the forms and includes a sequence of steps involved with investigating individuals. In addition, the training module urges reviewers to stop a staff complaint inquiry if they become aware of misconduct that could lead to adverse action against staff; and also includes detailed instructions for complying with notification rules and recording rules to protect staff member rights when staff are called as subjects or witnesses.

Upon querying the training instructor, we learned that the two-hour training course the department offered to reviewers was never intended to help reviewers understand best practices when interviewing appellants, witnesses, or subjects. Our review of the course materials led us to conclude that the training was inadequate for preparing reviewers to conduct a staff complaint inquiry review using best practices.

Some Reviewers' Performances Were Very Good

Despite our overall conclusion that the quality of more than half of the staff complaint inquiries was inadequate, some of the reviewers' performances were very good. The following are examples of interviews that reviewers conducted properly:

- In one case, the appellant, who was part of the enhanced outpatient program and who had a low reading-comprehension level, was interviewed by the reviewer about his allegations. The reviewer asked simple initial questions, posed appropriate follow-up questions, and allowed the appellant to thoroughly explain his complaint (Case 63).
- In another case, the reviewer asked several open-ended questions and follow-up questions. The reviewer also attempted to address the appellant's concerns that were based on a letter he had received from the legal processing unit. Also, when the appellant offered to withdraw his complaint if the reviewer would just get him some assistance, the reviewer advised him the process did not work in that manner, and that he would help the appellant and still process the complaint appropriately (Case 113).
- In another case, even though the reviewer interviewed the subject before interviewing the appellant, the reviewer studied relevant operating procedures before conducting his interview of the appellant, asked relevant follow-up questions, and appropriately confirmed the appellant had received medical assistance after his alleged fall (Case 162).
- In one instance, a reviewer told an OIG monitor an inmate had approached the captain and stated he wanted to withdraw one of his appeals. The OIG monitor observed the reviewer speak privately with the appellant to confirm whether the appellant really wanted to withdraw the appeal or not, that he was doing so of his own accord, and that he had not been threatened or promised anything to coerce the withdrawal (Case 115).

- In another case, even though the reviewer interviewed the subject before interviewing the appellant, the reviewer conducted a very thorough telephonic interview of the appellant. He went through the list of the appellant's allegations and then talked with the appellant about each of them. He asked appropriate follow-up questions, requested inmate and staff witness names (or descriptions if the appellant did not know their names), and took extensive notes. The reviewer also asked the appellant to pause while speaking, so the reviewer could write down as much detail as possible (Case 104).
- In another case, at the conclusion of an interview with the appellant, the reviewer actually read his notes back to the appellant and asked if he had documented the appellant's statement and concerns correctly. The inmate replied, "Yes" (Case 156).

We also noted some reviewers utilized good investigative techniques, including the example below:

- An appellant alleged that he was constantly provided meals with flies on them or that the food was cold. In addition to interviewing staff and other inmates in the housing area, the reviewer interviewed the central kitchen sergeant regarding the types of trays the meals were served on and how food was kept hot before it was distributed to the inmates. The reviewer also observed the process of meal pass on two separate shifts, during which time he observed staff prepare the meal trays, witnessed the use of the "hot cart," which keeps food warm during preparation, and even tested the temperature of the food with a thermometer just before it was passed out to the inmates. The reviewer also provided on-the-job training to officers regarding the inspection of food trays after he observed a fly on one (Case 135).

In addition, many of the reviewers appeared eager for guidance and training to learn the process correctly and to improve their interviewing techniques and abilities. The following include some of our interactions with staff reviewers:

- One lieutenant informed us that he took a week of leave to attend an "Interviews and Interrogations" course on his own time.

- One sergeant asked a lieutenant if he could sit in and observe the lieutenant's interview as a training opportunity; the lieutenant agreed. When the OIG later monitored this sergeant conducting interviews, we observed that he seemed well-prepared.
- One sergeant told a lieutenant, before an interview took place, that this was the sergeant's first time reviewing a staff complaint and said to the lieutenant, "I don't know what I am doing." The lieutenant quickly outlined the process for the sergeant and gave him some advice about conducting the interview. The lieutenant also offered to provide further assistance if the sergeant had any questions about writing his report.

Salinas Valley's Staff Complaint Review Process Lacked Independence

Our assessment revealed that Salinas Valley's process for reviewing staff complaints lacked independence: that is, the staff complaint inquiries were conducted by individuals who typically worked closely with those accused of misconduct. For instance, staff reviewers who conducted staff complaint inquiries typically worked with the accused staff on the same yard or were sometimes involved with the incident related to the complaint. We also observed instances wherein staff reviewers demonstrated their bias in favor of their coworkers and against inmates by including their own opinions as evidence in their reviews. Staff reviewers also discounted or ignored inmates' corroborating statements. In addition, staff complaint reviewers frequently compromised the confidentiality of the review process, potentially exposing the appellants to retaliation for filing a complaint. Collectively, these concerns undermine the integrity of the process and the trust of inmates who file complaints alleging staff misconduct.

Staff Members Assigned to Conduct Staff Complaint Inquiries Did Not Function Independently: They Were Often Assigned to the Same Work Location or Were Peers of the Subjects, and They Were Sometimes Involved in the Incident Related to the Complaint

In our opinion, staff complaint inquiries must be conducted by individuals who are independent. The reviewer assigned to conduct a staff complaint inquiry must have no personal involvement with the subject matter of the staff complaint inquiry nor with any person involved in the matter, whether that person is a witness, a subject, or an appellant. In a workplace setting, independence requires that the reviewer not investigate coworkers with whom the reviewer has close working relationships and personal alliances or who may at some future date investigate the reviewer. Moreover, independence requires that the reviewer, whose report may influence the career of the subject staff, not share the same career ladder as subject staff. When the workplace setting is a prison environment, independence requires that the reviewer not investigate staff upon whom the reviewer must rely for protection and support in the event of grave physical danger.

Salinas Valley's process for reviewing inmate allegations of staff misconduct was not independent. Reviewers worked each day in their capacities as custody staff while adding to their duties the task of investigating their fellow officers. Staff complaint inquiries are required to be assigned to a supervisor who occupies a position at least one rank

higher than that of the person accused of misconduct. In addition, the supervisor must not have participated in the event or decision being appealed.[18] At Salinas Valley, we found these conditions of independence frequently unmet. Specifically, in 113 instances, the reviewers generally worked in close proximity with the subject; in 11 instances, the reviewer held either the same rank or a rank lower than the subject's; and in five instances, the reviewer was involved in the incident related to the allegation. In all, we found the appropriateness of the assignment of the reviewer inadequate in 120 of the 188 staff complaint inquiries (64 percent).

The department's policy, in part, requires reviewers to be at least one rank above the subject, but it stops well short of requiring independence, such as prohibiting the reviewers from investigating staff who work on the same yard. However, we believe that staff complaint inquiries conducted by staff who work closely with one another—such as those who work on the same yard and on the same shift—cannot be independent. Work environments naturally include friendships and alliances. This is true of all workplace environments, not just prison work environments. The potential for a conflict of interest arising from conflicting loyalties is one of the primary reasons that impartiality and independence are generally best served by requiring that staff complaint inquiries or investigations be conducted by people who work outside of the workplace.

The prison work environment, however, calls for an additional need for independence because staff may need to investigate one another in a prison workplace, yet must also rely on one another during those occasions when great physical danger can ensue. In prisons, physical attacks by inmates against staff occur, and prison staff are trained to protect one another. At the same time, these same individuals must also, if involved in the department's staff complaint inquiry process, investigate one another when someone is accused of wrongdoing. Siding with fellow officers against an inmate may be one result of this lack of independence. An inherent bias against exposing a fellow officer to disciplinary action when a reviewer knows he or she will need to rely on

[18] Title 15, *California Code of Regulations*, Section 3084.7. *Levels of Appeal Review and Disposition* (d) Level of staff member conducting review. (1) Appeal responses shall not be reviewed and approved by a staff person who: (A) Participated in the event or decision being appealed. This does not preclude the involvement of staff who may have participated in the event or decision being appealed, so long as their involvement with the appeal response is necessary in order to determine the facts or to provide administrative remedy, and the staff person is not the reviewing authority and/or their involvement in the process will not compromise the integrity or outcome of the process. (B) Is of a lower administrative rank than any participating staff. This does not preclude the use of staff, at a lower level than the staff whose actions or decisions are being appealed, to research the appeal issue. (C) Participated in the review of a lower level appeal refiled at a higher level.

that individual in the future to defend him or her during an attack may be another result.

In Some Instances, Staff Reviewers Demonstrated an Appearance of Bias

We also found examples of reviewer bias in favor of the accused officer and against the appellant. In such cases, we noted that reviewers included their biases in the staff complaint inquiry report by supporting their conclusions with their own personal opinions. For example, an appellant in one case alleged that a sergeant had behaved unprofessionally during the course of an interview by yelling at and patronizing him, and by taking his personal property without cause. The reviewer in that case concluded:

> Upon review of this claim, the reviewing officer has found that there has not been any intentional inconvenience to the appellant and that [the sergeant] acted professionally with the appellant. It appears the appellant['s] mental health condition played a factor in his perception.

Rather than focus the report's narrative on the facts, the reviewer based his conclusion on his opinions of the subject and about the appellant's mental health condition (Case 59).

In another case, the reviewer commented on the subject's professionalism, demeanor, and pride while concluding that no policy violation occurred. The reviewer wrote:

> Through my observations [the subject] is very professional with staff and inmates. She has a no[-] nonsense demeanor about herself and takes a lot of pride in her job. Staff did not violate any policy.

Again, the reviewer's personal opinion in favor of his fellow coworker appeared to have been the primary basis for the conclusion. While the allegations against the subject employee may not have been true, the reviewer undermined the objectivity of his findings by interjecting his personal opinion, leading us to consider his conclusion to be a result of his bias (Case 103). Of additional concern, we found nearly the same verbiage in another staff complaint inquiry report a month later wherein the subject became the reviewer. This separate staff complaint inquiry report stated:

> Through my observations [the subject] is very professional with staff and inmates. She has a no[-]nonsense demeanor and takes a lot of pride in her job. The allegations that [the subject] was unprofessional are not true. Staff did not violate any policy.

Not only is it problematic for both reviewers to have included their personal opinions of the subject in the staff complaint inquiry report, but it concerns us that one reviewer copied the conclusions from another report nearly verbatim (Case 123).

In another case, an inmate alleged that two officers did not properly document the appellant's hunger strike nor would medical staff acknowledge his hunger strike unless custody staff notified them. We identified numerous problems with the reviewer's staff complaint inquiry work on this case. Of significance, we found the reviewer failed to interview medical staff whom the appellant spoke to during the hunger strike and a sergeant who authored the appellant's hunger strike chronological report. Perhaps most problematic was a statement in the report itself, which stated:

> Correctional staff are familiar with the Operational Procedure number 16 Inmate Hunger Strike and would have acted upon [the appellant] notifying staff that he was on a hunger strike and would have generated all the supporting documentation required.

The reviewer's comment that staff *would have* acted appropriately is speculative at best and clearly represents his personal opinion. The reviewer then concluded that there was no evidence to support the allegation of staff misconduct. The hiring authority agreed (Case 184).

In another case, an inmate complained about an unreasonable use of force, alleging that three officers had entered his cell, put him forcefully on the ground, twisted his arm, placed their boots on his back, leg, and neck, and dragged him out of his cell by his legs. The reviewer even documented in his report that two inmate witnesses stated in their interviews that they saw an inmate being dragged out of his cell by his legs. Nevertheless, despite the testimony of two inmate witnesses who corroborated the appellant's claim, the reviewer concluded there was no evidence to substantiate the claim, adding:

> It appears [the appellant is] providing an allegation of staff misconduct in an attempt to discredit custody staff and have [his rules violation report] dismissed.

The reviewer gave more credence to his personal opinion by speculating as to the intent of the appellant as opposed to addressing the evidence he collected, which weakened this investigation's objectivity (Case 24).

Staff Reviewers Ignored Corroborating Information Provided by Inmates

Our review found that staff reviewers frequently ignored corroborating evidence, both testimonial and documentary. In at least 19 cases, staff did not reference in their conclusions evidence that supported the inmate's allegations. Staff sometimes collected corroborating evidence and simply ignored it, concluding in their final report that no evidence existed to support an inmate's allegations. Other times, reviewers heard corroborating testimony from appellants and witnesses, but inaccurately reported that testimony in their reports. As part of their training, reviewers were taught the following: "If you [the reviewer] believe a witness is not credible, you must present facts that support such a conclusion. You cannot decline to interview a witness or reject their testimony 'because they are an inmate.'"[19] Despite this, reviewers neglected to assess the credibility of statements from staff and inmates. Such an assessment would provide hiring authorities with context and would facilitate their decision-making calculus.

Reviewers sometimes ignored corroborating evidence after first gathering it in the form of inmate witness interviews, falsely asserting in the report that no evidence corroborated the appellant's allegation. In one instance, an inmate alleged an officer used unreasonable force when he sprayed the inmate's face with pepper spray. The appellant said he immediately lay down on the ground in a prone position, but that the officer put his knee on the appellant's lower back and again sprayed the appellant's face. Upon review of the staff complaint inquiry report, we found that an inmate who witnessed the incident corroborated the appellant's account, affirming that the officer continued spraying the appellant after the inmate had assumed the prone position. Although the reviewer documented the corroborating witness statement, he nevertheless concluded that no testimony corroborated the appellant's allegations (Case 19).

[19] Departmental training module, p. 3, "Interview staff witnesses."

In another instance, an inmate alleged that a female officer told him to strip naked, or she would not permit him to leave his cell to attend morning activities in the yard. The reviewer interviewed the subject officer first, before interviewing the appellant or any witnesses; one inmate witness corroborated the appellant's account when he told the reviewer that he overheard a female officer telling the appellant "to strip naked or no yard." The subject staff had already been interviewed and therefore could not have been asked to respond to the inmate witness account. The reviewer incorrectly concluded that "no facts, evidence, or information were gathered which would support the [appellant's] contentions" (Case 48).

In yet another instance, staff ignored both testimonial and documentary evidence. In this case, the appellant requested to be moved from his cell because his cellmate was threatening him; however, an officer told him to wait until the following week. Two days later, the appellant's cellmate battered the appellant as the appellant lay on his bunk. In his complaint, the appellant alleged that not only did the officer fail to separate him from his cellmate, but also that a sergeant tried to cover up the officer's neglect of duty by issuing the appellant a rules violation report for fighting. The appellant also alleged that the sergeant forced the appellant to sign a compatibility agreement declaring that he and his cellmate were compatible and could live together safely. The appellant alleged that the sergeant threatened to place him in the administrative segregation unit—that is, in isolation—if he did not sign the compatibility agreement.

The reviewer of this staff complaint collected the incident report, the rules violation report, and a document dismissing the rules violation report. A handwritten note by the hiring authority at the end of the staff complaint inquiry report stated, "[correctional counselor name] claims that she interviewed building staff and they indicated they were [illegible text] prior to the battery, as claimed by [appellant]." It appeared the illegible portion of the note may have supported the appellant's allegation since the counselor who conducted the interviews was also the person who conducted an inquiry into the rules violation report and recommended its dismissal. The reviewer should have interviewed the same building staff that the counselor interviewed since they may have had relevant information regarding the incident. Instead, the reviewer relied only on the statements provided by the appellant, the officer, and the sergeant, and concluded: "Staff did not act unprofessionally. I find the appellant's allegations of staff misconduct to be vague at best with no witnesses or evidence presented" (Case 6).

We found yet another way of discounting corroborating inmate evidence when a reviewer, gathering evidence, dismissed an inmate's testimony because no staff member had verified it. For example, in one case we

reviewed, an inmate alleged that an officer saw him on two occasions making a noose, and that on the second occasion, the officer said to the appellant:

> If [you are] going to kill yourself, go ahead and f***ing do it.

Again, we were not permitted to observe the interviews of the subject officer nor of two other officers and one sergeant. However, we were present when the reviewer interviewed the appellant and one inmate witness who corroborated the appellant's allegation. The reviewer acknowledged in his report that the inmate witness corroborated the appellant's allegation, but noted that staff did not verify the witness's testimony. He then concluded that he could not determine whether the subject officer committed misconduct and recommended further action by the hiring authority. However, the reviewer then ignored his own recommendation and submitted a proposed appeal response to the hiring authority containing a finding that staff did not violate policy.

The hiring authority signed the proposed appeal response without ordering further action as recommended in the staff complaint inquiry report. Although the reviewer's conclusion appeared to place some significance on the inmates' statements, both the reviewer's and the hiring authority's actions of issuing an appeal response with a finding that staff did not violate policy demonstrated that the inmates' statements held no value as evidence, compared with statements made by staff. This directly contradicts the reviewer's training that we described earlier, which specifically instructs staff regarding the interviewing, or testimony, of inmate witnesses (departmental training module, p. 3; Case 139).

In a similar but perhaps more troubling discounting of evidence provided by an inmate, an inmate alleged that an officer made several derogatory remarks about the inmate's sexual identity. The reviewer did not collect the employee sign-in sheet to determine whether any staff witnesses were present. The reviewer interviewed an inmate witness who corroborated the appellant's allegation, but the reviewer concluded there was no additional evidence beyond the statements of these two inmates to support the allegation. The hiring authority assigned the case to the prison's Investigative Services Unit, but specified that the appellant's witness undergo a computerized voice stress analysis test (i.e., a lie detector). The witness, however, declined to participate once he learned of the lie detector test. With this approach to collecting evidence, an inmate's statements held no value as evidence unless it was validated by a machine (Case 1).

In another case, an appellant alleged that two officers and a nurse were inappropriately sharing his confidential case factors with other inmates. We were present for the interview with the appellant and an inmate witness, but not for the interview with a subject officer and a nurse. The reviewer did not interview one of the subject officers. According to the staff complaint inquiry report, the reviewer summarized the subject officer's statement in one sentence: "[Subject] stated that the appellant's claims are completely false and unfounded." The reviewer wrote in the staff complaint inquiry report that the inmate witness stated, "I don't know anything of the allegations.... He would not do that[;] he is one of the best officer's [*sic*] we have." The reviewer concluded: "The appellant's witness that he named did not corroborate the appellant's claims."

However, since we were present for the interview with the witness, we found this statement to be false and misleading. The OIG monitor noted that the witness did corroborate the appellant's claim, stating he had not observed one of the subjects share any confidential information, but had knowledge of other officers having done so. The reviewer never asked the witness to identify the names of the *other officers* nor did he include any of this information in his staff complaint inquiry report. The hiring authority found that staff did not violate policy, but obviously did not have sufficient information to render a fair decision (Case 151).

As we discussed earlier in the report, we also found that staff did not consistently collect relevant evidence. In many instances, staff neglected to gather evidence that could corroborate an inmate's claims: for example, we found that reviewers frequently neglected to interview witnesses who might have provided evidence against a fellow officer. We also observed staff ignoring potential leads to corroborating evidence, such as during interviews with inmates, when reviewers often neglected to ask obvious follow-up questions that could have led to evidence implicating a fellow officer. Most commonly, we observed that staff avoided collecting evidence by violating standard interview practices by interviewing the subject first. In this way, none of the inmate or witness statements or any documentary evidence would be available to generate questions for the subject to answer, aptly demonstrating why the interviewing sequence is so critical to this entire process.

Reviewers invalidate the staff complaint inquiry process when they ignore or discount corroborating evidence, whether by failing to collect it, failing to acknowledge it, mischaracterizing it, or discounting it because it came from an inmate. Doing so erodes any confidence inmates may have in the staff complaint inquiry process and the public's trust in the department's handling of inmate complaints.

Staff Frequently Compromised the Confidentiality of the Staff Complaint Inquiry Process

The staff complaint inquiry process culminates in a document that the department titles "Confidential Supplement to Appeal" (see Appendix D). Maintaining confidentiality while interviewing appellants, witnesses, and subjects is necessary to establish trust in the process as well as protect appellants from retaliation by staff or other inmates. Without confidentiality, witnesses can be intimidated or retaliated against. Moreover, appellants may not be completely candid or may even refuse to participate altogether.

During our review, we found numerous examples of staff who compromised the confidentiality of the process. For example, we frequently found instances when an appellant's identity or staff complaint was disclosed to nearby staff and inmates. Attorneys from the Prison Law Office who represent inmates told us their clients felt intimidated by the manner in which they were contacted to set up their interviews. Appellants claimed to have been summoned over the public-address system or when they were within listening range of other inmates and staff members.

Indeed, we observed one instance in which staff used the public-address system to call an appellant out of his cell for a staff complaint inquiry interview. The reviewer notified the control booth officer that he needed to speak with the appellant about his appeal. The control booth officer then announced over the public-address system, "[Appellant's name], 602 appeal. Come to the office." The phrase "602 appeal" refers to the department's appeal form number, and although this phrase could have referred to any type of appeal, the phrase used in this context raised unnecessary awareness of an issue and called attention to the appellant. When the appellant arrived at the office, he refused to be interviewed because he believed the reviewer had a conflict of interest related to the complaint. The prison later reassigned the appeal to another supervisor. When the new reviewer requested to interview the appellant, the control booth officer announced over the public-address system, "[Appellant's name], come on out." The announcement for this second interview attempt was more discreet (Case 117).

We noted compromised confidentiality during a total of 34 appellant interviews and 31 witness interviews. In one particularly egregious example, a reviewer told our monitor that the subject of the appellant's complaint was actually working in the control booth in the inmate's housing unit. Nevertheless, the reviewer conducted the interview in an office located immediately beneath the control booth, with the gun port

Figure 11. Configuration of Control Booth and Interview Office at Salinas Valley

Source: Photographs taken by the Office of the Inspector General.

window open (the window in the ceiling), and within visual and hearing range of the subject officer (see Figure 11, facing page, for photographs depicting the configuration of the control booth and the interview room). In fact, our monitor believed that the subject officer in the control booth was actively listening to the conversation.

The reviewer apparently thought he appropriately addressed the matter when he told the appellant that the subject officer was working in the control booth immediately over their room and would be able to overhear the interview. The reviewer then asked the appellant if the subject officer's listening to the interview bothered him; the appellant replied, "No." Notwithstanding the appellant's response, the interview should have taken place in a private setting, the subject officer should not have known the conversation was about the appeal, and the appellant should not have been asked to make that decision (Case 185).

The following are examples of other incidents we encountered that demonstrated this lack of concern with maintaining confidentiality:

- A reviewer, along with one sergeant and one officer, approached an appellant's cell and asked the appellant if he wanted to be interviewed about his staff complaint. Of significance, the officer accompanying the reviewer was a subject of the appellant's complaint. The reviewer would have known this since the officer's name was listed on the complaint form. Moreover, other inmates were within hearing distance in the showers adjacent to the appellant's cell (Case 92).
- A reviewer was conducting a telephone interview of an appellant in a small office. Also present in the room were an OIG monitor and a captain, a lieutenant, and a sergeant who were having a conversation without regard to the reviewer's interview and could easily hear the conversation taking place over the phone (Case 105).
- A reviewer approached an appellant in a holding cell and told the appellant that the reviewer was there because the appellant had submitted a staff complaint. This occurred within hearing range of officers and other health care clinicians working in the area (Case 180).

- A reviewer made a phone call to the appellant's housing unit and asked an officer to send the appellant to the program office. The officer called back a short time later, indicating the appellant refused to go to the program office. The reviewer then told the officer, "Tell him [reviewer's name] is calling him." The officer called back a second time and reported that the appellant still refused. The reviewer then told the officer, "Tell him it's about his 602; tell him it's about his staff complaint." The appellant again refused to report to the program office (Case 67).
- A reviewer did not close the office door while conducting an interview with an inmate witness about a complaint regarding meals being served to inmates in the administrative segregation unit. During the interview, other staff were nearby, and an officer uninvolved in the investigation stood in the doorway and interjected personal observations concerning the quality and the preparation of the inmate meals served in the unit (Case 135).

Salinas Valley Completed Most Staff Complaint Inquiries Within Required Time Frames, but Did Not Always Provide the Proper Notifications When Inquiries Were Late

The *California Code of Regulations* requires prisons to complete staff complaint inquiries within 30 working days, allowing exceptions only for certain limited circumstances.[20] The department takes this time frame seriously, as demonstrated by a January 2016 memorandum from an associate director to all wardens at prisons within the High Security Mission, which includes Salinas Valley. In this memorandum, the associate director stated, in part:

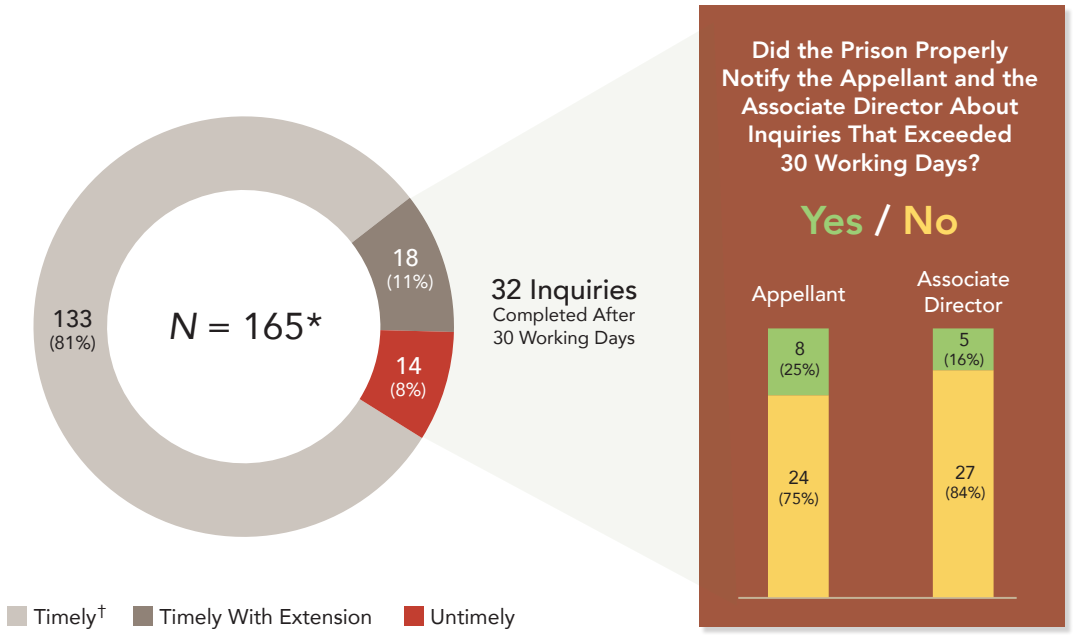
> The timely completion of inmate appeals, including Disability Placement Program (DPP) appeals, and modifications orders are critical to the success of each institution's mission, and to ensure due process for inmate complainants. […] **Wardens must have a zero tolerance policy for overdue appeals** [emphasis added].

On average, the prison took about 27 working days to complete 165 time-sensitive staff complaint inquiries during our paper and onsite review periods.[21] Completion time for reviewing these staff complaint inquiries ranged from five working days to 58 working days, with reviewers completing 133 of the 165 staff complaint inquiries (81 percent) within the 30-working-day requirement. Reviewers timely completed 18 other staff complaint inquiries after 30 working days, but within their allotted extensions of time. However, reviewers did not complete the remaining staff complaint inquiries in a timely manner, with 14 of them noted as having taken place between one and seven working days after their respective deadlines had passed (see Figure 12, following page).

[20] Title 15, Section 3084.8(d) allows exceptions to the time limits only in the event of (1) unavailability of the inmate or parolee, or staff, or witnesses; (2) the complexity of the decision, action, or policy requiring additional research; (3) necessary involvement of other agencies or jurisdictions; and (4) state of emergency pursuant to subsection 3383(c) requiring the postponement of nonessential administrative decisions and actions, including normal time requirements for such decisions and actions.

[21] This figure does not include 23 appeals for which the prison completed inquiries, but that were rejected for not meeting the criteria for staff complaints, or that the inmate withdrew after filing the appeal. The time frame for these cases was not applicable.

Figure 12. Timeliness of Staff Complaints the OIG Reviewed, December 1, 2017, Through May 31, 2018



* This figure does not include 23 staff complaint inquiries the prison completed even though the appeals were either rejected or withdrawn. Consequently, the regulatory time frame of 30 working days was not applicable.

† We considered an inquiry to be timely if it was completed within 30 working days or within the additional time afforded by an extension.

Source: Data and analysis by the Office of the Inspector General.

When reviewers request extensions for additional time to review complaints, they must also inform the appellant of the delay; yet in most of the staff complaint inquiries triggering this notification, staff did not inform the appellants. The *California Code of Regulations* requires the prison to provide an explanation to an appellant when it cannot meet the required 30-day time limit and to include the reasons for the delay as well as an estimated completion date. However, of the 32 staff complaint inquiries that took longer than 30 working days to complete, Salinas Valley failed to notify the appellants in 24 instances (75 percent).

Moreover, the associate director of the High Security Mission issued a directive as part of a memorandum in January 2016 that required prisons within the mission to notify the associate director in writing of all appeals prison staff could not complete within the 30-day time limit. This memorandum stated in part:

> From this point forward, late appeals will require proper follow-up. This includes a monthly memorandum from each institution listing any late appeals and/or modification orders. The memorandum shall include the appeal log number, inmate name and number, reason for [the] delay, and corrective action taken to address the failure in timely completion.

We found that the prison did not notify the associate director in 27 of the 32 staff complaint inquiries (84 percent) it completed beyond 30 working days. Had the associate director been aware of these late staff complaint inquiries, he or she would have had an opportunity to address them.

Staff complaint inquiry review promptness is important not only to comply with policy, but also as a means to maintain discipline since disciplinary action must be taken within a statute of limitations. The hiring authority must take any disciplinary action against an employee within an applicable statute of limitations; for peace officers, this disciplinary window is generally one year. After completing a staff complaint inquiry, if the hiring authority has a reasonable belief that misconduct occurred that might result in adverse action, then he or she must refer the matter to the department's Office of Internal Affairs to request an investigation or authorization to take direct action regarding the alleged misconduct. Any delay erodes the Office of Internal Affairs' available time to complete a full investigation and shortens the hiring authority's time after the investigation is concluded to consider the matter and take disciplinary action, if warranted.

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The Office of the Inspector General's Analysis of Nine Additional Complaints at Salinas Valley Submitted to the Department by the Prison Law Office

In addition to the 188 staff complaint inquiries the OIG reviewed during the paper review and the onsite review periods, the OIG also reviewed an additional nine complaints at Salinas Valley submitted to the department by the Prison Law Office.[22] These cases originated from written complaints the Prison Law Office submitted to the department regarding various allegations of staff misconduct made by inmates housed at Salinas Valley. The prison processed these complaints separately from the staff complaint inquiry process. Salinas Valley assigned one staff member from its Investigative Services Unit to conduct the inquiries related to eight of the nine complaints. A lieutenant from another institution completed the remaining inquiry as a result of a conflict of interest. For each of the nine cases, the assigned reviewer conducted an allegation inquiry and submitted a confidential inquiry report to the hiring authority.

We assessed these nine allegation inquiries in a manner similar to that which we used to review the 188 staff complaint inquiries in the paper review and onsite review periods. Most of the allegation inquiries occurred during a period outside of the OIG's onsite review period. However, in a few of the cases, the OIG was able to monitor interviews conducted by the reviewers. The OIG monitored five interviews in cases emanating from the written complaints submitted by the Prison Law Office. Unlike most of the staff complaint inquiry reports assessed during the paper and onsite review periods, the allegation inquiry reports for these cases were generally longer and more detailed. The reviewers analyzed and summarized documentary evidence and were generally more descriptive regarding the documentary evidence they reviewed in connection with their inquiries. In two cases, the reviewers also included photographic evidence they obtained during the inquiry. Furthermore, as to the five interviews monitored by the OIG, they were thorough and the reviewers demonstrated a general understanding of the complaints.

[22] The engagement letter outlining the scope of work (see Appendix A) reflected that the OIG would assess the department's handling and response to ten specific complaints submitted by the Prison Law Office; however, the department consolidated two of the complaints into one inquiry, therefore resulting in the nine allegation inquiries to which we refer in this report.

However, we noted similar inadequacies in the allegation inquiries conducted relative to the nine complaints as we noted in the 188 staff complaint inquiries we reviewed. The most common shortcomings we identified were the failure to interview the subjects of the allegation inquiries; the failure to interview all relevant witnesses; not addressing all the allegations reflected in the written complaints; and the reviewers interviewing the complainant after interviewing witnesses and, in some cases, after subjects were interviewed. Also, other than the two allegation inquiry reports that contained photographic evidence, the reviewers did not attach documentary evidence to the inquiry reports they submitted to the hiring authority. In November 2018, we contacted one of the reviewers who advised us that the reviewers collected, analyzed, and retained the documentary evidence as part of their case files, but did not present the documentary evidence to the hiring authority; he also recognized the benefit of doing so and stated he would discuss implementing that change with his supervisor.

Therefore, as to the majority of the documentary evidence collected by the reviewers, the hiring authority, who was charged with making a final determination as to the resolution of each case, did not review the actual source documents, but relied only on summaries of the documents compiled by the reviewers.

Salinas Valley had previously reviewed the vast majority of the allegations contained in the nine complaints submitted by the Prison Law Office, largely in the form of staff complaint inquiries in connection with prior complaints submitted by the inmates. In fact, instead of conducting an independent review or investigation of the allegations, the two reviewers often relied on prior investigative work completed by the reviewers who were assigned to conduct those prior staff complaint inquiries. In one case, the reviewer interviewed the complaining inmate, reviewed the prior staff complaint inquiry report, and indicated that he agreed with the findings made during the prior inquiry, without completing any other independent investigative work. Given that staff at the prison had previously reviewed the vast majority of the allegations and conducted staff complaint inquiries, it would have been prudent for the hiring authority to have forwarded these particular complaints from the Prison Law Office to an independent investigative body within the department, such as its Office of Internal Affairs, for an independent inquiry or investigation.

In sum, based on the above, we assessed seven of the nine allegation inquiry reports as inadequate and only two as adequate.

Prison Law Office Case 1: Allegations of an unprofessional cell search, threats, unsafe housing conditions, excessive use of force, false rules violations, and unfair disciplinary hearings

Allegation background and summary: On January 8, 2018, the Prison Law Office requested the department investigate allegations of staff misconduct on behalf of an inmate who is an Armstrong[23] *class member.*

The Prison Law Office reported the complainant alleged that on April 7, 2017, an officer searched his cell and confiscated property that was not identified on a confiscated items receipt. The complainant stated that he confronted the officer about the missing property, and the officer threatened him. The complainant reported that on June 9, 2017, he was falsely accused of sexual disorderly conduct by the same officer. The complainant reported that the officer was in the control booth at the time and that the complainant was in his cell cleaning himself with the lights out, suggesting it would have been impossible for the officer to see him. The Prison Law Office further alleged that the complainant is physiologically unable to perform the acts he was alleged to have committed and that the complainant did not receive a fair disciplinary hearing because the hearing officer failed to ask relevant questions of staff and because the hearing was untimely.

The Prison Law Office alleged that on two occasions, June 9, 2017, and June 11, 2017, the complainant reported seeing a known enemy on the yard. On June 9, 2017, the complainant reported no action was taken. On June 11, 2017, the complainant told his clinician about his concerns, who contacted a sergeant. The sergeant spoke with the complainant and informed him that he would be returned to his same housing unit; the complainant refused to return to his assigned housing unit due to safety concerns. The sergeant then ordered four officers to take the complainant to a holding cell in the gym. The complainant reported that he feared going to the empty gym because he had heard rumors that officers "brutalize inmates" there. When taken to the gym, the complainant alleged that officers forced him out of his wheelchair, and they placed him in a standing holding cell that could not accommodate a full-time wheelchair user. The officers allegedly grabbed him around the neck, slammed him to the ground, and began kicking and punching him until they heard other staff approaching the gym. The complainant stated that he was issued a false rules violation report for battery on a peace officer arising out of this incident and was later found guilty. The Prison Law Office also alleged that the complainant did not receive a fair

[23] *Armstrong* v. *Wilson* is a class-action lawsuit brought about under the Americans with Disabilities Act and the Rehabilitation Act on behalf of inmates with vision, hearing, mobility, kidney, speech, and learning disabilities. (942 F.Supp. 1252 (N.D. Cal. 1996)).

disciplinary hearing because the hearing officer failed to ask relevant questions of staff and because the hearing was untimely.

On March 12, 2018, the department assigned a staff member from the Investigative Services Unit to conduct a review of the allegations. The review was ongoing during the OIG assessment period, allowing the OIG to engage in real-time monitoring of the complainant's interview.

OIG analysis and conclusion of the prison's handling of the allegations: The OIG monitored the interview of the complainant and noted that it was conducted in a confidential setting. The reviewer asked him detailed questions about five allegations, including whether he had any additional witnesses to support the allegations.

The OIG was provided a copy of the inquiry report for this complaint, which summarized the allegations in the Prison Law Office letter and identified five allegations to be reviewed during the inquiry. Although the reviewer addressed each of these five allegations, because he failed to identify several additional allegations in the Prison Law Office letter, these additional issues went unaddressed during the inquiry. Specifically, the inquiry report did not address allegations that an officer threatened the complainant after he asked the officer why his property had been confiscated, that the hearing officer failed to ask relevant questions of the witnesses at two rules violation hearings, and that the rules violation hearings were untimely.

A review of the inquiry report identified additional deficiencies with the thoroughness of the inquiry. First, although an OIG monitor attended the interview of the complainant and noted that the reviewer thoroughly inquired about the five allegations he identified, the summary of the interview contained in the inquiry report did not adequately summarize the complainant's statements about the allegations. This lack of detail in the report gives the reader the false impression that the reviewer did not sufficiently address the allegations during the interview even though the reviewer thoroughly inquired about these allegations. Second, the reviewer interviewed two subjects and one witness before interviewing the complainant. However, the reviewer partially resolved this mistake by re-interviewing one of the subjects following the complainant's interview. Third, the reviewer did not interview the two subjects who were alleged to have used excessive force, and relied entirely on the officers' written reports provided after the incident. Finally, although the reviewer independently identified a policy violation not included among the allegations in the Prison Law Office letter (that the complainant was placed in handcuffs locked in front of his body while seated in his wheelchair), he failed to take adequate steps to determine which staff member committed the policy violation, concluding: "Although this is a violation, there is no clear

identification as to which staff placed him in the restraints on the facility. Due to this, focused action is not possible on a specific staff member." Before arriving at this conclusion, the reviewer should have interviewed the two officers who escorted the complainant to ask whether they could recall if one of them had applied the handcuffs to the complainant while he was in his wheelchair.

With the exception of the above concerns, the report summarized every document reviewed and every interview conducted for each allegation separately and in a well-organized manner, providing a specific conclusion for each allegation. The report included recommendations for training in two areas. First, the reviewer noted that the temporary holding cell used on June 11, 2017, was not an approved temporary holding cell for inmates with disabilities and recommended that all custody staff receive training in *Armstrong* Custody Staff Responsibilities regarding reasonable accommodations. He further recommended that all custody captains ensure that their respective areas have disability accommodating temporary holding cells and should immediately request such cells if necessary. Second, the reviewer noted that custody staff members restrained the complainant in front of his body in violation of policy and recommended training on the usage of mechanical restraints be added to the annual block training all officers receive. The reviewer also took independent steps to address the complainant's enemy concern, even reaching out to an outside agency to gain additional information about the identity of the enemy who allegedly attacked the complainant before he was incarcerated; the enemy had a very common name that caused the complainant to mistakenly identify other inmates as enemies because they had similar names.

Overall, the quality of the inquiry was inadequate.

Prison Law Office Case 2: Allegations of improper commitment offense disclosure, unaddressed safety concerns, coercion, and retaliation

Allegation background and summary: On December 21, 2017, the Prison Law Office requested the department investigate allegations of staff misconduct on behalf of an inmate who is an Armstrong *class member.*

On March 16, 2017, the Prison Law Office met with the complainant. The complainant reported that the following day, the television he was loaned was confiscated. The complainant alleged that an officer took away his television and disclosed to other inmates in his housing unit the nature of his commitment offense in retaliation for speaking with the Prison Law Office. The complainant reported to the Prison Law

Office that he was told by other inmates that the information "came from up top." The Prison Law Office also alleged that staff members disclosed information regarding the nature of the complainant's commitment offense and, as a result, the complainant was assaulted twice and received a false rules violation report for engaging in mutual combat. The Prison Law Office further alleged that staff were not taking the complainant's safety concerns seriously; that he was forced to sign documents stating he was compatible with certain inmates; that an inmate housed in another housing unit was allowed to come to his unit and assault him; and that mental health staff told the complainant he would have to eat and spread his own feces in his cell to attain single cell status.

On December 26, 2017, the department assigned a staff member from the Investigative Services Unit to conduct a review of the allegations. Because the review was completed prior to the OIG assessment period, the OIG did not monitor any of the interviews performed as part of the inquiry.

OIG analysis and conclusion of the prison's handling of the allegations: The OIG was provided a copy of the inquiry report, which summarized the allegations of the Prison Law Office letter and identified seven allegations to be reviewed during the inquiry. The reviewer summarized an interview he conducted with the complainant and one inmate witness. One other inmate witness refused to be interviewed. The reviewer also summarized documents reviewed during the inquiry.

A review of the inquiry report identified several deficiencies with the thoroughness of the inquiry. First, the reviewer did not interview any of the subjects implicated in the allegations of misconduct: the officer who allegedly confiscated the complainant's television and was allegedly overheard discussing complainant's commitment offense; one other officer who was allegedly overheard discussing complainant's commitment offense; the officer who allegedly issued the false rules violation report; the sergeant who allegedly did not address complainant's enemy concerns and coerced the complainant into signing a housing form; and the psychologist who allegedly told the complainant he had to eat and spread his feces on the wall to attain single-cell status. Second, the reviewer failed to interview the inmate who allegedly overheard two officers discussing his commitment offense. Third, the reviewer determined the allegation that staff disclosed complainant's commitment offense to other inmates lacked merit because of a slight variance in the statements contained in the Prison Law Office letter and the statements the complainant made during his interview; because the complainant acknowledged that other inmates had spread information about his commitment offense; and because the complainant reported that although staff had disclosed that

he was convicted of a sex offense, staff had not discussed "any specifics of his case."

However, even if some inmates were already aware of the complainant's commitment offense, staff are still not permitted to discuss an inmate's commitment offense in front of other inmates; the reviewer should not have dismissed this allegation on these bases. Fourth, the reviewer did not take adequate steps to resolve the allegations that the officer's statement in the rules violation report that the complainant engaged in mutual combat was false and that the complainant only protected himself from the assailant's attacks. The reviewer determined the statements the officer included in the rules violation report were true because, in his opinion, the statements were "clearly articulate[d]." Despite interviewing the alleged assailant, who stated he targeted the complainant due to his commitment offense and pressure from other inmates in the housing unit, the reviewer did not ask the assailant whether the complainant fought back. Finally, the reviewer interviewed the complainant after the only witness interviewed in connection with the inquiry.

The reviewer also recommended corrective action be provided to the psychologist who suggested the complainant eat and spread his own feces in order to attain single-cell status, but never interviewed the psychologist about this allegation.

Overall, the quality of the inquiry was inadequate.

Prison Law Office Case 3: Allegations of discrimination, falsifying a rules violation report, and discouraging inmates from filing appeals

Allegation background and summary: On January 9, 2018, the Prison Law Office requested the department investigate allegations of staff misconduct on behalf of two inmates who are Armstrong *class members.*

The Prison Law Office reported that on June 14, 2017, the complainant alleged that a control booth officer had been discriminating against him on the basis of his hearing disability by repeatedly releasing him last for pill call. Because the complainant had difficulty explaining things in writing, he asked another inmate to help him write a reasonable accommodation request (request) to address the issue, which the complainant then signed and submitted. The prison treated the request as an appeal and assigned a sergeant to perform the staff complaint inquiry.

On June 16, 2017, the sergeant allegedly called the complainant for an interview, during which he questioned the request's authenticity,

demanded the complainant provide a writing sample, asked detailed questions about information contained in the request, accused the complainant of playing games with the appeal process, threatened the complainant with rules violation reports and a bed move, and ultimately had the complainant sign a withdrawal of his appeal. After the complainant allegedly confirmed he authorized the second inmate to complete the request form for him and approved everything written in the request, the sergeant concluded in his appeal response that the complainant did not write or submit the request, and a second inmate submitted the request without the complainant's knowledge. Based on this allegedly false conclusion, the sergeant issued the second inmate a rules violation for falsifying a document, stating, "[Complainant] stated that he did not fill out the form and didn't even know what it stated[.]... [The second inmate] transcribed the [request] with the content unbeknownst to [complainant]." The complainant alleged that during his interview, the sergeant asked him to state that he did not know what was written on the request form, which the complainant refused to do, expressly reaffirming that he knew what was written on the request form. The second inmate was later found not guilty of the rules violation.

On March 9, 2018, the department assigned a staff member from the Investigative Services Unit to conduct a review of the allegations. The review was ongoing during the during the OIG assessment period, allowing the OIG to engage in real-time monitoring of the complainant's interview.

OIG analysis and conclusion of the prison's handling of the allegations: The OIG monitored the interview of one of the complainants and noted that it was conducted in a confidential setting. During the interview, the reviewer summarized the allegations contained in the letter received from the Prison Law Office and asked the complainant detailed questions about the allegations, including whether the complainant had any additional witnesses in support of the allegations, which he did not. He was only able to provide a description of a neighboring inmate. In the OIG's opinion, the interview was thorough and complete.

The OIG was provided with a copy of the inquiry report for this complaint, which identified two allegations to be reviewed during the inquiry. Although the reviewer addressed both of these allegations, because he failed to identify additional allegations contained in the Prison Law Office letter, these additional issues went unaddressed during the inquiry. The Prison Law Office letter raised specific concerns with the sergeant's actions, noting the office received many complaints from inmates at the prison alleging that staff had discouraged inmates from filing appeals. Despite these concerns, the inquiry report did not address the allegation that a sergeant issued the second inmate a rules

violation report for falsifying a document, which included allegations the sergeant knew to be untrue. The inquiry report also did not address the allegations that the sergeant accused the complainant of playing games with the appeal process and threatened him with rules violation reports and a bed move.

With regard to the allegations that were addressed during the inquiry, the report was very detailed and demonstrated the reviewer performed a thorough and complete review of these particular allegations. The report indicated the reviewer interviewed the two complainants, two staff witnesses, three inmate witnesses, and a subject officer to determine whether the control booth officer discriminated against disabled inmates and whether they noticed issues with inmates not being released for pill call.

With the exception of the reviewer also interviewing four witnesses before interviewing the complainant, the report appeared to contain thorough summaries of the interviews. The interviews revealed that the physical structure of the housing unit might have restricted the control booth officer's view of certain cells in one corner of the housing unit, which made it difficult for the control booth officer to see when inmates were flashing their lights and asking to be released for pill call. To confirm these reports, the reviewer visited the housing unit and took multiple photographs of the cells in question and of the view of these cells from the control booth, demonstrating that the physical layout of the housing unit did, in fact, obstruct the view of the complainant's cell.

The reviewer also determined that the control booth officer and the complainant discussed the issues the complainant raised regarding being released last for pill call and that these issues were resolved to the complainant's satisfaction. The complainant indicated that after speaking with the control booth officer about the issues, from that point forward, he was always released for pill call when he requested to be released and had no further complaints with the process.

The reviewer also adequately addressed the allegation that the sergeant questioned the authenticity of the complainant's appeal. The reviewer interviewed the complainant, the sergeant, and the only staff witness to the incident and thoroughly summarized their statements regarding that allegation in the inquiry report.

Although the reviewer thoroughly addressed the issues he identified in his inquiry report, he disregarded critical allegations also contained in the Prison Law Office letter.

The overall quality of the inquiry was inadequate.

Prison Law Office Case 4: Allegations of neglect of duty, improper placement in administrative segregation, coercion, and threats

Allegation background and summary: On January 9, 2018, the Prison Law Office requested the department investigate allegations of staff misconduct on behalf of an inmate who is an Armstrong *and a* Clark[24] *class member.*

The Prison Law Office reported that on May 16, 2017, the complainant was attacked by another inmate in a dining hall and that no officers were present at the time, which allowed the attack to occur. The complainant suffered head trauma as a result of the attack. The Prison Law Office further stated that the complainant was threatened with a rules violation report and placement in the administrative segregation unit if he did not sign a document indicating he was compatible with the inmate who attacked him. The Prison Law Office noted that the complainant was deemed an immediate threat to institutional safety and placed in administrative segregation on May 16, 2017, despite being the victim of an assault. The complainant's case was not reviewed until September 1, 2017, at which time the department noted that the inmate who attacked him had transferred to another institution and ordered the complainant released from administrative segregation. However, the Prison Law Office alleged the complainant was not released until six days after the order was issued. On September 11, 2017, after refusing on several prior occasions, the complainant signed a document indicating he was compatible with the inmate who attacked him and was told his rules violation report would be dismissed.

On January 16, 2018, the department assigned a staff member from the Investigative Services Unit to conduct a review of the allegations. The review was completed during the OIG's assessment period; however, the reviewer was not advised of the OIG's request to engage in real-time monitoring of this case. As a result, the OIG did not monitor any of the interviews performed as part of the inquiry.

OIG analysis and conclusion of the prison's handling of the allegations: The OIG was provided a copy of the inquiry report, which thoroughly summarized all of the allegations in the Prison Law Office letter. The report indicates the reviewer interviewed the officer assigned to the dining hall and the officer assigned to the observation post above the dining hall to determine what they witnessed. The report summarized their statements with sufficient detail. The report also indicates the reviewer reviewed and summarized two documents that discussed the

[24] *Clark* v. *California* is a class-action lawsuit brought about under the Americans with Disabilities Act and the Rehabilitation Act on behalf of inmates with developmental disabilities. (123 F.3d 1267 (9th Cir. 1997)).

incident in which the complainant was attacked by another inmate and determined the complainant was found not guilty of the rules violation. The report thoroughly summarized the reviewer's interview with the complainant regarding the attack.

The report also indicates the reviewer adequately addressed the allegations regarding the complainant's placement in administrative segregation and the length of his placement. The reviewer thoroughly summarized an interview he conducted with the correctional counselor who performed the institutional classification committee hearing and spoke with the complainant multiple times to explain the purpose of the compatibility form and the consequences of not signing the form. The reviewer also reviewed and summarized three documents that identified the date on which the rules violation report was dismissed, the date the complainant was ordered released from administrative segregation, the date the complainant was actually released from administrative segregation, and the date the complainant signed the compatibility form. The report thoroughly summarized the reviewer's interview with the complainant regarding his placement in administrative segregation, the attempts to convince him to sign the compatibility form, and his reason for signing the form.

The reviewer then used the evidence collected during the inquiry to arrive at conclusions regarding each allegation in the Prison Law Office letter. Although the complainant was interviewed after all three witnesses, the overall quality of the inquiry was adequate.

Prison Law Office Case 5: Allegations of unprofessionalism and failure to respond to a medical emergency

Allegation background and summary: On January 10, 2018, the Prison Law Office requested the department investigate allegations of staff misconduct on behalf of an inmate who is an Armstrong *class member.*

The Prison Law Office reported the complainant alleged that staff failed to respond to a medical emergency and conducted an unprofessional cell search. In particular, the complainant alleged that on June 19, 2017, the complainant fell out of his wheelchair while on the yard, and four officers failed to initiate an alarm or assist the inmate. Further, the complainant alleged that on July 13, 2017, two officers searched his cell and left his property in disarray. On January 16, 2018, the department assigned a staff member from the Investigative Services Unit to conduct a review of the allegations. The majority of the review was completed prior to the OIG assessment period.

OIG analysis and conclusion of the prison's handling of the allegations: The OIG was provided a copy of the inquiry report, which summarized the allegations of the Prison Law Office letter and identified two allegations to be reviewed during the inquiry. As to the first allegation regarding the wheelchair incident, the reviewer analyzed and summarized a prior appeal inquiry report regarding the incident and interviewed inmates who were present and some officers to determine whether they witnessed the incident. However, the reviewer did not interview the complainant, nor did he interview any of the four subject officers. The reviewer noted that some of the subject officers were on their routine days off from work or were assigned to another yard on the day in question. However, the reviewer did not identify in his report which particular officer or officers were off work or purportedly working on another yard. While the reviewer confirmed that one of the subject officers was working on the yard on the day in question, the reviewer did not interview that officer either. The reviewer did not give a reason for not interviewing the one officer whom he identified as having worked in the unit on the day in question and who was identified by the complainant as a subject.

As to the second allegation, the reviewer did not interview the complainant and did not interview the two subject officers. The reviewer did not identify a reason for not interviewing the complainant or the subject officers. The reviewer analyzed records to determine which other officers were working in the unit the day of the incident and interviewed those officers. The reviewer interviewed one officer identified by the complainant as having observed the cell in disarray after the search.

The reviewer concluded there was no evidence to substantiate the allegations and that no further investigation was warranted. However, the reviewer did not interview the complainant regarding either allegation, nor did he interview any of the subjects identified by the complainant as having committed the misconduct set forth in the allegations.

Overall, the quality of the inquiry was inadequate.

Prison Law Office Case 6: Allegations of inappropriate housing assignment, civil rights violations, and unprofessionalism

Allegation background and summary: On January 10, 2018, the Prison Law Office requested the department investigate allegations of staff misconduct on behalf of an inmate who is an Armstrong *class member.*

The Prison Law Office reported the complainant alleged he was issued a false rules violation report for fighting, denied single-cell status, not

permitted to shower, forced to stay in a cell with a broken toilet for multiple days and had to damage his cell before officers would respond, and that he was left in a temporary holding cell for over four hours. The complainant also alleged that staff wrote and utilized inappropriate nicknames on the inmates' picture cards posted in the housing unit.

On January 16, 2018, the department assigned a staff member from the Investigative Services Unit to conduct a review of the allegations. The review was completed prior to the OIG assessment period.

OIG analysis and conclusion of the prison's handling of the allegations: The OIG was provided a copy of the inquiry report, which summarized the allegations of the Prison Law Office letter and identified five allegations to be reviewed during the inquiry. The reviewer interviewed the complainant and another inmate who provided information regarding the incident in which the complainant purportedly engaged in a fight. The reviewer also conducted an informational interview with a sergeant regarding the shower issue; interviewed an inmate, a psychologist, and two nurses regarding the complainant's retention in a temporary holding cell; interviewed multiple inmates regarding the complainant's clogged toilet; and interviewed a staff member and an inmate regarding the complainant's allegation regarding the use of inappropriate nicknames. The reviewer also analyzed the rules violation report, documentation reflecting the complainant's prior statements to staff regarding the fight, medical reports of injury, documentation regarding the complainant's housing classification, a memorandum from a sergeant, shower logs, a work order regarding the toilet issue, and various logbooks.

The reviewer also noted that with regard to the allegation that staff did not permit the complainant to shower, the reviewer spoke to several inmates "in passing" regarding their ability to shower, and none reported any concern. However, the reviewer did not note which inmates he spoke to in passing to obtain this information, nor did he indicate whether he interviewed those inmates in a confidential setting. Furthermore, the reviewer did not interview the officer identified by the complainant as having refused to let the complainant shower; nor did he interview the two officers the complainant identified as having refused to move the complainant to another cell when the toilet in his cell was not working or the officer who allegedly secured the complainant in a temporary holding cell for over four hours.

The reviewer concluded the complainant's allegations were not substantiated and that no further investigation was necessary. Although the reviewer interviewed the complainant and several witnesses, and gathered and reviewed several pieces of documentary evidence, he

did not interview any of the staff members whom the complainant identified as committing misconduct. He also conducted several informal interviews with inmates "in passing" without identifying the identities of those inmates or whether he conducted those interviews in confidential settings.

Overall, the quality of the inquiry was inadequate.

Prison Law Office Case 7: Allegations of harassment and intimidation

Allegation background and summary: On January 12, 2018, the Prison Law Office requested the department investigate allegations of staff misconduct on behalf of an inmate who is an Armstrong *class member.*

The Prison Law Office reported a complainant alleged that staff had been harassing and intimidating him since reporting an incident of excessive force. The complainant reported that on February 28, 2017, staff unnecessarily placed him in a temporary holding cell after requesting that staff replace a medical brace which had been taken during a cell search. Upon release from the holding cell, the inmate, who suffered from a medical condition and could fall frequently, became dizzy and fell to the floor. The complainant reported that staff ordered the complainant to get up from the floor and, when he could not, several officers assaulted him. The department then issued the complainant a rules violation report for battery on a peace officer. The complainant stated that staff, including two officers, two sergeants, and a lieutenant, harassed him since the incident, including various incidents of verbal degradation and mocking, banging the complainant's face on a holding cell door, and threatening further rules violation reports.

On January 16, 2018, the department assigned a staff member from the Investigative Services Unit to conduct a review of the allegations. The review was ongoing during the OIG assessment period, allowing the OIG to engage in real-time monitoring of the complainant's interview.

OIG analysis and conclusion of the prison's handling of the allegations: The OIG was provided a copy of the inquiry report, which summarized the allegations of the Prison Law Office letter and identified five allegations to be reviewed during the inquiry. The reviewer conducted a thorough interview of the complainant in a confidential setting, asking him questions about each allegation. The reviewer conducted the interview prior to interviewing other witnesses. The inquiry report included a thorough summary of the complainant's statements regarding each allegation.

The reviewer also interviewed relevant staff witnesses and three of the five subjects (two officers and a sergeant) regarding the allegations, reviewed relevant documents, and visited the scene of the incident, which occurred in the temporary holding cell, and took photographs of the temporary holding cell. The reviewer included photographs in his inquiry report.

The reviewer concluded that the allegations against the staff members, except a lieutenant, were not substantiated. The reviewer recommended that the lieutenant receive formalized training regarding ethics and professionalism concerning the statement he made during a conversation with the inmate.

As to the quality of the inquiry, the reviewer did not interview two of the five subjects: a sergeant and a lieutenant. The reviewer did not explain why he did not interview the sergeant, but the sergeant had previously provided a statement during a prior inquiry conducted regarding the allegation against him. The reviewer did not note why he did not interview the lieutenant, and there is no indication that the lieutenant previously submitted to an interview. Nevertheless, the other interviews conducted by the reviewer were thorough, he obtained and reviewed relevant documentary evidence, and visited and took photographs of the scene of one of the incidents.

Overall, the quality of the inquiry was adequate.

Prison Law Office Case 8: Allegations of harassment, retaliation, and unprofessionalism

Allegation background and summary: On January 18, 2018, the Prison Law Office requested the department investigate allegations of staff misconduct on behalf of two inmates who are Armstrong *class members.*

The Prison Law Office reported that the complainants, who were housed in the same cell at Salinas Valley, alleged that various staff members harassed, intimated, and retaliated against them, conducted unprofessional searches, planted evidence, confiscated legal mail and other items without cause, and denied them access to inmate appeals or complaint forms.

On April 11, 2018, the department assigned a lieutenant from another institution to conduct a review of the allegations. The review was ongoing during the OIG assessment period, allowing the OIG to engage in real-time monitoring of one inmate's interview.

OIG analysis and conclusion of the prison's handling of the allegations: The OIG was provided a copy of the inquiry report, which summarized the allegations of the Prison Law Office letter and identified five allegations to be reviewed during the inquiry. The Prison Law Office reported that on June 9, and 10, 2017, staff interviewed one of the complainants in a nonconfidential setting about allegations against staff and, thereafter, several other inmates questioned the complainants about being called to speak to investigators, questioned them about speaking to the Prison Law Office, and informed the complainants that a particular officer would be planting a weapon in their cell. The reviewer interviewed both complainants about the allegations. However, the reviewer did not interview the lieutenant who allegedly conducted the interviews in the nonconfidential setting, did not interview an officer who allegedly was told about the plan to plant a weapon in the complainants' cell, and did not interview the officer who allegedly planned to plant the weapon. The complainants provided the names of three inmates who approached them after the nonconfidential interviews and questioned them and made statements about them reporting misconduct. The reviewer only interviewed one of the three inmates. The reviewer did not provide a reason for not interviewing the other two inmates. The reviewer concluded that the interviews were conducted in a manner which was not conducive to concealing the identity of the inmates involved and recommended that staff conduct interviews in a confidential setting. The reviewer also found that there was a previous inquiry regarding the allegations and agreed with the prior finding that staff did not violate policy.

The complainants also reported that on September 12, 2017, officers searched their cell in an unprofessional manner, leaving their cell in complete disarray, and also confiscated their legal mail. One officer also allegedly stated, "It's payback time." The reviewer obtained and analyzed documentation regarding a prior appeal submitted by one of the complainants regarding the search, and he also interviewed both complainants regarding the allegations. However, the reviewer did not interview any of the officers or other staff members involved in the cell search, including the officer who allegedly made the retaliatory comment. The reviewer also did not interview a captain to whom the complainants previously reported the allegation shortly after the incident. The reviewer did not attach to his inquiry report any of the documentation from the prior review, nor did he note or summarize any prior staff interviews. Therefore, it is not clear whether any of the staff members were ever interviewed about the allegations. The reviewer found that there was a previous inquiry regarding the allegations and agreed with the prior finding that staff did not violate policy.

In addition, the complainants reported that from September 15, 2017, through October 24, 2017, various staff made numerous verbal threats, incited other inmates to assault them, and conducted a cell search during which staff planted a weapon that resulted in a false weapons charge. The reviewer obtained and analyzed documentation regarding a previous appeal regarding some of these allegations and interviewed one of the two complainants, and two staff witnesses: a captain and a sergeant. The complainant provided the reviewer with the names of two other inmates who possessed information regarding the allegations. The reviewer did not independently interview them, but instead relied upon information they provided as set forth in the documentation regarding the prior appeal. The reviewer did not interview an officer who allegedly made verbal threats against the inmates and incited other inmates to assault them and another officer who also allegedly threatened them. The reviewer did not interview a sergeant who allegedly made intimidating statements to the inmates. The reviewer did not interview any of the six officers or two sergeants who allegedly participated in the search of the complainants' cell and all potential subjects regarding the allegation that staff planted a weapon in their cell. The reviewer concluded that he was unable to substantiate any of the complainants' allegations.

Lastly, the complainants reported that during various periods, including in October 2017, staff failed to provide vision-related accommodations to one of the complainants and denied both complainants access to the appeals process, including access to the complainant's appeal or complaint forms. The reviewer obtained and reviewed documentation from a prior inmate appeal regarding these issues. He also interviewed both complainants. The reviewer did not interview any staff members regarding these allegations, including one staff member whom one of the complainants specifically identified as having committed the alleged misconduct. The reviewer noted that he was unable to substantiate the allegations made by the complainants.

Although the reviewer interviewed both complainants as to the allegations and reviewed documentation from prior inquiries regarding some of the allegations, he failed to interview various relevant inmates and staff witnesses. In particular, the reviewer did not interview any of the staff members who allegedly committed misconduct.

Overall, the quality of the inquiry was inadequate.

Prison Law Office Case 9: Allegations of unnecessary force, retaliation for filing a staff complaint, and disclosure of confidential medical information

Allegation background and summary: On January 23, 2018, the Prison Law Office requested the department investigate allegations of staff misconduct on behalf of an inmate who is an Armstrong *class member.*

The Prison Law Office alleged that on May 8, 2017, the complainant was subjected to unnecessary force and suffered injuries and ongoing medical difficulties as a result of the use of force. The complainant was on the yard when a fight broke out, at which point he took a seated position away from the fight. An officer responding to the fight turned away from the fight and threw a pepper spray grenade in the complainant's direction. The grenade landed in the complainant's lap, where it detonated, causing severe pain, burning, and other ongoing medical problems. The complainant alleged that after the fight was resolved, he approached a sergeant on the yard, who denied his request to be decontaminated from the pepper spray and threatened to issue him a rules violation report. Twelve days after the incident, the complainant sought medical attention for the ongoing medical problems he was experiencing as a result of the incident. The complainant filed an appeal alleging unnecessary force and describing the medical problems he was suffering from as a result of the incident. The complainant alleged the officer who used the unnecessary force then retaliated against him for filing the appeal by disclosing his personal medical information to other inmates, causing him embarrassment. The complainant also alleged another officer disclosed his personal medical information and refused his request to be housed in the same cell as his brother, who was also housed at the prison, in retaliation for filing the appeal.

On January 24, 2018, the department assigned a staff member from the Investigative Services Unit to conduct a review of the allegations. The review was completed prior to the OIG assessment period.

OIG analysis and conclusion of the prison's handling of the allegations: The OIG was provided a copy of the inquiry report, which briefly summarized the allegations of the Prison Law Office letter and identified two allegations to be reviewed during the inquiry. Although the reviewer addressed both of these allegations, because he failed to identify two additional allegations in the Prison Law Office letter, these issues went unaddressed during the inquiry. Specifically, the inquiry did not address the allegation that a sergeant refused the complainant's request to decontaminate after being exposed to pepper spray and that staff disclosed his

embarrassing personal medical information in retaliation for filing his appeal.

A review of the inquiry report identified additional deficiencies with the thoroughness of the inquiry. First, the reviewer only interviewed the appellant and two staff witnesses during the inquiry. He did not interview, or provide a justification for not interviewing, the officer who allegedly threw the pepper spray grenade in his direction and later disclosed his confidential medication information; the sergeant who allegedly refused to allow him to decontaminate and threatened him with a rules violation; or the two officers who allegedly refused to house him with his brother and disclosed his confidential medication information. Second, although the reviewer reviewed the documents generated during the institution's review of the use-of-force incident, he did not interview any of the involved officers or witnesses to that incident to inquire as to whether they observed an officer throw a pepper spray grenade in complainant's direction. The reviewer relied entirely on the reports the officers wrote after the incident. Third, although the reviewer thoroughly summarized the complainant's interactions with health care and mental health staff after the incident, the reviewer failed to interview a mental health clinician whose report stated the ongoing medical problems the complainant was suffering could have been caused by medication he was taking. The reviewer relied on this information to support one of his conclusions, but did not interview the clinician to determine whether his medical problems were more likely caused by the use of force or the medication.

With the exception of the above concerns, the report summarized every document reviewed and every interview conducted during the inquiry. The reviewer also gathered extensive documentation during the inquiry that was relevant to the issues presented and thoroughly analyzed the evidence gathered during the inquiry. However, because the reviewer did not address all the allegations from the Prison Law Office letter and did not interview or provide justifications for not interviewing the subjects of the complaint, the overall quality of the inquiry was inadequate.

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Recommendations

The problems we encountered require substantial changes at Salinas Valley. Although this special review focused only on Salinas Valley, the process we reviewed is in place at prisons statewide. Therefore, the conditions we found may also exist to some degree at other institutions. Toward that end, we offer the following recommendations for consideration at the departmental level:

To address the independence and quality issues we identified, the department should consider a complete overhaul of the staff complaint inquiry process. Specifically, we urge the department to reassign the responsibility of conducting staff complaint inquiries to employees who work outside of the prison's command structure, which is the Division of Adult Institutions.

To the extent the department utilizes staff from outside the prison's command structure, the department should consider adopting a regionalized model for staffing purposes. For instance, the reviewers should not work or be co-located in the facilities where they are assigned to conduct staff complaint inquiries. The department currently uses a regionalized model for special agents who work in the Office of Internal Affairs.

To ensure that all prison employees who conduct staff complaint inquiries possess the requisite knowledge and skills to perform staff complaint inquiry activities effectively and efficiently, the department should:

- Provide comprehensive and ongoing training to all staff members who may be assigned to conduct staff complaint inquiries. This training should provide, at a minimum, an understanding of the staff complaint inquiry process; best practices to apply when interviewing appellants, witnesses, and subjects; best practices to apply for maintaining impartiality and confidentiality; instructions in effective techniques in collecting and preserving evidence; and instructions in effective report writing techniques.
- Consider requiring reviewers receive a certificate from the California Commission on Peace Officer Standards and Training with respect to conducting investigations.
- Assign staff complaint inquiries to only those employees who have received training and are certified on how to properly conduct them.

To ensure that the hiring authority has the most complete information at his or her disposal when making decisions regarding staff complaint inquiry determinations, the department should consider requiring audio-recorded interviews of staff subjects and witnesses. If this is not permitted under existing labor Memoranda of Understanding, then this recommendation may require negotiating with the respective labor organizations to effectuate such a change. Furthermore, the department should require reviewers to video-record (or at least, audio-record) all appellant and inmate witness interviews.

To better align the processes of a staff complaint inquiry and an investigation, the department should:

- Consider redefining an inquiry so that it is not perceived as a less-laborious process or as an inferior process when compared with an investigation. As we describe in the body of this report, inquiries consist of the same basic activities as investigations and, for results to be meaningful, they must include thorough interviews of the appellant, all pertinent witnesses, and all subjects. The staff complaint inquiry must also include all relevant supporting documentation and a complete and accurate written report. A reviewer cannot cut corners on these steps without compromising quality.
- Require reviewers to report all evidence they have uncovered in the staff complaint inquiry reports, and prohibit them from including their personal opinions or from making conclusions and recommendations in the staff complaint inquiry report.

To improve communication with appellants, the department should evaluate its notification procedures to ensure it promptly notifies appellants when reviewers need additional time to process staff complaint inquiries, beyond the regulatory time frame.

To ensure better follow-through on identified policy deviations, the department should routinely audit whether employees who were found to be out of compliance as part of a staff complaint inquiry actually received the corrective or adverse actions ordered by the hiring authority and then report the findings publicly.

Appendices

Appendix A. Engagement Letter Outlining the Scope of Work

Roy W. Wesley, Inspector General

Office of the Inspector General

The Office of the Inspector General will assess the effectiveness of Salinas Valley State Prison's process of handling inmate complaints alleging staff misconduct (referred to as "staff complaints"). This will include staff complaints originating from the inmate appeals process (Form 602), use of force reviews, the Prison Rape Elimination Act, or from any other official complaint-reporting method covered in policy. The scope of our review will include the following:

1. Review and evaluate the department's policies, procedures, and regulations significant to the handling of staff complaints. This will also include a review of the prison's relevant supplemental local operating procedures.

2. Obtain and review the prison's tracking logs and related documentation for staff complaints.

3. Interview key staff who work in the prison's appeals office and other staff as necessary to gain a better understanding of the staff complaint-handling process.

4. Assess the training provided to staff involving staff complaints. Determine whether relevant prison staff received periodic training on how to conduct inquiries or investigations into staff complaints, including whether the training focused on interviewing techniques of inmates and staff.

5. Assess the department's handling and response to ten specific complaints submitted by the Prison Law Office between November 14, 2017, and January 23, 2018.

6. Review and evaluate the documentation of all staff complaints resolved at the prison between December 1, 2017, and February 28, 2018. For these complaints, determine whether the prison followed its policies when resolving such complaints. We will focus on timeliness, completeness, and due process-related issues.

7. Monitor in real-time all staff complaints submitted at the prison for a period of 90 days, beginning with those received on March 1, 2018, through May 31, 2018. During this period, we will monitor the prison's process for screening complaint-related documentation, collecting evidence, conducting interviews of the complainant, conducting interviews of staff who are identified as subjects and/or witnesses, and reaching the final disposition of the complaint. We will also assess the timeliness, completeness, and due process-related issues of the staff complaints in this period. As requested by the department, we will not attend in person any of the interviews of departmental, non-medical staff. However, as requested by the federal Receiver, we will attend in person all interviews of medical staff. For transparency, we will note in our public report as a scope limitation that we were unable to attend interviews of non-medical staff.

8. Compare how the department handled complaints in steps six and seven, above. Determine whether our real-time monitoring had an effect on the department's handling of staff complaints. Toward that end, interview a sample of inmates and staff to obtain their perspective of the process before and during our involvement.

9. Identify strengths and weaknesses of the department's policies and procedures related to its handling of staff complaints. To the extent applicable, determine whether the department's proposed changes to its appeals process will address any of the weaknesses identified during this review.

Edmund G. Brown, Jr., Governor

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Note: The OIG letter sent to the department on February 28, 2018.

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Appendix B. Detail of Staff Complaint Cases and Outcomes, as Determined by the Department

In this appendix, we present various conclusions made by the hiring authority in the 188 staff complaints included in this special review. Those numbered one through 61 cover the paper review period (those the prison completed between December 1, 2017, and February 28, 2018) and those numbered 62 through 188 cover the onsite review period (those the prison initiated between March 1, 2018, and May 31, 2018).

The following table summarizes "yes" or "no" answers that we applied to each case, corresponding to whether the hiring authority determined any of the following:

- policy violation
- a referral to the prison's Investigative Services Unit for an Allegation Inquiry
- a referral to the department's Office of Internal Affairs for investigation
- corrective action
- adverse action

The table also summarizes the type of allegation for each case, the location of the appellant at the time of filing the appeal, and whether the appellant was a member of the *Armstrong* or *Coleman* litigation classes (*Armstrong* v. *Wilson*, 942 F.Supp. 1252 (N.D. Cal. 1996); *Coleman* v. *Wilson*, 912 F.Supp. 1282 (E.D. 1995)).

Finally, the table also includes the number of subjects in each case and their corresponding rank.

Appendix B. Detail of Staff Complaint Cases and Outcomes, as Determined by the Department

Case	Allegation Types	Appellant Housing Location	*Armstrong* or *Coleman* Litigation Status*	Number of Subjects	Rank of Subjects	Determinations Made by the Hiring Authority				
						Policy Violation	Referral to ISU	Referral to OIA	Corrective Action	Adverse Action
Paper Review Period										
1	Discourteous Treatment	A Yard	Coleman	1	CO	No	Yes	No	No	No
2	Discrimination Retaliation/Threats	A Yard	Coleman	1	Custodian	No	No	No	No	No
3	Discourteous Treatment	D Yard	Coleman	1	Supervising Cook	No	No	No	No	No
4	Discourteous Treatment Neglect of Duty	C Yard	None	1	CO	No	No	No	No	No
5	Neglect of Duty	D Yard	Coleman	Unknown	CO	No	No	No	No	No
6	Neglect of Duty Retaliation/Threats	A Yard	Armstrong, Coleman	2	SGT, CO	No	Yes	No	No	No
7	Discourteous Treatment	ASU (D1)	None	1	CO	No	No	No	No	No
8	Discourteous Treatment Retaliation/Threats	CTC	Armstrong, Coleman	1	CO	No	No	No	No	No
9	Discourteous Treatment Neglect of Duty	A Yard	Armstrong	2	CO	No	No	No	No	No
10	Discourteous Treatment	ASU (Z9)	Coleman	4	CO (x3), RT	No	No	No	No	No
11	Neglect of Duty Retaliation/Threats	M	None	1	SGT	No	No	No	No	No
12	Unreasonable Use of Force Discourteous Treatment	D Yard	Coleman	1	CO	No	No	No	No	No
13	Retaliation/Threats Dishonesty/Falsified Documentation Neglect of Duty	ASU (Z9)	Coleman	2	CO	No	Yes	No	No	No
14	Unreasonable Use of Force Dishonesty/Falsified Documentation	A Yard	Coleman	2	CO	Yes	No	No	Yes	No
15	Retaliation/Threats Dishonesty/Falsified Documentation Neglect of Duty	A Yard	Armstrong, Coleman	1	CO	No	Yes	No	No	No
16	Retaliation/Threats	ASU (D1)	Armstrong, Coleman	1	CO	No	No	No	No	No
17	Unreasonable Use of Force	D Yard	Armstrong, Coleman	1	SGT	No	No	No	No	No

* *Armstrong* v. *Wilson*, 942 F.Supp. 1252 (N.D. Cal. 1996); *Coleman* v. *Wilson*, 912 F.Supp. 1282 (E.D. 1995).

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Appendix B. Detail of Staff Complaint Cases and Outcomes, as Determined by the Department (continued)

Case	Allegation Types	Appellant Housing Location	*Armstrong* or *Coleman* Litigation Status*	Number of Subjects	Rank of Subjects	Determinations Made by the Hiring Authority				
						Policy Violation	Referral to ISU	Referral to OIA	Corrective Action	Adverse Action
18	Dishonesty/Falsified Documentation	D Yard	None	1	CPT	No	No	No	No	No
19	Unreasonable Use of Force	D Yard	Coleman	1	CO	No	No	No	No	No
20	Discourteous Treatment	A Yard	Armstrong, Coleman	1	Plumber	No	No	No	No	No
21	Unreasonable Use of Force Neglect of Duty	ASU (D1)	Armstrong	1	LT	No	No	No	No	No
22	Unreasonable Use of Force	C Yard	Coleman	3	SGT, CO, MTA	No	No	No	No	No
23	Unreasonable Use of Force Retaliation/Threats	D Yard	Armstrong	1	CO	No	No	No	No	No
24	Unreasonable Use of Force	ASU (D1)	None	3	CO	No	No	No	No	No
25	Unreasonable Use of Force	ASU (D1)	None	3	CO	No	No	No	No	No
26	Dishonesty/Falsified Documentation	ASU (D1)	Armstrong, Coleman	1	CO	No	No	No	No	No
27	Discourteous Treatment Retaliation/Threats	D Yard	Coleman	3	SGT, CO(x2)	No	No	No	No	No
28	Discourteous Treatment Neglect of Duty	A Yard	Coleman	1	CO	No	No	No	No	No
29	Discourteous Treatment Retaliation/Threats	D Yard	Armstrong	1	CO	No	No	No	No	No
30	Unreasonable Use of Force	ASU (D1)	None	2	CO	No	No	No	No	No
31	Discourteous Treatment	D Yard	Coleman	1	CO	No	No	No	No	No
32	Discrimination Discourteous Treatment	D Yard	None	1	CO	No	No	No	No	No
33	Retaliation/Threats Neglect of Duty Discourteous Treatment	ASU (Z9)	None	4	CO	No	No	No	No	No
34	Retaliation/Threats	TC 2	Coleman	1	CO	No	No	No	No	No
35	Discourteous Treatment	A Yard	Coleman	1	CO	No	No	No	No	No
36	Discrimination Discourteous Treatment	B Yard	None	1	CO	No	No	No	No	No
37	Neglect of Duty	ASU (Z9)	None	1	CO	No	No	No	No	No

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Appendix B. Detail of Staff Complaint Cases and Outcomes, as Determined by the Department (cont.)

Case	Allegation Types	Appellant Housing Location	*Armstrong* or *Coleman* Litigation Status*	Number of Subjects	Rank of Subjects	Determinations Made by the Hiring Authority				
						Policy Violation	Referral to ISU	Referral to OIA	Corrective Action	Adverse Action
38	Discourteous Treatment	D Yard	Armstrong, Coleman	1	CO	No	No	No	No	No
39	Unreasonable Use of Force	D Yard	Coleman	1	CO	No	No	No	No	No
40	Neglect of Duty	A Yard	Armstrong, Coleman	5	SGT(x1), CO(x4)	No	No	No	No	No
41	Unreasonable Use of Force	ASU (D1)	Coleman	Unknown	Unknown	No	No	No	No	No
42	Discourteous Treatment Dishonesty/Falsified Documentation	A Yard	Armstrong, Coleman	1	CO	No	No	No	No	No
43	Neglect of Duty	D Yard	Armstrong, Coleman	2	CPT, CCII	No	No	No	No	No
44	Unreasonable Use of Force Dishonesty/Falsified Documentation	A Yard	Coleman	Unknown	Unknown	No	No	No	No	No
45	Unreasonable Use of Force	B Yard	Coleman	2	MTA, CO	No	Yes	No	No	No
46	Discourteous Treatment	ASU (D1)	None	1	CO	No	No	No	No	No
47	Discourteous Treatment	B Yard	Coleman	2	CO	No	No	No	No	No
48	Sexual Misconduct	C Yard	Coleman	1	CO	No	No	No	No	No
49	Unreasonable Use of Force	ASU (D1)	None	1	CO	No	No	No	No	No
50	Unreasonable Use of Force	CTC	Coleman	3	CO	No	No	No	No	No
51	Unreasonable Use of Force Discourteous Treatment	ASU (Z9)	Coleman	1	CO	No	No	No	No	No
52	Unreasonable Use of Force	D Yard	Coleman	1	CO	No	No	No	No	No
53	Unreasonable Use of Force	ASU (Z9)	Coleman	2	CO	No	No	No	No	No
54	Neglect of Duty Discourteous Treatment	D Yard	Coleman	1	CO	No	No	No	No	No
55	Sexual Misconduct Discourteous Treatment Neglect of Duty Retaliation/Threats	A Yard	Armstrong, Coleman	1	CO	No	No	No	No	No
56	Unreasonable Use of Force	A Yard	None	2	CO	No	No	No	No	No
57	Discourteous Treatment	B Yard	None	1	CO	No	No	No	No	No

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Appendix B. Detail of Staff Complaint Cases and Outcomes, as Determined by the Department (cont.)

Case	Allegation Types	Appellant Housing Location	*Armstrong* or *Coleman* Litigation Status*	Number of Subjects	Rank of Subjects	Determinations Made by the Hiring Authority				
						Policy Violation	Referral to ISU	Referral to OIA	Corrective Action	Adverse Action
58	Discourteous Treatment	D Yard	Coleman	1	CCI	No	No	No	No	No
59	Retaliation/Threats Neglect of Duty	A Yard	Coleman	1	SGT	No	No	No	No	No
60	Retaliation/Threats	D Yard	None	1	CO	No	No	No	No	No
61	Sexual Misconduct Retaliation/Threats	A Yard	Armstrong, Coleman	2	CO	No	No	No	No	No
Onsite Review Period										
62	Sexual Misconduct Neglect of Duty	C Yard	Coleman	2	PT, MTA	No	No	No	No	No
63	Retaliation/Threats	ASU (Z9)	Armstrong, Coleman	Unknown	Unknown	No	No	No	No	No
64	Unreasonable Use of Force Discourteous Treatment	ASU (Z9)	Coleman	3	CO	No	No	No	No	No
65	Neglect of Duty	D Yard	Coleman	2	CO	Yes	No	No	Yes	No
66	Discourteous Treatment	ASU (Z9)	Armstrong, Coleman	3	CO	No	No	No	No	No
67	Neglect of Duty Discourteous Treatment	B Yard	None	2	CO	No	No	No	No	No
68	Neglect of Duty	B Yard	Armstrong	1	CO	No	No	No	No	No
69	Unreasonable Use of Force Neglect of Duty	D Yard	Coleman	Unknown	Unknown	No	No	No	No	No
70	Sexual Misconduct	D Yard	Coleman	1	CO	No	No	No	No	No
71	Discourteous Treatment	D Yard	Coleman	1	LT	No	No	No	No	No
72	Neglect of Duty Discourteous Treatment	B Yard	Armstrong, Coleman	1	CO	No	No	No	No	No
73	Unreasonable Use of Force	A Yard	Coleman	2	CO	No	No	No	No	No
74	Neglect of Duty	B Yard	Coleman	1	CO	No	No	No	No	No
75	Retaliation/Threats Dishonesty/Falsified Documentation Discourteous Treatment	C Yard	Armstrong, Coleman	1	CO	No	No	No	No	No
76	Neglect of Duty	ASU (Z9)	Coleman	1	CPT	No	No	No	No	No

Continued on next page.

Appendix B. Detail of Staff Complaint Cases and Outcomes, as Determined by the Department (cont.)

Case	Allegation Types	Appellant Housing Location	*Armstrong* or *Coleman* Litigation Status*	Number of Subjects	Rank of Subjects	Determinations Made by the Hiring Authority				
						Policy Violation	Referral to ISU	Referral to OIA	Corrective Action	Adverse Action
77	Discourteous Treatment Dishonesty/Falsified Documentation	B Yard	None	1	CO	No	No	No	No	No
78	Neglect of Duty	A Yard	Coleman	2	CCII	No	No	No	No	No
79	Retaliation/Threats Dishonesty/Falsified documentation Neglect of Duty	D Yard	Armstrong, Coleman	1	LT	No	No	No	No	No
80	Unreasonable Use of Force	CMC	Coleman	2	CO	Yes	No	No	Yes	No
81	Neglect of Duty	A Yard	Coleman	Unknown	Unknown	No	No	No	No	No
82	Dishonesty/Falsified Documentation	A Yard	Armstrong, Coleman	3	CO	No	No	No	No	No
83	Unreasonable Use of Force Discourteous Treatment	ASU (D1)	None	1	CO	No	No	No	No	No
84	Discourteous Treatment	D Yard	Armstrong, Coleman	1	CO	No	No	No	No	No
85	Dishonesty/Falsified Documentation Discourteous Treatment	B Yard	Coleman	2	CPT, LT	No	No	No	No	No
86	Unreasonable Use of Force Discourteous Treatment Retaliation/Threats	A Yard	Armstrong, Coleman	1	CO	No	No	No	No	No
87	Unreasonable Use of Force	ASU (Z9)	Coleman	2	CO	No	No	No	No	No
88	Unreasonable Use of Force	ASU (Z9)	None	1	CO	No	No	No	No	No
89	Discourteous Treatment	ASU (Z9)	Coleman	1	CCI	No	No	No	No	No
90	Discourteous Treatment	D Yard	Armstrong, Coleman	1	CO	No	No	No	No	No
91	Discourteous Treatment	ASU (Z9)	Coleman	1	LT	No	No	No	No	No
92	Neglect of Duty Discourteous treatment	ASU (Z9)	Armstrong, Coleman	1	CO	No	No	No	No	No
93	Discourteous Treatment Retaliation/Threats	A Yard	Coleman	1	Custodian	No	No	No	No	No
94	Unreasonable Use of Force	A Yard	Coleman	1	CO	No	No	No	No	No
95	Neglect of Duty	D Yard	None	1	LT	No	No	No	No	No
96	Unreasonable Use of Force	D Yard	Coleman	1	CO	No	No	No	No	No

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Appendix B. Detail of Staff Complaint Cases and Outcomes, as Determined by the Department (cont.)

Case	Allegation Types	Appellant Housing Location	*Armstrong* or *Coleman* Litigation Status*	Number of Subjects	Rank of Subjects	Determinations Made by the Hiring Authority				
						Policy Violation	Referral to ISU	Referral to OIA	Corrective Action	Adverse Action
97	Discourteous Treatment	D Yard	Armstrong	3	CO	No	No	No	No	No
98	Unreasonable Use of Force	D Yard	Coleman	1	CO	No	No	No	No	No
99	Unreasonable Use of Force	A Yard	Coleman	1	CO	No	No	No	No	No
100	Discourteous Treatment	TC 2	Coleman	2	SMTA, MTA	No	No	No	No	No
101	Unreasonable Use of Force	ASU (D1)	Coleman	2	CO	No	No	No	No	No
102	Neglect of Duty	C Yard	Armstrong, Coleman	2	CO	No	No	No	No	No
103	Discourteous Treatment	A Yard	Coleman	1	Non-Sworn Manager	No	No	No	No	No
104	Unreasonable Use of Force	ASU (Z9)	Armstrong, Coleman	1	CO	No	No	No	No	No
105	Discourteous Treatment	D Yard	Coleman	1	CO	No	No	No	No	No
106	Unreasonable Use of Force Dishonesty/Falsified Documentation Neglect of Duty	ASU (Z9)	Armstrong, Coleman	4	CO(x3), Senior Psychologis t	No	No	No	No	No
107	Sexual Misconduct	B Yard	Armstrong, Coleman	1	CO	No	No	No	No	No
108	Unreasonable Use of Force	D Yard	Armstrong, Coleman	4	CO	No	No	No	No	No
109	Discourteous Treatment Retaliation/Threats	ASU (Z9)	Coleman	1	CO	No	No	No	No	No
110	Unreasonable Use of Force	C Yard	None	2	CO	No	No	No	No	No
111	Discourteous Treatment	B Yard	None	1	CO	No	No	No	No	No
112	Discrimination	B Yard	Coleman	Unknown	Unknown	No	No	No	No	No
113	Discourteous Treatment Neglect of Duty	D Yard	Coleman	1	CCI	No	No	No	No	No
114	Unreasonable Use of Force	CMF	Coleman	4	CO	No	No	No	No	No
115	Neglect of Duty	B Yard	None	2	CO	No	No	No	No	No
116	Neglect of Duty Dishonesty/Falsified Documentation	C Yard	Armstrong, Coleman	2	CO	No	No	No	No	No

Continued on next page.

Appendix B. Detail of Staff Complaint Cases and Outcomes, as Determined by the Department (cont.)

Case	Allegation Types	Appellant Housing Location	*Armstrong* or *Coleman* Litigation Status*	Number of Subjects	Rank of Subjects	Determinations Made by the Hiring Authority				
						Policy Violation	Referral to ISU	Referral to OIA	Corrective Action	Adverse Action
117	Unreasonable Use of Force Dishonesty/Falsified Documentation	B Yard	None	1	SGT	No	No	No	No	No
118	Discourteous Treatment	A Yard	Coleman	1	SGT	No	No	No	No	No
119	Neglect of Duty	A Yard	Armstrong, Coleman	Unknown	Unknown	No	No	No	No	No
120	Retaliation Threats Dishonesty/Falsified Documentation	ASU (Z9)	Armstrong, Coleman	1	LT	No	No	No	No	No
121	Dishonesty/Falsified Documentation Retaliation/Threats	D Yard	None	1	CO	No	No	No	No	No
122	Discourteous Treatment	C Yard	None	2	SGT, CO	No	No	No	No	No
123	Discourteous Treatment	ASU (Z9)	Coleman	1	Supervising Cook	No	No	No	No	No
124	Discourteous Treatment	D Yard	Coleman	1	CO	No	No	No	No	No
125	Unreasonable Use of Force	ASU (Z9)	Coleman	4	CO	No	No	No	No	No
126	Retaliation/Threats Neglect of Duty Discourteous Treatment	A Yard	Coleman	4	CO	No	No	No	No	No
127	Sexual Misconduct	M	None	1	CO	No	Yes	Yes	No	No
128	Retaliation/Threats Dishonesty/Falsified Documentation	B Yard	Coleman	1	SGT	No	No	No	No	No
129	Discourteous Treatment Retaliation/Threats	C Yard	None	5	LT, CO(x4)	No	No	No	No	No
130	Discourteous Treatment	B Yard	None	1	CO	No	No	No	No	No
131	Discourteous Treatment	A Yard	Armstrong, Coleman	1	CO	No	No	No	No	No
132	Dishonesty/Falsified Documentation Discourteous Treatment	B Yard	Armstrong	1	CCI	No	No	No	No	No
133	Dishonesty/Falsified Documentation	ASU (Z9)	Coleman	2	CO	No	No	No	No	No
134	Neglect of Duty	C Yard	None	1	Non-Sworn Staff Member	No	No	No	No	No
135	Discourteous Treatment	ASU (Z9)	Coleman	Unknown	Unknown	No	No	No	No	No
136	Retaliation/Threats Neglect of Duty Discourteous Treatment	D Yard	Armstrong	1	CO	No	No	No	No	No

Continued on next page.

Appendix B. Detail of Staff Complaint Cases and Outcomes, as Determined by the Department (cont.)

Case	Allegation Types	Appellant Housing Location	*Armstrong* or *Coleman* Litigation Status*	Number of Subjects	Rank of Subjects	Determinations Made by the Hiring Authority				
						Policy Violation	Referral to ISU	Referral to OIA	Corrective Action	Adverse Action
137	Unreasonable Use of Force	C Yard	Coleman	1	CO	No	No	No	No	No
138	Neglect of Duty	C Yard	None	2	CO	No	No	No	No	No
139	Discourteous Treatment	ASU (Z9)	Coleman	1	CO	No	No	No	No	No
140	Unreasonable Use of Force	CMC	Coleman	1	CO	No	No	No	No	No
141	Neglect of Duty	B Yard	Armstrong, Coleman	1	CO	No	No	No	No	No
142	Dishonesty/Falsified Documentation	C Yard	Coleman	1	CO	No	No	No	No	No
143	Neglect of Duty	SATF	Coleman	4	CO	No	No	No	No	No
144	Discourteous Treatment	ASU (Z9)	Coleman	1	CCII	No	No	No	No	No
145	Discourteous Treatment Neglect of Duty Dishonesty/Falsified Documentation	ASU (Z9)	None	3	CO	No	No	No	No	No
146	Neglect of Duty	C Yard	Armstrong	1	OA	No	No	No	No	No
147	Unreasonable Use of Force	LAC	Coleman	8	MD, RN, MTA(x3), CO, CCII, RT	No	No	No	No	No
148	Sexual Misconduct	M	None	1	CO	No	No	No	No	No
149	Retaliation/Threats	A Yard	Armstrong	3	CO	No	No	No	No	No
150	Discourteous Treatment Retaliation/Threats Dishonesty/Falsified Documentation	A Yard	Armstrong, Coleman	2	CO	No	No	No	No	No
151	Neglect of Duty	A Yard	Coleman	3	CO(x2), LVN	No	No	No	No	No
152	Neglect of Duty	D Yard	Armstrong, Coleman	5	SGT, CO(x4)	No	No	No	No	No
153	Neglect of Duty	ASU (D1)	Armstrong	1	Supervising Cook	No	No	No	No	No
154	Unreasonable Use of Force	A Yard	Armstrong, Coleman	1	LT	No	No	No	No	No
155	Discourteous Treatment Neglect of Duty	M	None	1	SGT	Yes	No	No	No	No
156	Unreasonable Use of Force	A Yard	Coleman	2	CO	No	No	No	No	No

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Appendix B. Detail of Staff Complaint Cases and Outcomes, as Determined by the Department (cont.)

Case	Allegation Types	Appellant Housing Location	*Armstrong* or *Coleman* Litigation Status*	Number of Subjects	Rank of Subjects	Determinations Made by the Hiring Authority				
						Policy Violation	Referral to ISU	Referral to OIA	Corrective Action	Adverse Action
157	Discourteous Treatment	D Yard	Armstrong	1	LT	No	No	No	No	No
158	Neglect of Duty	A Yard	None	3	CO	No	No	No	No	No
159	Retaliation/Threats	ASU (Z9)	Coleman	1	CO	No	No	No	No	No
160	Retaliation/Threats	ASU (Z9)	Coleman	1	CO	No	No	No	No	No
161	Discrimination Retaliation/Threat	D Yard	Coleman	1	CO	No	No	No	No	No
162	Discourteous Treatment Neglect of Duty	A Yard	Armstrong	2	CO	No	No	No	No	No
163	Discourteous Treatment	B Yard	None	1	CO	Yes	No	No	Yes	No
164	Discourteous Treatment	ASU (Z9)	Coleman	2	CO	No	No	No	No	No
165	Neglect of Duty	A Yard	Armstrong	1	CO	No	No	No	No	No
166	Neglect of Duty	ASU (D1)	Coleman	2	SMTA, Psychiatrist	No	No	No	No	No
167	Neglect of Duty	A Yard	Armstrong	1	CO	No	No	No	No	No
168	Retaliation/Threats Neglect of Duty	ASU (D1)	None	1	CO	No	No	No	No	No
169	Neglect of Duty	B Yard	Coleman	1	Supervising Cook	No	No	No	No	No
170	Discourteous Treatment	A Yard	Coleman	2	CO	No	No	No	No	No
171	Retaliation/Threats Discourteous Treatment	B Yard	Armstrong, Coleman	3	CO	No	No	No	No	No
172	Neglect of Duty	A Yard	Coleman	1	CCII	No	No	No	No	No
173	Retaliation/Threats Neglect of Duty Sexual Misconduct	A Yard	Coleman	3	LT, SGT, CO	No	No	No	No	No
174	Dishonesty/Falsified Documentation	A Yard	Coleman	2	SGT	No	No	No	No	No
175	Neglect of Duty Discourteous Treatment Retaliation/Threats	A Yard	Armstrong	2	CO	No	No	No	No	No
176	Discourteous Treatment	B Yard	Coleman	1	CO	No	No	No	No	No

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Appendix B. Detail of Staff Complaint Cases and Outcomes, as Determined by the Department (cont.)

Case	Allegation Types	Appellant Housing Location	*Armstrong* or *Coleman* Litigation Status*	Number of Subjects	Rank of Subjects	Determinations Made by the Hiring Authority				
						Policy Violation	Referral to ISU	Referral to OIA	Corrective Action	Adverse Action
177	Unreasonable Use of Force	CHCF	Armstrong, Coleman	3	CO(x2), Physician	No	No	No	No	No
178	Retaliation/Threats Discourteous Treatment	A Yard	Armstrong	2	CO	No	No	No	No	No
179	Neglect of Duty	B Yard	None	1	CO	No	No	No	No	No
180	Discrimination	D Yard	Coleman	2	CO	No	No	No	No	No
181	Dishonesty/Falsified Documentation Neglect of Duty	ASU (D1)	None	1	LT	No	No	No	No	No
182	Retaliation/Threats Dishonesty/Falsified Documentation	B Yard	None	1	CO	No	No	No	No	No
183	Discourteous Treatment Discrimination	D Yard	Coleman	1	CO	No	No	No	No	No
184	Neglect of Duty Discourteous Treatment	D Yard	Armstrong, Coleman	2	CO	No	No	No	No	No
185	Neglect of Duty Discourteous Treatment	B Yard	None	1	CO	No	No	No	No	No
186	Neglect of Duty	B Yard	None	8	SGT(x2), CO(x6)	No	No	No	No	No
187	Discourteous Treatment	A Yard	Armstrong, Coleman	1	CO	No	No	No	No	No
188	Discourteous Treatment	B Yard	None	2	Non-Sworn Manager, Teacher	No	No	No	No	No
					Total Yes:	5	6	1	4	0

Appendix C. Detail of Staff Complaint Cases and Outcomes, as Determined by the OIG

In this appendix, we present our determinations of quality for each of the 188 staff complaint inquiries included in this special review. We assessed "quality" subjectively, using our own professional experience in monitoring investigations and other departmental processes. We assessed the appropriateness of the reviewer's assignment; the interviews conducted with appellants, witnesses, and subjects; evidence collected; and thoroughness of the inquiry report. Our qualitative assessments, however, were not intended to reflect the validation or invalidation of the department's policy determinations. An adequate rating reflected our opinion that, overall, the inquiry was performed using sound investigative practices. Below, we present the six primary assessment questions and the general methodology we applied to assess each.

1. Was the staff complaint inquiry assigned to an appropriate reviewer?
To assess the appropriateness of the assignment, we looked to see if the reviewer held a rank at least one level higher than the subject, worked on a different yard than the subject, or was uninvolved with the incident giving rise to the appeal. We evaluated this question for both review periods.

2. Did the reviewer properly conduct an interview of the appellant?
We evaluated whether the reviewer interviewed the appellant in the proper order (i.e., before interviewing witnesses or the subject); maintained confidentiality during the interview, including when the appellant was asked to be interviewed; maintained professionalism and impartiality during the interview; seemed prepared for the interview; and asked relevant questions and follow-up questions during the interview, including whether the appellant knew of any witnesses. We evaluated this question only for the onsite review period.

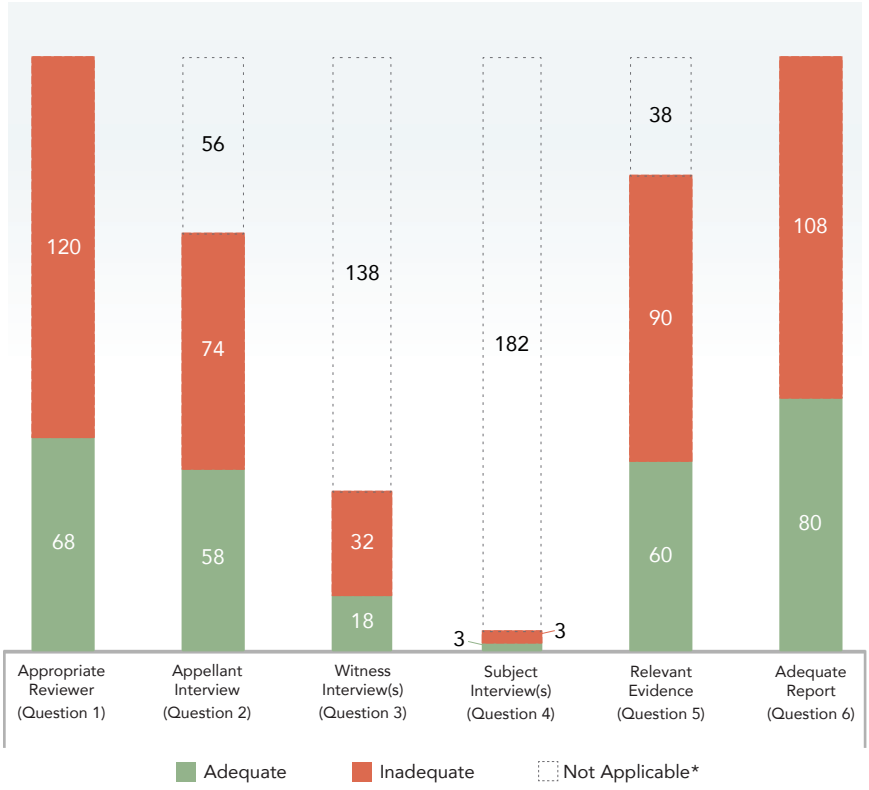
3. Did the reviewer properly conduct an interview of the witness(es)?
We applied the same standards described in question 2. We evaluated this question only for the onsite review period. However, we were not able to observe interviews of peace officers employed by the department.

4. Did the reviewer properly conduct an interview with the subject(s)?
We applied the same standards described in question 2. We evaluated this question only for the onsite review period. However, we were not able to observe interviews of peace officers employed by the department.

5. Did the reviewer collect all relevant documentary evidence?
We evaluated this question for both review periods and determined whether the reviewer collected and attached relevant documents that could support or refute allegations of staff misconduct. In the absence of collecting documents that may not have actually existed, we looked to see if the reviewer documented his or her attempt to validate their existence.

6. Did the reviewer prepare an adequate inquiry report?
We performed this evaluation for both review periods and evaluated the overall thoroughness of the report, including whether the reports were complete and accurate. An inquiry report is referred to as the Confidential Supplement to Appeal (or Attachment C).

Figure 13. Number of Adequate and Inadequate Ratings, by Assessment Question



* Our assessment questions were not always applicable. For instance, since we did not witness in person any of the interviews during the paper review period, we could only assess whether interviews were conducted in the proper order for question 2, but we could not assess questions 3 and 4 in their entirety. Additionally, we were not notified of some interviews during the onsite review period and, therefore, we could not make assessments for those instances, either. Finally, there were 38 inquiries for which we believed that, given the nature of the allegation, documentary evidence was not necessary to collect.

Source: Data and analysis by the Office of the Inspector General.

Appendix C. Detail of Staff Complaint Cases and Outcomes, as Determined by the OIG

Case	Allegation Types	Q1 Appropriate Reviewer	Q2 Appellant Interview	Q3 Witness Interviews	Q4 Subject Interviews	Q5 Relevant Evidence	Q6 Adequate Report	Overall
Paper Review Period								
1	Discourteous Treatment	●	●	●	●	●	●	●
2	Discrimination Retaliation/Threats	●	●	●	●	●	●	●
3	Discourteous Treatment	●	●	●	●	●	●	●
4	Discourteous Treatment Neglect of Duty	●	●	●	●	●	●	●
5	Neglect of Duty	●	●	●	●	●	●	●
6	Neglect of Duty Retaliation/Threats	●	●	●	●	●	●	●
7	Discourteous Treatment	●	●	●	●	●	●	●
8	Discourteous Treatment Retaliation/Threats	●	●	●	●	●	●	●
9	Discourteous Treatment Neglect of Duty	●	●	●	●	●	●	●
10	Discourteous Treatment	●	●	●	●	●	●	●
11	Neglect of Duty Retaliation/Threats	●	●	●	●	●	●	●
12	Unreasonable Use of Force Discourteous Treatment	●	●	●	●	●	●	●
13	Retaliation/Threats Dishonesty/Falsified Documentation Neglect of Duty	●	●	●	●	●	●	●
14	Unreasonable Use of Force Dishonesty/Falsified Documentation	●	●	●	●	●	●	●
15	Retaliation/Threats Dishonesty/Falsified Documentation Neglect of Duty	●	●	●	●	●	●	●
16	Retaliation/Threats	●	●	●	●	●	●	●
17	Unreasonable Use of Force	●	●	●	●	●	●	●
18	Dishonesty/Falsified Documentation	●	●	●	●	●	●	●
19	Unreasonable Use of Force	●	●	●	●	●	●	●

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Appendix C. Detail of Staff Complaint Cases and Outcomes, as Determined by the OIG (continued)

Case	Allegation Types	Q1 Appropriate Reviewer	Q2 Appellant Interview	Q3 Witness Interviews	Q4 Subject Interviews	Q5 Relevant Evidence	Q6 Adequate Report	Overall
20	Discourteous Treatment	●	●	●	●	●	●	●
21	Unreasonable Use of Force Neglect of Duty	●	●	●	●	●	●	●
22	Unreasonable Use of Force	●	●	●	●	●	●	●
23	Unreasonable Use of Force Retaliation/Threats	●	●	●	●	●	●	●
24	Unreasonable Use of Force	●	●	●	●	●	●	●
25	Unreasonable Use of Force	●	●	●	●	●	●	●
26	Dishonesty/Falsified Documentation	●	●	●	●	●	●	●
27	Discourteous Treatment Retaliation/Threats	●	●	●	●	●	●	●
28	Discourteous Treatment Neglect of Duty	●	●	●	●	●	●	●
29	Discourteous Treatment Retaliation/Threats	●	●	●	●	●	●	●
30	Unreasonable Use of Force	●	●	●	●	●	●	●
31	Discourteous Treatment	●	●	●	●	●	●	●
32	Discrimination Discourteous Treatment	●	●	●	●	●	●	●
33	Retaliation/Threats Neglect of Duty Discourteous Treatment	●	●	●	●	●	●	●
34	Retaliation/Threats	●	●	●	●	●	●	●
35	Discourteous Treatment	●	●	●	●	●	●	●
36	Discrimination Discourteous Treatment	●	●	●	●	●	●	●
37	Neglect of Duty	●	●	●	●	●	●	●
38	Discourteous Treatment	●	●	●	●	●	●	●
39	Unreasonable Use of Force	●	●	●	●	●	●	●

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Appendix C. Detail of Staff Complaint Cases and Outcomes, as Determined by the OIG (cont.)

Case	Allegation Types	Q1 Appropriate Reviewer	Q2 Appellant Interview	Q3 Witness Interviews	Q4 Subject Interviews	Q5 Relevant Evidence	Q6 Adequate Report	Overall
40	Neglect of Duty	🔴	⚪	⚪	⚪	🔴	🔴	🔴
41	Unreasonable Use of Force	🟢	⚪	⚪	⚪	🔴	🟢	🟢
42	Discourteous Treatment Dishonesty/Falsified Documentation	🔴	⚪	⚪	⚪	🟢	🔴	🔴
43	Neglect of Duty	🔴	⚪	⚪	⚪	🔴	🟢	🟢
44	Unreasonable Use of Force Dishonesty/Falsified Documentation	🟢	⚪	⚪	⚪	🔴	🟢	🟢
45	Unreasonable Use of Force	🔴	⚪	⚪	⚪	🔴	🔴	🔴
46	Discourteous Treatment	🟢	⚪	⚪	⚪	🟢	🔴	🔴
47	Discourteous Treatment	🔴	⚪	⚪	⚪	🟢	🔴	🔴
48	Sexual Misconduct	🔴	🔴	⚪	⚪	🟢	🔴	🔴
49	Unreasonable Use of Force	🟢	⚪	⚪	⚪	🔴	🟢	🟢
50	Unreasonable Use of Force	🔴	⚪	⚪	⚪	🔴	🔴	🔴
51	Unreasonable Use of Force Discourteous Treatment	🔴	⚪	⚪	⚪	🔴	🔴	🔴
52	Unreasonable Use of Force	🟢	⚪	⚪	⚪	🔴	🔴	🔴
53	Unreasonable Use of Force	🔴	⚪	⚪	⚪	🔴	🔴	🔴
54	Neglect of Duty Discourteous Treatment	🟢	⚪	⚪	⚪	🟢	🟢	🟢
55	Sexual Misconduct Discourteous Treatment Neglect of Duty Retaliation/Threats	🟢	⚪	⚪	⚪	⚪	🟢	🟢
56	Unreasonable Use of Force	🔴	⚪	⚪	⚪	🔴	🔴	🔴
57	Discourteous Treatment	🟢	⚪	⚪	⚪	🔴	🔴	🔴
58	Discourteous Treatment	🔴	⚪	⚪	⚪	🔴	🟢	🟢
59	Retaliation/Threats Neglect of Duty	🔴	⚪	⚪	⚪	🔴	🟢	🟢

Continued on next page.

Appendix C. Detail of Staff Complaint Cases and Outcomes, as Determined by the OIG (cont.)

Case	Allegation Types	Q1 Appropriate Reviewer	Q2 Appellant Interview	Q3 Witness Interviews	Q4 Subject Interviews	Q5 Relevant Evidence	Q6 Adequate Report	Overall
60	Retaliation/Threats	●	●	●	●	●	●	●
61	Sexual Misconduct Retaliation/Threats	●	●	●	●	●	●	●
Onsite Review Period								
62	Sexual Misconduct Neglect of Duty	●	●	●	●	●	●	●
63	Retaliation/Threats	●	●	●	●	●	●	●
64	Unreasonable Use of Force Discourteous Treatment	●	●	●	●	●	●	●
65	Neglect of Duty	●	●	●	●	●	●	●
66	Discourteous Treatment	●	●	●	●	●	●	●
67	Neglect of Duty Discourteous Treatment	●	●	●	●	●	●	●
68	Neglect of Duty	●	●	●	●	●	●	●
69	Unreasonable Use of Force Neglect of Duty	●	●	●	●	●	●	●
70	Sexual Misconduct	●	●	●	●	●	●	●
71	Discourteous Treatment	●	●	●	●	●	●	●
72	Neglect of Duty Discourteous Treatment	●	●	●	●	●	●	●
73	Unreasonable Use of Force	●	●	●	●	●	●	●
74	Neglect of Duty	●	●	●	●	●	●	●
75	Retaliation/Threats Dishonesty/Falsified Documentation Discourteous Treatment	●	●	●	●	●	●	●
76	Neglect of Duty	●	●	●	●	●	●	●
77	Discourteous Treatment Dishonesty/Falsified Documentation	●	●	●	●	●	●	●
78	Neglect of Duty	●	●	●	●	●	●	●

Continued on next page.

Appendix C. Detail of Staff Complaint Cases and Outcomes, as Determined by the OIG (cont.)

Case	Allegation Types	Q1 Appropriate Reviewer	Q2 Appellant Interview	Q3 Witness Interviews	Q4 Subject Interviews	Q5 Relevant Evidence	Q6 Adequate Report	Overall
79	Retaliation/Threats Dishonesty/Falsified documentation Neglect of Duty	●	●	●	●	●	●	●
80	Unreasonable Use of Force	●	●	●	●	●	●	●
81	Neglect of Duty	●	●	●	●	●	●	●
82	Dishonesty/Falsified Documentation	●	●	●	●	●	●	●
83	Unreasonable Use of Force Discourteous Treatment	●	●	●	●	●	●	●
84	Discourteous Treatment	●	●	●	●	●	●	●
85	Dishonesty/Falsified Documentation Discourteous Treatment	●	●	●	●	●	●	●
86	Unreasonable Use of Force Discourteous Treatment Retaliation/Threats	●	●	●	●	●	●	●
87	Unreasonable Use of Force	●	●	●	●	●	●	●
88	Unreasonable Use of Force	●	●	●	●	●	●	●
89	Discourteous Treatment	●	●	●	●	●	●	●
90	Discourteous Treatment	●	●	●	●	●	●	●
91	Discourteous Treatment	●	●	●	●	●	●	●
92	Neglect of Duty Discourteous treatment	●	●	●	●	●	●	●
93	Discourteous Treatment Retaliation/Threats	●	●	●	●	●	●	●
94	Unreasonable Use of Force	●	●	●	●	●	●	●
95	Neglect of Duty	●	●	●	●	●	●	●
96	Unreasonable Use of Force	●	●	●	●	●	●	●
97	Discourteous Treatment	●	●	●	●	●	●	●
98	Unreasonable Use of Force	●	●	●	●	●	●	●

Continued on next page.

Appendix C. Detail of Staff Complaint Cases and Outcomes, as Determined by the OIG (cont.)

Case	Allegation Types	Q1 Appropriate Reviewer	Q2 Appellant Interview	Q3 Witness Interviews	Q4 Subject Interviews	Q5 Relevant Evidence	Q6 Adequate Report	Overall
99	Unreasonable Use of Force	●	●	●	●	●	●	●
100	Discourteous Treatment	●	●	●	●	●	●	●
101	Unreasonable Use of Force	●	●	●	●	●	●	●
102	Neglect of Duty	●	●	●	●	●	●	●
103	Discourteous Treatment	●	●	●	●	●	●	●
104	Unreasonable Use of Force	●	●	●	●	●	●	●
105	Discourteous Treatment	●	●	●	●	●	●	●
106	Unreasonable Use of Force Dishonesty/Falsified Documentation Neglect of Duty	●	●	●	●	●	●	●
107	Sexual Misconduct	●	●	●	●	●	●	●
108	Unreasonable Use of Force	●	●	●	●	●	●	●
109	Discourteous Treatment Retaliation/Threats	●	●	●	●	●	●	●
110	Unreasonable Use of Force	●	●	●	●	●	●	●
111	Discourteous Treatment	●	●	●	●	●	●	●
112	Discrimination	●	●	●	●	●	●	●
113	Discourteous Treatment Neglect of Duty	●	●	●	●	●	●	●
114	Unreasonable Use of Force	●	●	●	●	●	●	●
115	Neglect of Duty	●	●	●	●	●	●	●
116	Neglect of Duty Dishonesty/Falsified Documentation	●	●	●	●	●	●	●
117	Unreasonable Use of Force Dishonesty/Falsified Documentation	●	●	●	●	●	●	●
118	Discourteous Treatment	●	●	●	●	●	●	●

Continued on next page.

Appendix C. Detail of Staff Complaint Cases and Outcomes, as Determined by the OIG (cont.)

Case	Allegation Types	Q1 Appropriate Reviewer	Q2 Appellant Interview	Q3 Witness Interviews	Q4 Subject Interviews	Q5 Relevant Evidence	Q6 Adequate Report	Overall
119	Neglect of Duty	●	●	●	●	●	●	●
120	Retaliation/Threats Dishonesty/Falsified Documentation	●	●	●	●	●	●	●
121	Dishonesty/Falsified Documentation Retaliation/Threats	●	●	●	●	●	●	●
122	Discourteous Treatment	●	●	●	●	●	●	●
123	Discourteous Treatment	●	●	●	●	●	●	●
124	Discourteous Treatment	●	●	●	●	●	●	●
125	Unreasonable Use of Force	●	●	●	●	●	●	●
126	Retaliation/Threats Neglect of Duty Discourteous Treatment	●	●	●	●	●	●	●
127	Sexual Misconduct	●	●	●	●	●	●	●
128	Retaliation/Threats Dishonesty/Falsified Documentation	●	●	●	●	●	●	●
129	Discourteous Treatment Retaliation/Threats	●	●	●	●	●	●	●
130	Discourteous Treatment	●	●	●	●	●	●	●
131	Discourteous Treatment	●	●	●	●	●	●	●
132	Dishonesty/Falsified Documentation Discourteous Treatment	●	●	●	●	●	●	●
133	Dishonesty/Falsified Documentation	●	●	●	●	●	●	●
134	Neglect of Duty	●	●	●	●	●	●	●
135	Discourteous Treatment	●	●	●	●	●	●	●
136	Retaliation/Threats Neglect of Duty Discourteous Treatment	●	●	●	●	●	●	●
137	Unreasonable Use of Force	●	●	●	●	●	●	●
138	Neglect of Duty	●	●	●	●	●	●	●

Continued on next page.

Appendix C. Detail of Staff Complaint Cases and Outcomes, as Determined by the OIG (cont.)

Case	Allegation Types	Q1 Appropriate Reviewer	Q2 Appellant Interview	Q3 Witness Interviews	Q4 Subject Interviews	Q5 Relevant Evidence	Q6 Adequate Report	Overall
139	Discourteous Treatment	●	●	●	●	●	●	●
140	Unreasonable Use of Force	●	●	●	●	●	●	●
141	Neglect of Duty	●	●	●	●	●	●	●
142	Dishonesty/Falsified Documentation	●	●	●	●	●	●	●
143	Neglect of Duty	●	●	●	●	●	●	●
144	Discourteous Treatment	●	●	●	●	●	●	●
145	Discourteous Treatment Neglect of Duty Dishonesty/Falsified Documentation	●	●	●	●	●	●	●
146	Neglect of Duty	●	●	●	●	●	●	●
147	Unreasonable Use of Force	●	●	●	●	●	●	●
148	Sexual Misconduct	●	●	●	●	●	●	●
149	Retaliation/Threats	●	●	●	●	●	●	●
150	Discourteous Treatment Retaliation/Threats Dishonesty/Falsified Documentation	●	●	●	●	●	●	●
151	Neglect of Duty	●	●	●	●	●	●	●
152	Neglect of Duty	●	●	●	●	●	●	●
153	Neglect of Duty	●	●	●	●	●	●	●
154	Unreasonable Use of Force	●	●	●	●	●	●	●
155	Discourteous Treatment Neglect of Duty	●	●	●	●	●	●	●
156	Unreasonable Use of Force	●	●	●	●	●	●	●
157	Discourteous Treatment	●	●	●	●	●	●	●
158	Neglect of Duty	●	●	●	●	●	●	●

Continued on next page.

Appendix C. Detail of Staff Complaint Cases and Outcomes, as Determined by the OIG (cont.)

Case	Allegation Types	Q1 Appropriate Reviewer	Q2 Appellant Interview	Q3 Witness Interviews	Q4 Subject Interviews	Q5 Relevant Evidence	Q6 Adequate Report	Overall
159	Retaliation/Threats	●	●	●	●	●	●	●
160	Retaliation/Threats	●	●	●	●	●	●	●
161	Discrimination Retaliation/Threat	●	●	●	●	●	●	●
162	Discourteous Treatment Neglect of Duty	●	●	●	●	●	●	●
163	Discourteous Treatment	●	●	●	●	●	●	●
164	Discourteous Treatment	●	●	●	●	●	●	●
165	Neglect of Duty	●	●	●	●	●	●	●
166	Neglect of Duty	●	●	●	●	●	●	●
167	Neglect of Duty	●	●	●	●	●	●	●
168	Retaliation/Threats Neglect of Duty	●	●	●	●	●	●	●
169	Neglect of Duty	●	●	●	●	●	●	●
170	Discourteous Treatment	●	●	●	●	●	●	●
171	Retaliation/Threats Discourteous Treatment	●	●	●	●	●	●	●
172	Neglect of Duty	●	●	●	●	●	●	●
173	Retaliation/Threats Neglect of Duty Sexual Misconduct	●	●	●	●	●	●	●
174	Dishonesty/Falsified Documentation	●	●	●	●	●	●	●
175	Neglect of Duty Discourteous Treatment Retaliation/Threats	●	●	●	●	●	●	●
176	Discourteous Treatment	●	●	●	●	●	●	●
177	Unreasonable Use of Force	●	●	●	●	●	●	●
178	Retaliation/Threats Discourteous Treatment	●	●	●	●	●	●	●

Continued on next page.

Appendix C. Detail of Staff Complaint Cases and Outcomes, as Determined by the OIG (cont.)

Case	Allegation Types	Q1 Appropriate Reviewer	Q2 Appellant Interview	Q3 Witness Interviews	Q4 Subject Interviews	Q5 Relevant Evidence	Q6 Adequate Report	Overall
179	Neglect of Duty	●	●	●	●	●	●	●
180	Discrimination	●	●	●	●	●	●	●
181	Dishonesty/Falsified Documentation Neglect of Duty	●	●	●	●	●	●	●
182	Retaliation/Threats Dishonesty/Falsified Documentation	●	●	●	●	●	●	●
183	Discourteous Treatment Discrimination	●	●	●	●	●	●	●
184	Neglect of Duty Discourteous Treatment	●	●	●	●	●	●	●
185	Neglect of Duty Discourteous Treatment	●	●	●	●	●	●	●
186	Neglect of Duty	●	●	●	●	●	●	●
187	Discourteous Treatment	●	●	●	●	●	●	●
188	Discourteous Treatment	●	●	●	●	●	●	●

Continued on next page.

Appendix C. Detail of Staff Complaint Cases and Outcomes, as Determined by the OIG (cont.)

	Q1 Appropriate Reviewer	Q2 Appellant Interview	Q3 Witness Interview(s)	Q4 Subject Interview(s)	Q5 Relevant Evidence	Q6 Adequate Report	Overall
Paper Review Period							
Total ●	25	0	0	0	20	26	27
Total ●	36	11	0	0	32	35	34
Total ●	0	50	61	61	9	0	0
Onsite Review Period							
Total ●	43	58	18	3	40	54	57
Total ●	84	63	32	3	58	73	70
Total ●	0	6	77	121	29	0	0
Combined Review Periods							
Total ●	68	58	18	3	60	80	84
Total ●	120	74	32	3	90	108	104
Total ●	0	56	138	182	38	0	0

Appendix D. The Appeal Package: CDCR Form 602 and Attachments A Through F

STATE OF CALIFORNIA
INMATE/PAROLEE APPEAL
CDCR 602 (REV. 03/12)

DEPARTMENT OF CORRECTIONS AND REHABILITATION

Side 1

IAB USE ONLY	Institution/Parole Region:	Log #:	Category:

FOR STAFF USE ONLY

You may appeal any California Department of Corrections and Rehabilitation (CDCR) decision, action, condition, policy or regulation that has a material adverse effect upon your welfare and for which there is no other prescribed method of departmental review/remedy available. See California Code of Regulations (CCR), Title 15, Section 3084.1. You must send this appeal and any supporting documents to the Appeals Coordinator (AC) within 30 calendar days of the event that led to the filing of this appeal. If additional space is needed, only one CDCR Form 602-A will be accepted. Refer to CCR 3084 for further guidance with the appeal process. No reprisals will be taken for using the appeal process.

Appeal is subject to rejection if one row of text per line is exceeded. **WRITE, PRINT, or TYPE CLEARLY in black or blue ink.**

Name (Last, First):	CDC Number:	Unit/Cell Number:	Assignment:

State briefly the subject of your appeal (Example: damaged TV, job removal, etc.):

A. Explain your issue (If you need more space, use Section A of the CDCR 602-A):

B. Action requested (If you need more space, use Section B of the CDCR 602-A):

Supporting Documents: Refer to CCR 3084.3.

☐ Yes, I have attached supporting documents.

List supporting documents attached (e.g., CDC 1083, Inmate Property Inventory; CDC 128-G, Classification Chrono):

☐ No, I have not attached any supporting documents. Reason :

Inmate/Parolee Signature: **Date Submitted:**

☐ **By placing my initials in this box, I waive my right to receive an interview.**

STAFF USE ONLY

C. First Level - Staff Use Only **Staff – Check One: Is CDCR 602-A Attached?** ☐ **Yes** ☐ **No**

This appeal has been:

☐ Bypassed at the First Level of Review. Go to Section E.
☐ Rejected (See attached letter for instruction) Date: Date: Date: Date:
☐ Cancelled (See attached letter) Date:
☐ Accepted at the First Level of Review.

Assigned to: Title: Date Assigned: Date Due:

First Level Responder: Complete a First Level response. Include Interviewer's name, title, interview date, location, and complete the section below.

Date of Interview: Interview Location:

Your appeal issue is: ☐ Granted ☐ Granted in Part ☐ Denied ☐ Other:

See attached letter. If dissatisfied with First Level response, complete Section D.

Interviewer: (Print Name) Title: Signature: Date completed:

Reviewer: (Print Name) Title: Signature:

Date received by AC:

AC Use Only
Date mailed/delivered to appellant ____ / ____ / ____

Appendix D. The Appeal Package (continued)

STATE OF CALIFORNIA
INMATE/PAROLEE APPEAL
CDCR 602 (REV. 03/12)

DEPARTMENT OF CORRECTIONS AND REHABILITATION

Side 2

D. If you are dissatisfied with the First Level response, explain the reason below, attach supporting documents and submit to the Appeals Coordinator for processing within 30 calendar days of receipt of response. If you need more space, use Section D of the CDCR 602-A.

Inmate/Parolee Signature: _____ **Date Submitted :** _____

E. Second Level - Staff Use Only **Staff – Check One: Is CDCR 602-A Attached?** ☐ **Yes** ☐ **No**

This appeal has been:

☐ By-passed at Second Level of Review. Go to Section G.
☐ Rejected (See attached letter for instruction) Date: _____ Date: _____ Date: _____ Date: _____
☐ Cancelled (See attached letter)
☐ Accepted at the Second Level of Review

Assigned to: _____ Title: _____ Date Assigned: _____ Date Due: _____

Second Level Responder: Complete a Second Level response. If an interview at the Second Level is necessary, include interviewer's name and title, interview date and location, and complete the section below.

Date of Interview: _____ Interview Location: _____

Your appeal issue is: ☐ Granted ☐ Granted in Part ☐ Denied ☐ Other: _____

See attached letter. If dissatisfied with Second Level response, complete Section F below.

Interviewer: _____ (Print Name) Title: _____ Signature: _____ Date completed : _____

Reviewer: _____ (Print Name) Title: _____ Signature: _____

Date received by AC: _____

AC Use Only
Date mailed/delivered to appellant ____ /____ /____

F. If you are dissatisfied with the Second Level response, explain reason below; attach supporting documents and submit by mail for Third Level Review. It must be received within 30 calendar days of receipt of prior response. Mail to: Chief, Inmate Appeals Branch, Department of Corrections and Rehabilitation, P.O. Box 942883, Sacramento, CA 94283-0001. If you need more space, use Section F of the CDCR 602-A.

Inmate/Parolee Signature: _____ **Date Submitted:** _____

G. Third Level - Staff Use Only

This appeal has been:

☐ Rejected (See attached letter for instruction) Date: _____ Date: _____ Date: _____ Date: _____ Date: _____
☐ Cancelled (See attached letter) Date: _____
☐ Accepted at the Third Level of Review. Your appeal issue is ☐ Granted ☐ Granted in Part ☐ Denied ☐ Other: _____
See attached Third Level response.

Third Level Use Only
Date mailed/delivered to appellant ____ /____ /____

H. Request to Withdraw Appeal: I request that this appeal be withdrawn from further review because; State reason. (If withdrawal is conditional, list conditions.)

_____ Inmate/Parolee Signature: _____ Date: _____

Print Staff Name: _____ Title: _____ Signature: _____ Date: _____

Appendix D. The Appeal Package (cont.)

Template Date: April 4, 2012
State of California

Attachment A
Department of Corrections and Rehabilitation

Memorandum

Date :

To :

Subject: DETERMINATION OF STAFF COMPLAINT

The attached appeal from Inmate, dated alleges staff misconduct. Pursuant to Department policy, please review the attached appeal and determine the following:

Brackets ( ) are for Appeal Coordinator (AC) recommendation, boxes ☐ are for Hiring Authority (HA) determination.

( ) ☐ Refer to the Office of Internal Affairs (OIA) via CDCR Form 989 for Investigation/notification of direct adverse action (reasonable belief misconduct occurred and adverse action likely).

( ) ☐ Refer to Institutional Services Unit (ISU) for Allegation Inquiry (additional information needed to establish likelihood of adverse action per Department Operations Manual (DOM) Section 31140.14.

( ) ☐ Refer to [ ] for an Appeal Inquiry to be conducted by appropriate supervisory staff (adverse action unlikely). The Original of the completed "Confidential Supplement to Appeal, Appeal Inquiry" (Attachment C) is to be forwarded to the Inmate Appeals Office for filing with the appeal. Inmates/Parolees will not be provided a copy of this confidential report.

( ) ☐ Process as a routine appeal. Appeal does not meet criteria for assignment as a staff complaint (no misconduct identified, even if facts as alleged are assumed to be true) — accept, reject or cancel in accordance with CCR Title 15, Section 3084.5.

APPEAL SUBJECT TO CANCELLATION IN ACCORDANCE WITH CCR, TITLE 15, SECTION 3084.6(c): REASON:

( ) ☐ Cancel/Reject with no Investigation/Inquiry.

( ) ☐ Cancel. Assign for review outside Appeal Process via an Inquiry or Investigation (Offender will *not* be notified, Attachment E not used).

Print name and sign below:

Name: _____ Sign_____ _____
Appeals Coordinator Date

Name: _____ Sign_____ _____
Hiring Authority Date

Appeal Log Number:_____

Appendix D. The Appeal Package (cont.)

Template Date: 4/4/2012 Attachment B

Date Received in Appeals Office: _____

APPEAL INQUIRY CHRONOLOGICAL TRACKING WORKSHEET

Inmate Name: _____ **CDCR #:** _____

Appeal Log Number: _____ **Appeal Category/Issue:** Staff Complaint

To ISU:_____ by:_____ Duplicate: YES / NO

if duplicate : Log #_____ Category:_____
Comments:_____

To ERO:_____ by:_____ Duplicate: YES / NO

if duplicate : Log #_____ Category:_____
Comments:_____

To CDW:_____ by:_____ Date Rec'd:_____

CDW:_____

Returned to Appeals Office/Assigned or Rejected:_____

Due Date: _____ **Date Received Complete:** _____

Comments:

ALLEGATIONS INVOLVING THE USE OF EXCESSIVE OR UNNECESSARY FORCE

Injuries claimed (if any).

Date, time, and place of occurrence:

- Incident Report No: (if available)
- Notification of video interview/medical documentation (if necessary);

1st or 2nd line manager: Associate Warden _____ and Captain _____

Date notified: _____

Appeal Log Number:_____

Appendix D. The Appeal Package (cont.)

Template Date: 4/4/2012 Attachment C

CONFIDENTIAL SUPPLEMENT TO APPEAL
"APPEAL/ALLEGATION INQUIRY"
DO NOT COPY OR DISTRIBUTE EXCEPT PURSUANT TO CCR Title 15, Section 3084.9(i)(3)(B)1.

Date:_____

Appeal Log Number:_____

Inmate/Parolee Name:_____

CDC Number:_____

Assigned Staff: Name and Title _____

Date and place of interview:_____

_____

Accused Staff Member(s):
(Delete all italicized language from final copy) *Identify accused staff by first initial, last name, civil service classification and area of assignment.*

Synopsis of Allegation:
Summarize the allegation. Be brief while providing sufficient information to present a complete picture of the allegation(s).

Witnesses: *(Identify witnesses interviewed. Identify requested witnesses not interviewed and note reason (lack of relevance, etc.) If the testimony of any staff witness conflicts with that of other staff witnesses, be sure to include the statements of all staff witnesses. *(See definitions of pertinent witnesses below).*

Findings:
This section will include any additional statements from the person making the allegation, statements from all pertinent witnesses, and accused staff if necessary, along with a detailed description of any other evidence reviewed. Ensure that staff witnesses are identified by first initial, last name, and current assignment and inmates/parolees are identified by name, CDCR number, and current housing.

If, during the course of the review, serious misconduct (conduct which would likely lead to Adverse Personnel Action) is discovered or suspected regarding staff, then immediately terminate the review. The reviewer will then notify the hiring authority or designee of the information revealed.

Conclusion:
Summarize the Appeal Inquiry and include a finding and detailed conclusion relative to the allegations of misconduct. The finding will establish whether the alleged policy was or was not violated with regard to the conduct and whether further administrative actions is necessary. In the case where policy was violated with regard to one or more of the allegations but not all, the response should note that fact. If the inquiry reveals a violation of policy not alleged, it is subject to administrative action, but should not be identified in the finding as a violation of policy with respect to the staff complaint.

Note: If it is determined that the complaint is based upon information the inmate/parolee knew was false and the inmate/parolee made the false allegations with the intent to do harm to the accused or defraud the state for monetary advantage, the interviewer will recommend disciplinary action.

Print and sign below:

Name _____ Sign_____ _____
Interviewer Date

Name _____ Sign_____ _____
Hiring Authority Date

Definition of **pertinent witnesses is the number of witnesses necessary to reasonably conclude whether:*
- *Adverse action is likely and the matter is being referred for an investigation*
- *Evidence or testimony is sufficient to reasonably establish misconduct did not occur or cannot be demonstrated.*

Appeal Log Number:_____

Appendix D. The Appeal Package (cont.)

Template Date 4/4/2012
State of California

Attachment D
Department of Corrections and Rehabilitation

Memorandum

Date
:

To : [Insert name of employee]

Subject: **NOTICE OF INTERVIEW RE: COMPLAINT AGAINST STAFF (CDCR FORM 602) LOG #**

You are instructed to report for an Appeal Inquiry. This interview will be conducted by *(insert name)*. You are the subject of a CDCR Form 602 staff complaint by inmate/parolee*(insert name and number)*, and this interview is being conducted regarding allegations of *(insert allegations)*.

The interview is scheduled as follows

Date:	Time:
Location:	

You may bring a representative, if you so desire. The representative cannot be a person involved in this matter. You may record any portion of this interview. If you wish to bring a recording device, check ☐ box and initial here _____. You will be notified in advance if any further proceedings are contemplated and prior to any subsequent interview.

You are being provided at least 24-hours notice prior to the interview being conducted. If you wish to waive the 24-hour notice requirement, check ☐ box and initial here _____. If you have any questions or you are unable to appear for this interview, please contact the undersigned staff interviewer at *(insert phone number)*.

This is an ongoing appeal inquiry. Therefore, you are admonished not to discuss this inquiry with anyone other than the assigned interviewer and your representative should you choose to have one.

Please print and sign below:

_____ /_____ _____
Staff Interviewer Date

_____ /_____ _____
Employee Date

_____ /_____ _____
Server Date

cc: Employee
Appeal Log Number:_____

Appendix D. The Appeal Package (cont.)

Template Date 4/4/2012
State of California

Attachment E-1
Department of Corrections and Rehabilitation

Memorandum

Date
:

To
:
Insert inmate name, # Insert inmate number
Insert inmate housing and institution

Subject
:
STAFF COMPLAINT RESPONSE - APPEAL # ***FIRST/SECOND*** **LEVEL RESPONSE**

APPEAL ISSUE: ***Provide a complete account of the issue(s) raised by the inmate. Then include the following:*** All issues unrelated to the allegation of staff misconduct must be appealed separately and will not be addressed in this response. You do not exhaust administrative remedies on any unrelated issue not covered in this response or concerning any staff member not identified by you in this complaint. If you are unable to name all involved staff you may request assistance in establishing their identity.

DETERMINATION OF ISSUE: A review of the allegations of staff misconduct presented in the written complaint has been completed. Based upon this review your appeal is ***(Select one and delete other two)***:

- Being processed as an Appeal Inquiry.
- Pending review by ISU as an Allegation Inquiry.
- Being referred to Office of Internal Affairs.

You were interviewed on (date of interview) by (insert staff member's name). A review of the Test of Adult Basic Education (TABE) list reveals the appellant has a TABE reading score of XXXX. The appellant's Disability Placement Program code is XXXX. The appellant is a participant in the Mental Health Services Delivery System (MHSDS) at the XXXX level of care. During the interview, the interviewer utilized simple English spoken slowly to ensure effective communication. During the interview, the appellant was afforded the opportunity to further explain his appeal issue and to provide any supporting evidence or documents. The appellant reiterated the statements contained in the appeal, demonstrating that effective communication was achieved. (Inmates' statement summarized).

OR You will be interviewed during the process of your inquiry/investigation
Your appeal is PARTIALLY GRANTED in that: ***(Select one of three options below and delete the other two)***

Option One

Select one, delete the other)

- An **Appeal Inquiry** will be conducted *(or)*

Appendix D. The Appeal Package (cont.)

Template Date 4/4/2012 Attachment E-1

Page 2

- The **Appeal inquiry** is complete/ has been reviewed and all issues were adequately addressed.

The following witness(es) will be / were questioned: [insert name(s)]. **[Delete following if not applicable]** *The following witnesses will not be / were not interviewed– give reason: i.e. not relevant etc.* The following information will be / was reviewed as a result of your allegations of staff misconduct: (indicate documents, etc. that will be / or were reviewed).

Staff: ***did*** ☐ ***did not*** ☐ violate CDCR policy with respect to one or more of the issues appealed.

Option Two

- **Allegation Inquiry**

Your appeal has been referred by the hiring authority to a trained investigator to determine whether the evidence warrants an investigation or an inquiry. After the determination has been made your complaint will be processed accordingly and you will be notified of the outcome.

Option Three

- **Investigation**

This matter has been referred to the Office of Internal Affairs for follow-up and a possible investigation. If investigated, upon completion of that investigation, you will be notified as to whether the allegations were SUSTAINED, NOT SUSTAINED, UNFOUNDED, EXONERATED or there was NO FINDING. In the event that the matter is not investigated, but returned by OIA to the institution or region to conduct an Appeal Inquiry, you will be notified upon the completion of that inquiry whether it was determined that staff did, or did not, violate policy.

On _____, the Institutional Executive Review Committee (IERC) conducted a review of the allegations. The IERC reviewed and determined [staff member] and [staff member] were in compliance with departmental policy regarding the Use of Force allegations. However, thorough review of all allegations revealed staff did violate California Department of Corrections and Rehabilitation policy with respect to one or more of the issues appealed.

ALL STAFF PERSONNEL MATTERS ARE CONFIDENTIAL IN NATURE.

- As such, the details of any inquiry will not be shared with staff, members of the public, or offender appellants.
- Although you have the right to submit a staff complaint, a request for administrative action regarding staff or the placement of documentation in a staff member's personnel file is beyond the scope of the staff complaint process. A variety of personnel actions may be initiated by the Department based upon the content of your complaint and the outcome of any investigation or inquiry conducted as a result of your complaint.
- Allegations of staff misconduct do not limit or restrict the availability of further relief via the inmate appeals process.

Appeal Log No:_____

Appendix D. The Appeal Package (cont.)

Template Date 4/4/2012 Attachment E-1

Page 3

If you wish to appeal the decision and/or exhaust administrative remedies, you must submit your staff complaint appeal through all levels of appeal review up to, and including, the Secretary's/Third Level of Review. Once a decision has been rendered at the Third Level, administrative remedies will be considered exhausted.

[Print Name, Sign and Date]:

Print:_____ Sign: _____ Date: _____
Interviewer

Print:_____ Sign: _____ Date: _____
Reviewing Authority

Appeal Log No:_____

Appendix D. The Appeal Package (cont.)

Template Date 4/4/2012
State of California

Attachment E-2
Department of Corrections and Rehabilitation

Memorandum

Date
:

To
:
Insert inmate name, # Insert inmate number
Insert inmate housing and institution

Subject
:
STAFF COMPLAINT RESPONSE - APPEAL # ____ ***FIRST/SECOND*** **LEVEL RESPONSE**

APPEAL ISSUE: ***Provide a complete account of the issue(s) raised by the inmate. Then include the following:*** All issues unrelated to the allegation of staff misconduct must be appealed separately and will not be addressed in this response. You do not exhaust administrative remedies on any unrelated issue not covered in this response or concerning any staff member not identified by you in this complaint. If you are unable to name all involved staff you may request assistance in establishing their identity.

DETERMINATION OF ISSUE: A review of the allegations of staff misconduct presented in the written complaint has been completed. Based upon this review your appeal is ***(Select one and delete other two)***:

- Being processed as an Appeal Inquiry.
- Pending review by ISU as an Allegation Inquiry.
- Being referred to Office of Internal Affairs.

You were interviewed on (date of interview) by (insert staff member's name). A review of the Test of Adult Basic Education (TABE) list reveals the appellant has a TABE reading score of XXXX. The appellant's Disability Placement Program code is XXXX. The appellant is a participant in the Mental Health Services Delivery System (MHSDS) at the XXXX level of care. During the interview, the interviewer utilized simple English spoken slowly to ensure effective communication. During the interview, the appellant was afforded the opportunity to further explain his appeal issue and to provide any supporting evidence or documents. The appellant reiterated the statements contained in the appeal, demonstrating that effective communication was achieved. (Inmates' statement summarized).

OR You will be interviewed during the process of your inquiry/investigation
Your appeal is PARTIALLY GRANTED in that: ***(Select one of three options below and delete the other two)***

Option One

Select one, delete the other)

- An **Appeal Inquiry** will be conducted *(or)*

Appendix D. The Appeal Package (cont.)

Template Date 4/4/2012 Attachment E-2

Page 2

➢ The **Appeal inquiry** is complete/ has been reviewed and all issues were adequately addressed.

The following witness(es) will be / were questioned: [insert name(s)]. **[Delete following if not applicable]** *The following witnesses will not be / were not interviewed– give reason: i.e. not relevant etc.* The following information will be / was reviewed as a result of your allegations of staff misconduct: (indicate documents, etc. that will be / or were reviewed).

Staff: ***did*** ☐ ***did not*** ☐ violate CDCR policy with respect to one or more of the issues appealed.

Option Two

➢ **Allegation Inquiry**

Your appeal has been referred by the hiring authority to a trained investigator to determine whether the evidence warrants an investigation or an inquiry. After the determination has been made your complaint will be processed accordingly and you will be notified of the outcome.

Option Three

➢ **Investigation**

This matter has been referred to the Office of Internal Affairs for follow-up and a possible investigation. If investigated, upon completion of that investigation, you will be notified as to whether the allegations were SUSTAINED, NOT SUSTAINED, UNFOUNDED, EXONERATED or there was NO FINDING. In the event that the matter is not investigated, but returned by OIA to the institution or region to conduct an Appeal Inquiry, you will be notified upon the completion of that inquiry whether it was determined that staff did, or did not, violate policy.

On _____, the Institutional Executive Review Committee (IERC) conducted a review of the allegations. The IERC reviewed and determined _____ and _____ were / were not in compliance with departmental policy regarding the Use of Force allegations. However, thorough review of all allegations revealed staff did or did not violate California Department of Corrections and Rehabilitation policy with respect to one or more of the issues appealed.

ALL STAFF PERSONNEL MATTERS ARE CONFIDENTIAL IN NATURE.

- As such, the details of any inquiry will not be shared with staff, members of the public, or offender appellants.
- Although you have the right to submit a staff complaint, a request for administrative action regarding staff or the placement of documentation in a staff member's personnel file is beyond the scope of the staff complaint process. A variety of personnel actions may be initiated by the Department based upon the content of your complaint and the outcome of any investigation or inquiry conducted as a result of your complaint.
- Allegations of staff misconduct do not limit or restrict the availability of further relief via the inmate appeals process.

Appeal Log No:_____

Appendix D. The Appeal Package (cont.)

Template Date 4/4/2012 Attachment E-2

Page 3

If you wish to appeal the decision and/or exhaust administrative remedies, you must submit your staff complaint appeal through all levels of appeal review up to, and including, the Secretary's/Third Level of Review. Once a decision has been rendered at the Third Level, administrative remedies will be considered exhausted.

[Print Name, Sign and Date]:

Print:_____ Sign: _____ Date: _____
Interviewer

Print:_____ Sign: _____ Date: _____
Reviewing Authority

Appeal Log No:_____

Appendix D. The Appeal Package (cont.)

Template date 4/4/2012
State of California

Attachment F
Department of Corrections and Rehabilitation

Memorandum

Date
:

To :

Subject: **ADVISEMENT OF RIGHTS – APPEAL INQUIRY (CDCR FORM 602 - COMPLAINT AGAINST STAFF Log #*(insert log number)***

The date is *(insert date)*. The time is approximately *(insert time)*.

You are a subject of a staff complaint by an inmate/parolee *(insert name and number)*

This is an official Appeal Inquiry concerning the California Department of Corrections and Rehabilitation, involving an allegation(s) of staff misconduct *(briefly describe the nature of the inquiry)*. The inquiry is being conducted at *(insert location)*. The individual conducting this interview is *(insert name)*. Also present and their interests in this matter is/are *(insert name and specify interest)*.

This is a CDCR Form 602 Appeal Inquiry and, as such, you do not have the right to refuse to answer. The truth is expected, as is your entire knowledge relative to items discussed. Refusal to respond or answer questions relating to the performance of your duties can be grounds for adverse personnel action, which could result in your dismissal from the Department. If you do answer, none of your statements nor any information or evidence which is gained by reason of such statements can be used against you in any criminal proceedings.

No promise or reward will be made as an inducement for the answer to any question.

The Department cannot initiate a recording without your permission but if you choose to record the interview the Department must conduct a separate recording. You may record any portion of this interview. You will be notified in advance if any further proceedings are contemplated and prior to any subsequent interview or interrogation.

You have the right to be represented by an individual of your choice who may be present at all times during your interview, providing the person chosen is not a witness or subject of this inquiry. Your representative may ask to have questions clarified, may suggest that you give a more complete answer, may object to questions outside the announced scope of the appeal inquiry, and may object to what he or she believes is harassment of you. However, your representative cannot impede the progress of the interview nor can he or she direct you not to answer any of the questions asked of you. Your understanding and acceptance of the conditions specified are denoted here: (initials) _____

If it is requested that this interview be recorded, each person present is required to identify himself/herself and his/her voice on the tape/recording by stating his/her name, title, and/or classification, and place of employment when applicable (be sure

Appeal Log #

Appendix D. The Appeal Package (cont.)

Template date 4/4/2012 Attachment F

Page 2

to record each individual). Your recording belongs to you but the Department's recording will be kept with the CDCR Form 602.

Understood & accepted? Initial(s) here _____.

If interview is being taped and a copy provided: initial here _____.

RECORDING(S) LEAVE BLANK IF NO RECORDING MADE			
WHOSE EQUIPMENT WAS USED? ☐ DEPARTMENTS ☐ OTHER	WERE OTHER RECORDINGS MADE? ☐ NO ☐ YES, BY:	HOW MANY STORAGE DEVICES WERE REQUIRED TO RECORD PROCEEDINGS? Specify Here:▶	No.
RECORDING DEVICE			
☐ COMPACT DISC ☐ CASSETTE TAPE ☐ DIGITAL VOICE RECORDER ☐ OTHER _____			
RECORDING I.D. NUMBER	STARTING MARK	ENDING MARK	TOPIC

Print and sign below:

_____/_____ _____

Staff Interviewer Date

Appeal Log #

Special Review of Salinas Valley State Prison's Processing of Inmate Allegations of Staff Misconduct

OFFICE *of the* INSPECTOR GENERAL

Roy W. Wesley
Inspector General

Bryan B. Beyer
Chief Deputy Inspector General

STATE *of* CALIFORNIA
January 2019

OIG

Exhibit YY

COMPSTAT DAI Statistical Report - 13 Month

Data Analysis 13 Month as of 07-11-2019
Location(s): CAC, CCI, COR, HDSP, KVSP, LAC, PBSP, SAC, SATF, SVSP

		2018								2019				
		May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
CAC	**Custody Operations**													
	Total Bed Capacity													
	Blueprint Crowding Capacity	0	0	0	0	0	0	0	0	0	0	0	0	0
	Maximum Capacity	0	0	0	0	0	0	0	0	0	0	0	0	0
	Design Beds	0	0	0	0	0	0	0	0	0	0	0	0	0
	Inmate Count	2,262	2,239	2,166	2,259	2,397	2,475	2,463	2,512	2,492	2,418	2,434	2,432	2,466
	% Institution Filled to Blueprint Crowding Capacity	**0 %**	**0 %**	**0 %**	**0 %**	**0 %**	**0 %**	**0 %**	**0 %**	**0 %**	**0 %**	**0 %**	**0 %**	**0 %**
	Inmate Security Level													
	Inmate Level I (Classification Score of 0-18)	218	194	162	157	163	186	192	204	204	188	196	209	244
	Out of Bed Level I Assignments	78	74	58	63	59	63	60	68	66	61	69	71	74
	% of Out of Level I Assignments	**36 %**	**38 %**	**36 %**	**40 %**	**36 %**	**34 %**	**31 %**	**33 %**	**32 %**	**32 %**	**35 %**	**34 %**	**30 %**
	Inmate Level II (Classification Score of 19-35)	1,829	1,828	1,786	1,852	1,976	2,038	2,014	2,041	2,028	1,984	1,996	1,992	1,999
	Out of Bed Level II Assignments	3	2	7	7	8	11	7	6	6	8	8	8	5
	% of Out of Level II Assignments	**0 %**	**0 %**	**0 %**	**0 %**	**0 %**	**1 %**	**0 %**	**0 %**	**0 %**	**0 %**	**0 %**	**0 %**	**0 %**
	Inmate Level III (Classification Score of 36-59)	211	214	205	242	250	243	252	256	245	235	231	224	217
	Out of Bed Level III Assignments	15	21	20	17	26	25	24	28	25	21	25	21	19
	% of Out of Level III Assignments	**7 %**	**10 %**	**10 %**	**7 %**	**10 %**	**10 %**	**10 %**	**11 %**	**10 %**	**9 %**	**11 %**	**9 %**	**9 %**
	Inmate Level IV (Classification Score of 60+)	4	3	13	8	8	8	5	11	15	11	11	7	6
	Out of Bed Level IV Assignments	0	0	1	0	0	1	2	2	1	2	0	0	2
	% of Out of Level IV Assignments	**0 %**	**0 %**	**8 %**	**0 %**	**0 %**	**13 %**	**40 %**	**18 %**	**7 %**	**18 %**	**0 %**	**0 %**	**33 %**
	Camps													
	Camps (CMC, CRC only)	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*
	Camps	0	0	0	0	0	0	0	0	0	0	0	0	0
	Pipeline	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*

COMPSTAT DAI Statistical Report - 13 Month

Data Analysis 13 Month as of 07-11-2019
Location(s): CAC, CCI, COR, HDSP, KVSP, LAC, PBSP, SAC, SATF, SVSP

		2018								2019				
		May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
HDSP	Attempted Homicide - Inmate	1	3	2	1	5	3	2	3	0	2	1	0	0
	Homicide	1	0	1	0	0	0	0	0	0	0	0	0	0
	Expected Death	0	0	0	0	0	0	0	0	0	0	0	0	0
	Unexpected Death	0	0	0	0	0	0	0	1	3	0	0	0	0
	Total Inmate Deaths	**1**	**0**	**1**	**0**	**0**	**0**	**0**	**2**	**3**	**0**	**0**	**0**	**0**
	Controlled Cell Phone Discoveries	3	2	9	6	2	5	11	6	15	8	3	4	26
	Uncontrolled Cell Phone Discoveries	5	0	1	0	0	0	0	2	0	0	0	0	0
	Cell Phone Seizures	8	2	10	6	2	5	11	8	15	8	3	4	26
	Fighting	11	8	7	5	10	12	6	11	6	5	9	10	3
	Miscellaneous	10	5	5	7	6	13	11	12	7	4	10	7	12
	Incidents Involving Mental Health Inmates													
	Number of Non UOF Incidents Involving Mental Health Inmates	12	7	12	12	10	18	9	15	14	6	14	15	14
	% of Non UOF Incidents Involving Mental Health Inmates	**34 %**	**33 %**	**41 %**	**29 %**	**45 %**	**46 %**	**24 %**	**39 %**	**42 %**	**25 %**	**48 %**	**58 %**	**39 %**
	Number of UOF Incidents Involving Mental Health Inmates	22	21	22	18	21	19	18	27	20	12	14	28	20
	% of UOF Incidents Involving Mental Health Inmates	**76 %**	**75 %**	**81 %**	**64 %**	**64 %**	**58 %**	**64 %**	**63 %**	**71 %**	**52 %**	**58 %**	**74 %**	**69 %**
	Contraband Surveillance Watch (CSW)													
	Inmate Placements on CSW	0	1	0	1	0	0	1	0	0	0	0	0	0
	Count of CSW Items Recovered	0	1	0	1	0	0	0	0	0	0	0	0	0
	CSW Search Warrants Requested	0	0	0	0	0	0	0	0	0	0	0	0	0
	Inmate Placements Exceeding 3 Days On CSW	0	0	0	1	0	0	0	0	0	0	0	0	0
	Inmate Placements Exceeding 6 Days On CSW	0	0	0	0	0	0	0	0	0	0	0	0	0
	In Cell Violence/Incidents													

COMPSTAT DAI Statistical Report - 13 Month

Data Analysis 13 Month as of 07-11-2019
Location(s): CAC, CCI, COR, HDSP, KVSP, LAC, PBSP, SAC, SATF, SVSP

		2018								2019				
		May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
LAC	Attempted Homicide - Inmate	1	1	1	1	0	2	0	1	1	0	1	1	1
	Homicide	0	0	0	0	0	0	1	0	0	0	0	0	0
	Expected Death	3	0	1	1	1	0	0	1	0	0	0	1	0
	Unexpected Death	1	0	0	0	2	0	0	0	0	1	1	2	1
	Total Inmate Deaths	**4**	**0**	**1**	**1**	**3**	**1**	**1**	**1**	**0**	**1**	**1**	**4**	**1**
	Controlled Cell Phone Discoveries	24	38	60	86	26	66	32	31	35	53	46	60	57
	Uncontrolled Cell Phone Discoveries	10	12	10	12	2	1	0	14	11	10	1	4	1
	Cell Phone Seizures	34	50	70	98	28	67	32	45	46	63	47	64	58
	Fighting	19	11	19	17	18	18	23	16	25	17	18	16	31
	Miscellaneous	17	5	8	9	12	16	6	6	14	9	14	16	14
	Incidents Involving Mental Health Inmates													
	Number of Non UOF Incidents Involving Mental Health Inmates	37	25	31	42	41	41	37	20	32	27	33	37	42
	% of Non UOF Incidents Involving Mental Health Inmates	**71 %**	**64 %**	**67 %**	**79 %**	**72 %**	**75 %**	**77 %**	**69 %**	**78 %**	**68 %**	**80 %**	**74 %**	**75 %**
	Number of UOF Incidents Involving Mental Health Inmates	49	38	42	42	47	42	35	28	45	29	40	46	50
	% of UOF Incidents Involving Mental Health Inmates	**88 %**	**93 %**	**82 %**	**78 %**	**84 %**	**89 %**	**73 %**	**90 %**	**88 %**	**88 %**	**87 %**	**85 %**	**81 %**
	Contraband Surveillance Watch (CSW)													
	Inmate Placements on CSW	1	1	1	0	0	2	1	0	0	0	0	0	1
	Count of CSW Items Recovered	1	1	1	0	0	1	1	0	0	0	0	0	1
	CSW Search Warrants Requested	0	0	0	0	0	0	0	0	0	0	0	0	0
	Inmate Placements Exceeding 3 Days On CSW	0	0	0	0	0	1	0	0	0	0	0	0	0
	Inmate Placements Exceeding 6 Days On CSW	0	0	0	0	0	0	0	0	0	0	0	0	0
	In Cell Violence/Incidents													

COMPSTAT DAI Statistical Report - 13 Month

Data Analysis 13 Month as of 07-11-2019
Location(s): CAC, CCI, COR, HDSP, KVSP, LAC, PBSP, SAC, SATF, SVSP

		2018								2019				
		May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
SAC	Attempted Homicide - Inmate	2	1	4	1	0	3	1	2	2	1	0	3	1
	Homicide	0	0	1	1	0	0	0	0	0	0	0	0	1
	Expected Death	0	0	0	0	0	0	0	0	0	0	0	0	0
	Unexpected Death	0	0	1	1	1	0	1	0	2	0	0	0	0
	Total Inmate Deaths	**0**	**0**	**2**	**2**	**1**	**0**	**1**	**1**	**3**	**0**	**1**	**0**	**1**
	Controlled Cell Phone Discoveries	88	67	69	7	67	43	62	54	49	83	0	44	29
	Uncontrolled Cell Phone Discoveries	16	0	15	0	27	7	0	0	0	0	0	0	2
	Cell Phone Seizures	104	67	84	7	94	50	62	54	49	83	0	44	31
	Fighting	9	4	6	10	4	8	7	9	8	7	2	10	17
	Miscellaneous	5	5	5	8	5	9	7	9	6	8	8	8	10
	Incidents Involving Mental Health Inmates													
	Number of Non UOF Incidents Involving Mental Health Inmates	54	54	45	55	42	45	64	50	47	47	51	38	62
	% of Non UOF Incidents Involving Mental Health Inmates	**92 %**	**86 %**	**82 %**	**83 %**	**79 %**	**79 %**	**83 %**	**79 %**	**87 %**	**69 %**	**88 %**	**84 %**	**79 %**
	Number of UOF Incidents Involving Mental Health Inmates	55	40	18	47	40	45	44	39	49	32	45	55	45
	% of UOF Incidents Involving Mental Health Inmates	**90 %**	**83 %**	**82 %**	**90 %**	**93 %**	**87 %**	**94 %**	**98 %**	**89 %**	**84 %**	**98 %**	**93 %**	**88 %**
	Contraband Surveillance Watch (CSW)													
	Inmate Placements on CSW	1	0	1	0	2	0	3	3	2	1	1	1	0
	Count of CSW Items Recovered	1	0	1	0	2	0	3	3	0	1	0	1	0
	CSW Search Warrants Requested	0	0	0	0	0	0	0	0	0	0	0	0	0
	Inmate Placements Exceeding 3 Days On CSW	0	0	0	0	0	0	0	1	0	1	0	0	0
	Inmate Placements Exceeding 6 Days On CSW	0	0	0	0	0	0	0	0	0	0	0	0	0
	In Cell Violence/Incidents													

COMPSTAT DAI Statistical Report - 13 Month

Data Analysis 13 Month as of 07-11-2019
Location(s): CAC, CCI, COR, HDSP, KVSP, LAC, PBSP, SAC, SATF, SVSP

		2018								2019				
		May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
SVSP	Attempted Homicide - Inmate	0	2	1	0	1	1	0	3	2	0	1	1	0
	Homicide	0	0	0	0	0	1	0	0	0	0	0	0	0
	Expected Death	0	0	1	1	0	1	0	1	0	0	0	1	0
	Unexpected Death	0	1	0	1	1	0	0	0	0	0	0	0	1
	Total Inmate Deaths	**0**	**1**	**1**	**2**	**1**	**2**	**0**	**1**	**0**	**0**	**0**	**1**	**1**
	Controlled Cell Phone Discoveries	40	37	43	35	50	36	80	34	35	64	76	104	80
	Uncontrolled Cell Phone Discoveries	10	48	12	20	20	18	26	5	39	27	20	41	54
	Cell Phone Seizures	50	85	55	55	70	54	106	39	74	91	96	145	134
	Fighting	20	8	16	9	24	18	13	23	17	20	23	13	18
	Miscellaneous	6	8	8	5	8	10	7	6	8	12	12	16	14
	Incidents Involving Mental Health Inmates													
	Number of Non UOF Incidents Involving Mental Health Inmates	37	37	37	40	35	26	40	27	27	48	36	54	51
	% of Non UOF Incidents Involving Mental Health Inmates	**70 %**	**77 %**	**70 %**	**71 %**	**59 %**	**50 %**	**65 %**	**68 %**	**59 %**	**71 %**	**65 %**	**62 %**	**66 %**
	Number of UOF Incidents Involving Mental Health Inmates	38	28	33	37	51	49	38	44	43	41	37	40	41
	% of UOF Incidents Involving Mental Health Inmates	**86 %**	**74 %**	**75 %**	**77 %**	**82 %**	**89 %**	**88 %**	**80 %**	**84 %**	**79 %**	**70 %**	**77 %**	**82 %**
	Contraband Surveillance Watch (CSW)													
	Inmate Placements on CSW	2	3	3	1	4	0	2	0	1	0	0	0	1
	Count of CSW Items Recovered	2	1	1	0	3	0	2	0	0	0	0	0	1
	CSW Search Warrants Requested	0	0	0	0	0	0	0	0	0	0	0	0	0
	Inmate Placements Exceeding 3 Days On CSW	0	1	0	0	1	0	0	0	0	0	0	0	0
	Inmate Placements Exceeding 6 Days On CSW	0	0	0	0	0	0	0	0	0	0	0	0	0
	In Cell Violence/Incidents													

Exhibit ZZ

Robert A. Barton
Inspector General

Office of the Inspector General

2015
Special Review:
High Desert State Prison
Susanville, CA

December 2015

Fairness ◆ Integrity ◆ Respect ◆
Service ◆ Transparency

Office of the Inspector General
2015 Special Review:
High Desert State Prison

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FOREWORD

On June 25, 2015, the Office of the Inspector General (OIG) received a request and authorization[1] from the Senate Committee on Rules, to review the practices at High Desert State Prison (HDSP) in Susanville, California, with respect to:

1. Excessive use of force against inmates,
2. Internal reviews of incidents involving excessive use of force against inmates,
3. Protection of inmates from assault and harm by others, and
4. *Armstrong* class inmates.[2]

In its request, the Senate Committee reported that a number of allegations surfaced that raised concerns about the safety of both inmates and staff. As part of this review, the OIG requested the California Department of Corrections and Rehabilitation's (CDCR or the department) Office of Internal Affairs (OIA) immediately open expedited investigations into each allegation; the OIG is monitoring these investigations. The incidents are discussed later in this report. In addition to these specific incidents, the Senate Committee noted that there have also been general allegations asserted that some members of custody staff at HDSP refer to inmates as "sodomites" or "sex offenders" in the presence of other inmates and disclose inmates' commitment offenses, placing inmates at risk of harm from other inmates.

Ultimately, this review is intended to determine whether there is a culture among the custody staff at HDSP that contradicts the CDCR's paramount objective of ensuring the safety of both inmates and staff in the prison system.

SCOPE, METHODOLOGY, AND OBJECTIVE

The scope of this special review encompasses the areas of the Senate Committee on Rules' request described above, along with the statutory mandate of Penal Code (PC) Section 6126, which requires the OIG to identify areas of full and partial compliance, or noncompliance, with departmental policies and procedures, specify deficiencies in the completion and documentation of processes, and recommend corrective actions, including, but not limited to, additional training, additional policies, or changes in policy, as well as any other findings or recommendations deemed appropriate.

During the course of its review, the OIG examined applicable laws, policies, and procedures; revisited past reports and media accounts; interviewed staff and inmates formerly assigned to HDSP; reviewed complaints filed by former HDSP staff and deposition testimony from the *Jones v. Cate* litigation; reviewed inmate appeals, disciplinary actions, confidential inmate files, and complaints against staff; reviewed misconduct allegation inquiry reports, internal affairs investigation reports, and death review reports; and actively monitored 20 misconduct investigations involving HDSP staff.

[1] A copy of the authorization can be found in Appendix A.
[2] The *Armstrong* class action lawsuit is discussed in detail on page 40 of this report.

SUMMARY OF FINDINGS

There is evidence that a perception of insularity and indifference to inmates exists at High Desert State Prison, exacerbated by the unique geographical isolation, the high stress environment, and a labor organization that opposes oversight to the point of actively discouraging members from coming forward with information that could in any way adversely affect another officer. These aspects coupled with the difficult missions at HDSP have helped create an entrenched culture of self-protection and loyalty to HDSP above everything else.

Accounts from both staff and inmates depict a culture of indifference perpetuated by at least some staff. Reports from inmates of appeals being read and destroyed and officers using profane and derogatory language directed at inmates were corroborated by at least some staff.

The conflicting missions at HDSP make it difficult for vulnerable inmates, whether by commitment offense or disability, to program safely. Hardline officers run some yards with little regard for vulnerable inmates. The most extreme example is the Level IV sensitive needs yard (SNY) facility, which is just as violent as the general population (GP) yards, with gang politics meting out abuse and punishment for drug and gambling debts and extorting vulnerable inmates for protection, all of which is exacerbated by the tacit acquiescence of custody staff.

The department's use of the R suffix to designate the restricted custody of certain inmates has served as a bull's-eye target at HDSP and other prisons, most notably on SNY yards. Based upon this review and observations in prior OIG reports, the continued use of sensitive needs yards merits a complete overhaul.

The inmate appeals system at HDSP is not functioning adequately and the staff complaint process is broken. Very few staff complaints were referred for investigation and those that were referred have not been adequately monitored and tracked for response. Also, HDSP does not have a process for addressing officers who are repeatedly accused of misconduct by different inmates. There are statistical trends, continued complaints, and recent misconduct allegations that cause alarm about the use of force at HDSP.

Finally, the OIG found that the use of resident agents by the Office of Internal Affairs is a poor practice, and should be discontinued, especially at HDSP in light of the issues that arose from the placement of a resident agent at that institution. Additionally, the processes in place for allegation inquiries at HDSP are inadequate, and could be improved statewide. The OIG is monitoring several misconduct investigations that, but for this review, may not have been opened or investigated to the broadest extent appropriate. Because the investigations have not been completed, only the general facts are discussed in this report, but results will be published in a future OIG Semi-Annual Report. The OIG made 7 broad findings and 45 specific recommendations during this review (see pages 55 to 60 for a detailed list).

--- ROBERT A. BARTON, INSPECTOR GENERAL

BACKGROUND

HIGH DESERT STATE PRISON

In 1995, the department activated High Desert State Prison adjacent to the grounds of the California Correctional Center (CCC), in Susanville, CA. Since its activation 20 years ago, HDSP has undergone continuing changes to its mission, and today each facility houses a population uniquely different from the adjacent yards. According to CDCR's website, the primary mission of HDSP is to provide for the housing[3] and programming of general population and sensitive needs high security (Level IV) and sensitive needs medium security (Level III) inmates. The inmate population consists of three Level IV yards, two of which are 180-degree design buildings (Facility C and Facility D), and one 270 design building (Facility B). Facility B was converted to a sensitive needs yard in October 2007, which houses Level IV SNY inmates.

HDSP Facility	Housing Type	Custody Level	Number of Housing Unit Buildings
A	SNY	III	4
	Reentry Hub	III	1
B	SNY	IV	5
C	EPF	IV	8
D	GP	IV	7
	ASU	III/IV	1
E	MSF	I	2
Z	ASU	III/IV	1

In mid-2015, Facility A was converted from a Level III general population yard to a Level III sensitive needs yard. The stated purpose of the conversion was to: 1) assist the department in reducing the number of Level III GP vacancies and reduce current Level III SNY overcrowding; 2) further allow increased Reception Centers (RC) inmate movement, and mitigate potential inmate backlogs in the RC, which impede CDCR's ability to accommodate weekly county intake; and 3) assist in efforts to meet the Level III SNY crowding standard, as outlined in *The Future of California Corrections Blueprint.* Facility A is also the home of the Reentry Hub Facility, which has the goal of providing relevant training and services to eligible and interested inmates in order to facilitate the successful transition back to their communities and reduce their likelihood of reoffending.

[3] An inmate's classification determines the type of housing in which he will be placed. Level I or II inmates may be housed in open dormitory settings. Level III and IV inmates are placed in 180-degree design or 270 celled housing units. The number of degrees refers to view from a central elevated control booth. The "180-degree" design is a configuration of the cellblocks (housing units). The cellblocks are partitioned into three separate, self-contained sections, forming a half circle (180 degrees). The partitioning of sections, blocks, and facilities ensures maximum control of movement and quick isolation of disruptive incidents, thereby ensuring effective overall management of inmates.

On January 1, 2014, Facility C became the location of one of CDCR's seven enhanced program facilities (EPF). According to CDCR's EPF activation memo,[4] EPFs are designed to "offer incentives for inmates who, based on their own behaviors and choices, are ready to take full advantage of programming opportunities." The EPFs are designed to provide programs and privileges not readily available on other yards, such as advanced college degree programs, increased canteen draw, and an expanded property allowance, with the goal to incentivize and reinforce positive behavior. While HDSP Facility C has been designated an EPF for nearly two years, it appears to be an EPF in name only, as staff estimate that 95 percent of the inmates in the EPF do not meet the criteria, and are only placed there because they meet the general Level IV housing criteria, with no enemy concerns, and not because they voiced a desire to participate in enhanced programming.

HDSP's Facility E is the minimum support facility (MSF), which houses non-camp eligible Level I inmates who perform job duties in various areas of the institution outside the secure perimeter.

The Administrative Segregation Unit (ASU) was originally located on Facility D, a 180-design housing unit, and consisted of two buildings, D7 and D8. Within the first three years of HDSP's activation, it became apparent that the building originally designed and designated as the ASU was not adequate to meet the demands of the inmate population who require segregated housing. Construction on a new stand-alone ASU began in October 2001. The new unit was named Facility Z and activated in September 2004, but buildings D7 and D8 continued to also serve as ASU beds, until just recently, when building D7 reverted back to GP housing.

Finally, while this area is addressed in depth later in this report, it should be noted that HDSP has been a designated Disability Placement Program (DPP) institution since at least 1997. This means that inmates with verified disabilities impacting their placement (such as wheelchair users or inmates with impairments to their mobility, vision, hearing, or speech) can be housed at HDSP, with the expectation that these inmates will be provided access to programs and services, with reasonable accommodation when required. The requirements of the DPP are laid out in the *Armstrong* court-ordered remedial plan. *Armstrong* is a class action lawsuit brought under the Americans with Disabilities Act (ADA) and the Rehabilitation Act in 1994, on behalf of inmates and parolees with disabilities.

No two yards at HDSP have the same mission. According to CDCR, the design capacity for housing inmates at HDSP is 2,324 with a staffed capacity of 3,461.[5] While the actual number of inmates housed at the prison changes daily, the total number of inmates housed at HDSP on November 30, 2015, was 3,482, or 149.8 percent of its design capacity.

[4] A copy of the EPF memo can be found in Appendix B.
[5] http://www.cdcr.ca.gov/Reports_Research/Offender_Information_Services_Branch/Monthly/TPOP1A/TPOP1Ad1511.pdf

In the last eight years, HDSP has had six different wardens or acting wardens. Suzanne Peery was the acting warden at HDSP from February 2, 2015, until December 1, 2015. Peery has spent her entire corrections career in Susanville, starting at CCC in 1988 before transferring to HDSP in 2006 as the employee relations officer, and ultimately working her way up to Chief Deputy Warden before being named acting warden.

Adjacent to HDSP is the California Correctional Center, which houses approximately 2,196 inmates with responsibility for an additional 1,726 inmates assigned to fire camps, giving it a total population of 3,922 inmates. It is also worth noting that located 37 miles south of Susanville is Federal Correctional Institution, Herlong, a medium security federal correctional institution with an adjacent minimum security satellite camp, which houses approximately 1,445 male offenders.

MEDIA ATTENTION, LEGISLATIVE SCRUTINY, AND PAST OIG REPORTS

2007 PBS documentary: Prison Town, USA

Susanville was the subject of a 2007 PBS documentary titled Prison Town, USA. The program focused on the prison building boom and the common practice of siting prisons in rural towns, due to the "NIMBY" (Not In My Back Yard) policies of large metropolitan cities, coupled with the desire of city officials to generate jobs in rural communities that have suffered an economic downturn due to the closure of anchor employers such as sawmills. The program examined the impact of building HDSP in a town that already had a State prison and a federal prison. The program followed the lives of specific officers (some of whom still work at a Susanville prison) and their families over the course of two years. According to the PBS website:

> The resulting story is one of hard choices and unanticipated consequences. As Susanville's good-hearted country-boys-turned-prison-guards soon learn, life outside the walls is developing eerie parallels to life on the inside. At the correctional officer training academy, officers have to learn new skills and attitudes, often quite foreign to their upbringing. Besides the obvious dangers of the job, the constant tension spills into the [officers'] home lives, changing how they relate to their families and friends. In a sense they, too, are imprisoned — a reality that is hard to shake once they leave work.

According to the documentary's co-director, Katie Galloway, one reason for making the film was: "We hope this film will awaken people to the real consequences of prison expansion, particularly in rural areas that have been so important in forming the history and character of California and the country."

July 2008 Evaluation of the Behavior Modification Unit Pilot Program at High Desert State Prison, Conducted by CDCR's Adult Research Branch

In July 2008, the department published an evaluation report of its Behavior Modification Unit (BMU) Pilot Program, which was implemented at HDSP on November 21, 2005. This program was developed and implemented to respond to disruptive inmate behavior

that was not serious enough to warrant ASU or Security Housing Unit (SHU) placement, but was disruptive to the general population. The report contained inmate interviews and stated that some of the accounts were rather typical inmate complaints, while others were serious allegations of mistreatment, such as inmates (some clad only in socks and boxer briefs) forced to stand outside in the snow for over two hours. Recurring themes included racism, retaliation for filing appeals, and officers provoking physical altercations.

May 2010 Sacramento Bee articles, written by Charles Piller, titled: "*Guards accused of cruelty, racism"* and "*California prison behavior units aim to control troublesome inmates"*

The headline for a two part series in the Sacramento Bee described the report as an "investigation into the behavior units at High Desert State Prison, including signed affidavits, conversations and correspondence with 18 inmates … [which] uncovered evidence of racism and cruelty at the Susanville facility."

December 2010 California State Senate Review of the BMU at HDSP

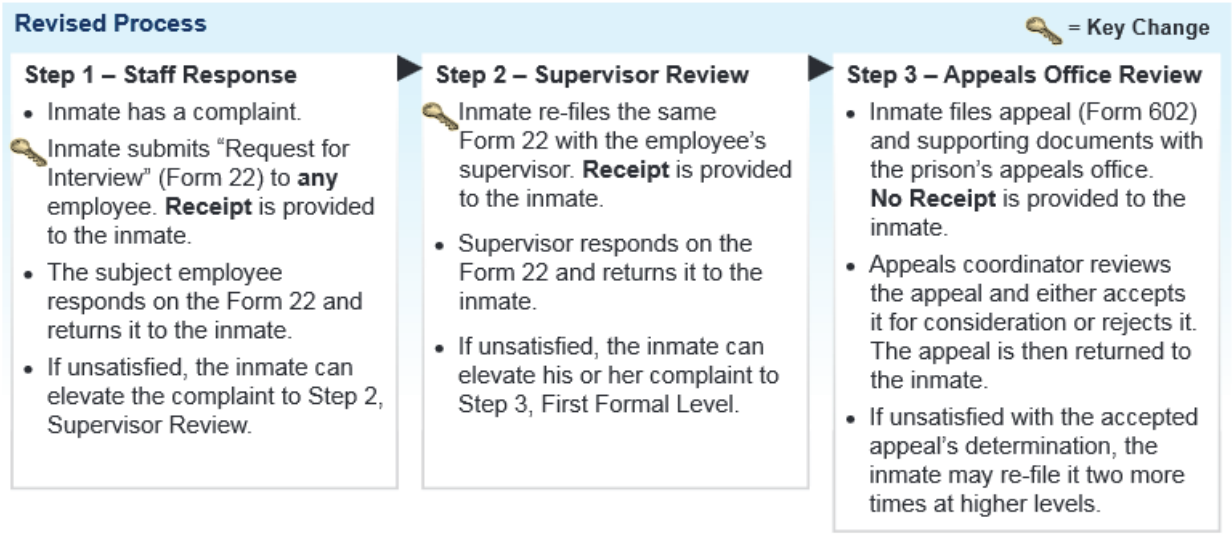
After the publication of the Sacramento Bee articles referenced above, staff working on behalf of the California State Senate reviewed hundreds of documents and conducted numerous interviews to better understand and assess the allegations referenced in the article. The Senate cited the need for improvement in the department's system of accountability to ensure that allegations of abuse and misconduct in correctional institutions are addressed swiftly, systematically, and fairly for all involved. The Senate's review of the circumstances that gave rise to the public scrutiny of conditions at the BMU at HDSP highlighted the importance of making sure that the department's methods for handling reports of inmate abuse or staff misconduct are performing well. The review stated, "Every means by which the department receives information about prison conditions - whether formal or informal, or from an inmate, employee or member of the public is a valuable opportunity for the department to ensure the integrity of its operations. Every observer ought to be regarded as an asset, and every supervisor ought to be empowered as a portal through which information about prison conditions will be shared, evaluated, investigated and addressed." The Senate's review of the BMU allegations suggested that the department would be well served by a recalibration of how it handles complaint allegations, from intake through investigation and resolution.

September 2011 OIG Special Report: CDCR's Revised Inmate Appeal Process Leaves Key Problems Unaddressed[6]

In January 2011, CDCR revised its inmate appeal process. One of the primary deficiencies CDCR identified in its appeals process was that appeals are not logged until they reach the Appeals Office and appeals do not have a receipt feature, leading to system-wide allegations that appeals were destroyed or lost, either intentionally or negligently.

[6] OIG reports can be accessed at www.oig.ca.gov

CDCR's revised process redirects the inmate to the written "request for interview" process, which does require a copy be given to the inmate; however, this report found that if the inmate bypasses this process or elevates the issue to the formal appeal level, there is still no receipt feature.



As a consequence, CDCR's appeal process still does not address inmate allegations that appeals are routinely discarded or read by custody staff and then destroyed if they contain accusations of misconduct.

In response to this report, the department issued a December 30, 2011, directive[7] to all institutions, which, among other mandates, prohibited the reading or inspecting of appeals by anyone other than Appeals Office staff, and required the installation of secure appeals lock boxes in the housing units, retrieval from which shall only be done by Appeals Office staff and/or staff designated by the warden.

October 2011 OIG Special Review

Between November 8, 2010, and June 16, 2011, the OIG conducted a review of allegations that HDSP staff violated the civil rights of inmates housed in Facility Z, often referred to as "Z Unit," the institution's stand-alone ASU. After reviewing a dozen different categories of alleged abuses, the OIG determined most of the allegations to be unfounded, but discovered concerns with inconsistent laundry exchange practices, a lack of policy direction regarding cold weather searches, inadequate law library access, and failure to provide the required ten hours of exercise yard time per week.

May 2012 OIG Special Review: High Desert State Prison

As a result of repeated complaints regarding HDSP staff, the Senate Committee requested the OIG conduct a special review to determine whether staff intentionally or negligently allowed inmates to identify sex offender inmates, thereby subjecting inmates to potential

[7] A copy of the directive can be found in Appendix C.

harm. Although the review did not result in enough corroboration to pursue all inmate allegations, the volume and relative consistency among the inmate complaints gave credence to the existence of a problem within the Level IV SNY facility at HDSP. The pervasive complaints and incidents revealed should have at least alerted the department and caused some action to make sure such practices were not occurring. However, it appears that no action was taken. It was evident from the number of inmate victims and assailants making allegations of officer misconduct that there was a culture of hostility toward sex offender inmates at HDSP. In addition, some of the officers interviewed at the time indicated that they believed there were officers at HDSP who would provoke inmates into physical altercations to necessitate the use of force. This raised a concern regarding a culture of abuse and code of silence at HDSP, and some of the inmates interviewed believed that they would be retaliated against just for talking to the OIG or CDCR's Office of Internal Affairs.

August 30, 2015 BuzzFeed News article written by Albert Samaha, titled: *The Job Made Me Do It. The Prison Guard Who Couldn't Escape Prison, Scott Jones loved being a correctional officer at California's High Desert State Prison. Then he saw his colleagues commit enough abuses that he saw no choice but to break the code of silence, turning himself into a pariah in a neighborhood called C/O Row.*

The BuzzFeed article chronicles the events leading up to an officer's suicide, after he "broke what one former prison guard called 'the green wall of silence' — the code of silence that has turned California's state prisons into insular and isolated facilities of unconstitutional conditions, where what happens on the Inside stays on the Inside. It is an unwritten rule meant to protect the men and women tasked with overseeing the state's 130,000 inmates, and Scott had to pay for violating it."

August 31, 2015 Rolling Stone Magazine article written by Jessica Pishko, titled: *High Desert Suicide: Was a Prison Guard Hazed to Death? At one of the country's most dangerous prisons, correctional officers face off against murderers, rapists, gangsters and each other.*

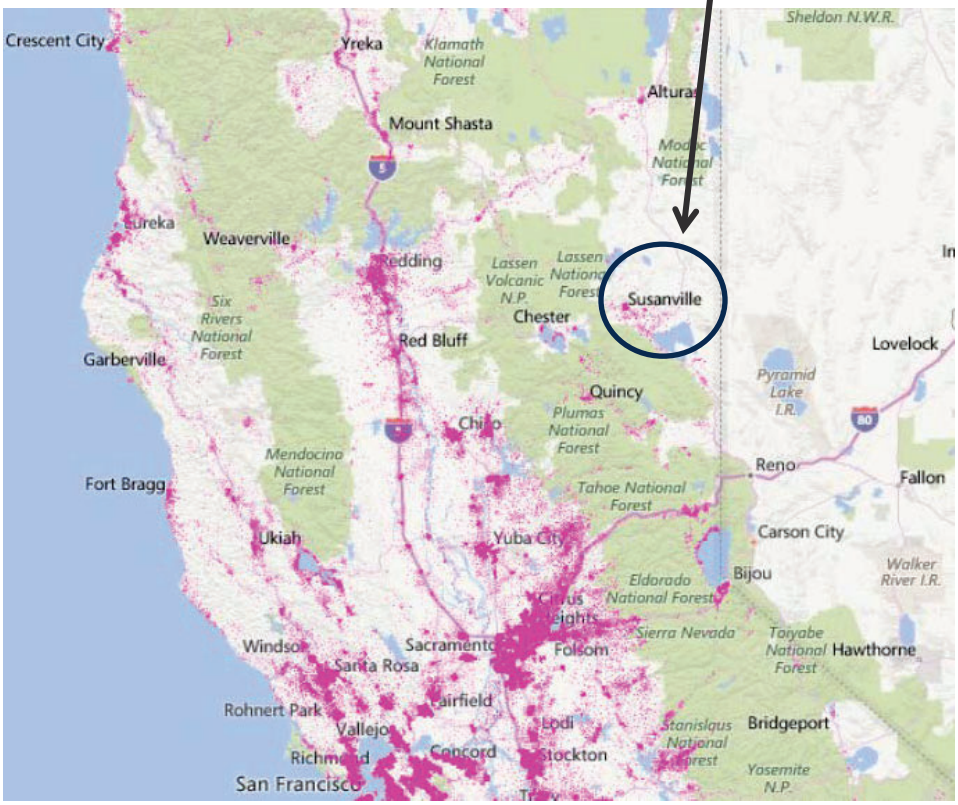
The Rolling Stone article explores the events leading up to the 2011 suicide of a High Desert State Prison correctional officer (one of five staff suicides since 2008, according to the article).

None of these prior articles or reviews has had the desired impact of permanently improving HDSP. Instead, they were mere harbingers of continued problems that still exist.

ENTRENCHED CULTURE

REMOTE LOCATION

Susanville is located in Lassen County, a remote location in rural northeast California. Susanville is located 86 miles from Reno, Nevada; 112 miles from Redding, California; and 106 miles from Red Bluff, California. The 2014 census population estimate for Susanville was 15,543. HDSP and CCC employ 953 and 871 staff, respectively, making them the largest employers in all of Lassen County.



California Population Density Map
Source: United States Census Bureau data compiled by censusviewer.com

Due to the remote location and distance from other communities, HDSP and CCC mostly pull staff from the local community of Susanville. More so than any other prison locale, those that work at the prisons also interact outside the prison on a daily basis. According to former HDSP staff, many employees' family members work together, socialize together, grew up together, and went to school together. Interacting with members of the prison staff in the community is part of daily life in Susanville. One former employee who relocated to another part of the State reported that when visiting family in Susanville, she stopped visiting any of the major grocery stores or shopping centers because it was inevitable that she would run into former co-workers. Even in the far reaches of Crescent City and Blythe, where prisons are located, there is still a significant percentage of staff that commute from different outlying areas and towns.

Interviews with other former HDSP staff indicated the majority of long term staff at HDSP are from the local community. Many cadets originally from major metropolitan areas of the State who graduate from the academy and get assigned to HDSP will leave as soon as they can transfer to another institution. Former non-white staff reported that Susanville's lack of diversity made it an undesirable community in which to live and they would not choose to return.

Inmate visiting statistics from the last calendar year for a sampling of institutions demonstrate how isolated Susanville is from the rest of the State. Only Pelican Bay State Prison (PBSP) located in Crescent City has comparable visitation statistics, making PBSP, HDSP, and CCC the least visited institutions of those sampled by almost 6,000 visitors per year. On the other hand, California State Prison, Los Angeles County (LAC) in Lancaster received as many visitors as all three of those prisons combined. Not only has a lack of visitors been tied to increased recidivism rates, but it also cuts down on the number of outlets inmates have to report misconduct. Inmates' friends and family members are valuable confidants for inmates to report issues they are experiencing inside the prison.

All of these attributes frame the picture of a location that presents a unique set of challenges that CDCR should factor into consideration for providing guidance and accountability over the management of the prisons it has sited there and the needs of the inmates they have designated for housing in these locations.

Visiting Statistics Calendar Year 2014[8]

Institution, Location	Number of Visitors
Los Angeles County (LAC), Lancaster	31,070
Pleasant Valley State Prison (PVSP), Coalinga	28,157
Kern Valley State Prison (KVSP), Delano	23,764
Mule Creek State Prison (MCSP), Ione	22,555
Folsom State Prison (FSP), Represa	22,426
Richard J Donovan (RJD), San Diego	21,758
Salinas Valley State Prison (SVSP), Soledad	20,340
California State Prison, Sacramento (SAC), Represa	17,445
High Desert State Prison (HDSP), Susanville	11,488
Pelican Bay State Prison (PBSP), Crescent City	11,373
California Correctional Center (CCC), Susanville[9]	7,638

[8] The OIG sampled PBSP due to its remote location, SAC and FSP due to their centralized location near the California capitol, HDSP and CCC due to their location in Susanville, and the remaining institutions because they house SNY inmates in various locations throughout the State.

THE SUSANVILLE "CAR" MENTALITY AND CODE OF SILENCE

Interviews of staff formerly assigned to HDSP indicated the existence of tight-knit social groups among employees, commonly referred to as "cars" within the correctional community. These groups of employees socialize frequently outside of work and are often comprised both of supervisors and correctional officers who work on the same housing units and during the same shifts. In addition, many of the staff are actually related. Spouses, siblings, and cousins are often employed at one or the other institution, literally creating "family" ties.

On one hand, some staff described these groups as mostly innocuous; they would eat lunch together, get each other things from the cafeteria, and barbecue and have drinks together on weekends. Even these former staff members who did not witness any misconduct indicated that supervisors who belonged to these groups would sometimes display favoritism towards the other members of their "car." One former staff member stated that supervisors would assign members of their "car" to favorable work assignments and working hours, such as administrative posts with weekends off, despite other staff being entitled to the positions by operation of the seniority provisions of the Bargaining Unit 6, Memorandum of Understanding[10] (MOU) (the correctional officers' union contract).

On the other hand, some former staff described the negative consequences that could occur if you were not a member of the "car" or if you spoke out or reported misconduct against a member of the "car." These consequences could include unfavorable job changes, being ostracized and labeled as a "rat," shunning in the community, retaliatory investigations, verbal badgering and abuse, the threat of not responding to an inmate assault on staff, and even physical assault by a custody supervisor.

The actual existence or even the perception of a management "car" can lead staff to participate in a code of silence, for fear that the consequences of reporting misconduct will outweigh the risk of remaining silent. Even though the department has a zero tolerance policy[11] for engaging in a code of silence, the OIG found several examples in the HDSP cases currently being monitored.

PEER REVIEW

In response to ongoing reports of issues at High Desert State Prison, CDCR sent a four-person team to HDSP to conduct a peer review in April 2015. At one time, peer reviews were conducted on a regular basis, although there is no record of one ever being conducted at HDSP prior to this one. CDCR reports that a HDSP peer review was scheduled to occur in May 2010, but did not occur, due to budget cuts.

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[9] This statistic only includes visitors to inmates housed at CCC in Susanville, not the 18 Northern California conservation camps associated with CCC.
[10] A copy of the MOU can be found at http://www.calhr.ca.gov/Documents/bu06-20130703-20150702-mou.pdf
[11] A copy of the zero tolerance policy can be found in Appendix D.

The peer review team interviewed selected members of HDSP staff and inmate advisory council (IAC) members representing the HDSP inmate populations; randomly interviewed staff and inmates on each facility; and reviewed a variety of documentation. The peer review team found 18 areas of non-compliance[12] at HDSP, some of which are as follows:

- Multiple infractions related to the requirements pertaining to disciplinary action logs, including failure of management to regularly review and approve.
- Lack of program opportunities on the Facility B sensitive needs yard.
- Inaccurate documentation on ASU isolation logs, reflecting inmates were receiving out-of-cell time, when they in fact were not.
- Multiple infractions related to the processing of inmate appeals, including appeals being screened out at a high rate; failure to follow the inmate appeal collection process outlined in policy; by routing appeals to the mailroom instead of the Appeals Office; several overdue inmate appeal modification orders; and failure of the appeals coordinator to meet with the IAC on a quarterly basis, as required.
- Underutilization of the custody sick leave monitoring process.
- Officers not appropriately completing cell search logs and issuing proper receipts, coupled with supervisors and managers not completing required weekly and monthly tours.
- Officers modifying inmate programs, without prior approval of the area manager or Administrative Officer-of-the-Day (AOD).
- Custody staff not carrying their required equipment.

While HDSP does have some new staff, the majority are tenured staff who should be well versed in CDCR's policies and procedures. The type of errors cited in the peer review are indicative of lax supervision, complacency, and management indifference. The institution completed a corrective action plan for all 18 areas of noncompliance and the overwhelming majority of recommendations made by the peer review team to remedy the infractions were for staff to be provided training, which was completed. However, one has to assume that this training was given previously, or should have been. Unfortunately, by requiring staff only receive one-time training, the department has failed to ensure the infractions will not continue to occur. There are no safeguards built into the peer review process, such as requiring HDSP leadership to provide proof that staff have not slipped back into old behaviors, or requiring the peer review team to conduct a follow-up review in a few months. Additionally, no one was held accountable for the policy violations or lack of training in the first place.

The department reports that it is currently in the process of developing a new peer review process. The OIG recommends that in doing so, in addition to requiring the institution to develop a corrective action plan addressing the deficiencies, the department must include a follow-up plan at the headquarters level, to ensure that the identified issues have been completely remedied and no longer exist. In addition, the tool should include an in-depth examination of areas such as inmate staff complaints, large volumes of appeals in

[12] A copy of the peer review report can be found in the Appendix E.

particular categories (such as, in the case of HDSP, property), and mandates such as a measurement of the institution's compliance with Department Operations Manual (DOM) Article 44, CDCR's Prison Rape Elimination Act (PREA) Policy.

RACISM AND IMPLICIT BIAS

In interviews conducted of inmates formerly assigned to HDSP, a common allegation was the existence of overt racism at HDSP. Several former inmates stated that the racism they experienced at HDSP was far worse than they experienced at any other institution where they had been housed. The following excerpts are summarized from individual inmate interviews, conducted separately over the course of this review:

.. officers called inmates the N-word or wetbacks. Black inmates wouldn't get enough time to eat; the officers would 'kick' the blacks out of the chow hall first and then the Hispanics. The white inmates didn't have to leave, they were running the kitchen.

.. officers were more racist than he experienced at his former prison and the white inmates were usually allowed to go to canteen first, and when it was the black inmates' turn, the yard would sometimes be recalled [not allowing time for canteen purchases].

.. never saw such a lack of respect toward black inmates than he experienced at HDSP. Officers called black inmates the N-word and threatened them. This disrespect occurred with free staff as well, including medical staff.

.. officers at HDSP were especially disrespectful to black inmates. Officers would search the cells of black inmates more often than those of other races, and often for no apparent reason. The disrespect and corrupt environment was far worse at HDSP than other prisons.

.. the staff at HDSP are absolutely racist. They are just a bunch of hateful people at that place. It was very different at HDSP compared to other prisons.

.. the white staff were very racist and bigoted, not just towards inmates but also towards officers that were of different a race. Staff would search the blacks more than others after chow. It wasn't the search so much; it was the way they did it. He got that KKK and green wall feeling from HDSP.

.. there were a lot of disrespectful staff at HDSP. The staff at HDSP were openly racist. The sergeants and lieutenants were worse than the officers. Blacks were treated very differently: they are on lockdowns a lot longer; they go to the hole for the smallest of reasons; and officers messed with their food.

.. officers were racist, called black inmates the N-word, and black inmates were locked down for longer periods of time than other races.

.. white inmates were assigned the better jobs.

.. officers were racist against black inmates because Susanville was a white community.

.. officers try hard to not to appear racist, but when you talk to them in private, they use the N-word when referring to black inmates and use derogatory terms directly to inmates.

.. the biggest issues are race-related. Once heard an officer call blacks "skid marks." Regardless of who was involved in an incident, the black population was always held responsible. Since HDSP was run by predominately white staff, the white inmates were favored. White inmates always got the better jobs. Clerical jobs were mainly given to white inmates. Black inmates have to wait at the end of the line during canteen. The canteen manager allows Hispanic and white inmates to run canteen, resulting in the black inmates often not getting a chance to have their canteen orders filled.

The racial composition of HDSP's inmate population and HDSP's custody staff differ drastically. Although 76 percent of custody staff are white, only 18 percent of the total inmate population identifies as white. Hispanic and Black comprise 79 percent of the inmate population at HDSP, but only 21 percent of the custody staff, which includes officers, supervisors, and managers.

SEPTEMBER 2015, HDSP RACE/ETHNICITY PERCENTAGES

	HISPANIC	BLACK	WHITE	ASIAN	OTHER*
HDSP Inmates	54%	25%	18%	2%	2%
HDSP Custody Officers	20%	3%	74%	3%	1%
HDSP Custody Supervisors & Managers	10%	1%	89%	0%	1%

*Other includes American Indian, Pacific Islander

OIG interviews highlighted a culture of racism and lack of acceptance of ethnic differences. From the casual use of derogatory racial terms to de facto discrimination, it became apparent to the OIG that there is a serious issue at HDSP and that the institution's leadership appears oblivious to these problems.

In addition, the remote, rural location and lack of diversity in the Susanville population could give the perception that non-white residents are not welcome. One former HDSP staff person stated that he was warned at the academy to be careful in Susanville due to his race. He said that other non-white staff that had formerly worked in Susanville stated they would never go back to Susanville, due to its lack of diversity.

The culture at HDSP could benefit from programs that are becoming more and more prevalent in police departments, which educate officers about the influence of implicit biases. Implicit bias describes the automatic association people make between groups of people and stereotypes about those groups. Under certain conditions, those automatic associations can influence behavior—making people respond in biased ways even when they are not explicitly prejudiced.

Discussions of implicit bias in policing tend to focus on implicit racial biases; however, implicit bias can be expressed in relation to non-racial factors, including gender, age, religion, or sexual orientation. As with all types of bias, implicit bias can distort one's

perception and subsequent treatment either in favor of or against a given person or group. In policing, this has resulted in widespread practices that focus undeserved suspicion on some groups and presume other groups innocent.

Research has shown that it is possible to address and reduce implicit bias through training and policy interventions with law enforcement agencies. Research suggests that biased associations can be gradually unlearned and replaced with nonbiased ones.[13]

In 2015, the US Department of Justice (DOJ) announced six cities to host pilot sites for the National Initiative for Building Community Trust and Justice, which will seek to assess the police-community relationship in each of the six pilot sites, as well as develop a detailed site-specific plan that will enhance procedural justice, reduce bias, and support reconciliation in communities where trust has been eroded. One of the host pilot sites is Stockton, CA. The three-year grant has been awarded to a consortium of national law enforcement experts from John Jay College of Criminal Justice, Yale Law School, UCLA's Center for Policing Equity, and the Urban Institute.

In addition, law enforcement agencies can request training, peer mentoring, expert consultation, and other types of assistance on implicit bias, procedural justice, and racial reconciliation through DOJ's Office of Justice Program's Diagnostic Center. The initiative launched a new online clearinghouse that includes up-to-date information about what works to build trust between citizens and law enforcement.[14]

THE NEED FOR INCREASED INMATE PROGRAMMING AND STAFF RESILIENCY TRAINING

As described earlier, HDSP houses high security (Level IV) general population and sensitive needs inmates and medium security (Level III) sensitive needs inmates. Three of the institution's four main yards are classified as Level IV housing. HDSP also maintains a stand-alone administrative segregation unit. As a high security institution, HDSP houses the most violent and dangerous male offenders.

Prison populations consisting predominantly of people serving long sentences can be difficult to manage because inmates can have a sense of hopelessness and a "what have I got to lose" attitude that can lead to continued criminality and violent behavior. Couple this with half of the HDSP inmate population[15] needing protection due to vulnerability based on commitment offense or disability, and correctional officers can be unprepared for dealing with these populations. One way to mitigate these behaviors is through meaningful programming opportunities and programs that offer incentives to those who participate, whether that means extra privileges or activities that give a sense of accomplishment. Unfortunately, HDSP's Level IV sensitive needs yard has very few programming opportunities, and the enhanced program facility on its Level IV general population yard, by staff's own account, consists mainly of inmates resistant to

[13] An article from the Fordham Law Review related to implicit bias can be found in Appendix F.
[14] The clearinghouse can be found at www.trustandjustice.org.
[15] Two of the four main facilities at HDSP house inmates designated as sensitive needs.

programming. Increasing programming on these yards and ensuring the right population is placed into the EPF could reduce the violence and continued criminality that exists at HDSP.

Working around such dangerous individuals on a daily basis can be a highly stressful experience. CDCR does not have a program that adequately trains its staff or gives them the tools to cope with working in such a stressful environment. Additionally, in the tightknit, rural community of Susanville, where many people work and socialize together, there are few outlets for staff to seek assistance when they feel their complaints of mistreatment are not being addressed by prison leadership. There have been staff suicides reported and some staff reported retaliation for bringing misconduct forward.

There is a staff resiliency training program being developed by the Center for Mindfulness in Corrections,[16] which CDCR is considering piloting at one of its Level IV institutions. The program is geared toward developing consistent and healthy self-care practices and a "safe environment to disengage from negative drama." This type of resiliency program is showing promising results in law enforcement agencies across the country. The department should consider piloting this or a similar program at HDSP, and then expanding statewide.

In addition, CDCR should ensure HDSP is following the requirements of DOM Sections 33010.30 – 33010.30.3, related to staff in high stress assignments. High stress assignments are defined as those in controlled housing units requiring direct and continuous contact with inmates confined therein because they present too great a management problem for housing in general population settings. Such housing unit assignments include, but are not limited to: SHUs, ASUs, psychiatric services units, and protective housing units. The policy requires:

- Employees be carefully evaluated before such assignment.
- Employees to have demonstrated a high degree of maturity, tolerance, and ability to cope with stressful situations.
- Assignments shall be limited to no longer than two years, with exceptions allowed by the warden when the employee indicates a desire to remain, or the employee's performance is completely satisfactory and does not reflect the effect of undue stress.
- Supervisors to evaluate the performance of employees on a continuous basis.
- Supervisors to act promptly to remedy stress-related problems that appear to adversely affect the employee's physical and mental health and effectiveness.
- Supervisors to take remedial action including placement in a less stressful assignment in or outside of the unit.

Increasing meaningful inmate programs and maximizing the EPF participation incentives, with the goal of decreasing inmate criminality and violence, while at the same time giving staff the tools to cope with working in a uniquely stressful environment, should result in improved staff morale and a healthier more resilient staff.

[16] An outline of the resiliency program can be found in Appendix G.

THE CALIFORNIA CORRECTIONAL PEACE OFFICERS ASSOCIATION

The California Correctional Peace Officers Association (CCPOA) is the labor union representing correctional officers. CCPOA's mission is "to promote and enhance the correctional profession, protect the safety of those engaged in corrections and advocate for the laws, funding and policies needed to improve prison operations and protect public safety."[17] However, during the course of the OIG's Senate-authorized review, OIG staff faced significant opposition from the union, which attempted to impede the OIG's informational, non-disciplinary interviews aimed at uncovering the veracity of allegations that the integrity of the correctional profession and the advancement of public safety at HDSP have been compromised.

Despite PC Section 6126.5's provision that all CDCR employees shall comply with the OIG's requests to be interviewed, with the consequence that failure to comply would be considered a misdemeanor, on October 15, 2015, CCPOA circulated the following instruction to its members:

ALL Unit 6 Employees.... ALL Unit 6 Employees

ALERT.... ALERT.... ALERT.... ALERT.... ALERT.... ALERT.... ALERT....

Agents of the Office of the Inspector General are interviewing CO's who work or worked at High Desert State Prison. We do not know what the interviews are about. The Agents maintain the interviews are "voluntary" however, they are not providing Officers advanced notice, the topic of the interview, or the opportunity to obtain legal representation. In at least one case, an Officer was ordered to interview after refusing to give a voluntary statement.

If you are contacted at work, or home, by Agents of the OIG and asked to interview, CCPOA suggests:

1. Immediately request a representative;
2. Give no voluntary statement; and
3. Do not allow the Agent into your home or have a conversation with them.

If required by OIG or ordered by a CDCR supervisor to participate in the interview do not disobey a direct order BUT DO CONTINUALLY REQUEST THE INTERVIEW BE SUSPENDED UNTIL YOU CAN TALK TO A LEGAL REPRESENTATIVE.

For Northern Institutions Contact:
Janice Shaw – 916-662-4385
Daniel Lindsay – 916-425-8466

For Central Valley Institutions Contact:
Shelley Lytle – 559-250-2862

For Southern Institutions Contact:
Sonia Garcia-Djajich – 909-677-9409

In an effort to maximize its reach, CCPOA e-mailed this instruction as an "Urgent Alert" to all CCPOA members and some CCPOA chapters recirculated the message on their Facebook pages. CCPOA based its advisement on the premise that the OIG's interviews somehow violated its members' rights under the Public Safety Officer Procedural Bill of

[17] https://www.ccpoa.org/about-us/

Rights Act [POBR, located at Government Code (GC) Section 3300, et seq.] and the MOU between the State Employer (CDCR) and CCPOA. CCPOA's instruction to its members was not only an inaccurate statement of its members' legal rights, but it also encouraged its members to commit acts qualifying as misdemeanor offenses under the law.

Before beginning the interviews of CDCR employees, the OIG informed the interviewees that the OIG was not conducting an investigation, that the employee being interviewed was not the subject of an investigation, and that the OIG would not use any statements provided during the interviews to initiate an investigation into the interviewee. The OIG did not permit these employees a representative during the interviews in order to prevent compromising the integrity of its review. There is a valid concern that CCPOA representatives were there not to protect any rights of the persons being interviewed, (who were never at peril of adverse action), but rather to find out which staff were telling on others, and what they were saying. In fact, none of the people interviewed still work at HDSP.

Pursuant to GC Section 3303, POBR rights apply only when a peace officer is "under investigation and subjected to interrogation by his or her commanding officer, or any other member of the employing public safety department." Because the OIG employees who conducted the interviews were not CDCR employees, pursuant to PC Section 6126.5(d), POBR rights did not apply to the OIG interviews unless "it appears that the facts of the case could lead to punitive action" against the officer being interviewed. Because the OIG was not performing an investigation into their misconduct and expressly informed these officers of that fact prior to the interviews, POBR did not provide the employees being interviewed with any rights to representation during the interviews, any right to advance notice of the interview, or to be made aware of the subject matter of the interview. As also set out in PC Section 6126.5(d), the terms of the MOU between the State and CCPOA do not apply to OIG interviews. No actions were ever contemplated and none were initiated against any of the interviewed employees.

CCPOA's State President also attempted to interfere with the OIG's authorized review by calling a member of CDCR's senior management on multiple occasions to complain about the OIG's interviews and CDCR's acquiescence to the OIG's requests to interview its employees. This interference also flies in the face of PC Section 6126.5(d), which requires that "[a]ny employee requested to be interviewed shall comply and shall have time afforded by the appointing authority for the purpose of an interview with the Inspector General or his or her designee."

On November 4, 2015, CCPOA filed a grievance against CDCR claiming CDCR's "acquiescence to the Office of the Inspector General's directives result[ed] in the violation of several Correctional Officers' MOU and POBR rights." Despite every correctional officer being informed prior to the interviews that they were not the subjects of an investigation and that they would not become the subjects of an investigation as a result of information provided during the interviews, CCPOA demanded expedited arbitration of the grievance, claiming that the OIG's interviews were causing its members "irreparable injury … for which there is no adequate remedy at law." As explained above, POBR did not provide the interviewees with any rights during their interviews with the

OIG. Even if officers' POBR rights had been violated, GC Section 3309.5 provides a remedy by authorizing the superior courts with initial jurisdiction to adjudicate alleged POBR violations and issue various forms of injunctive relief, including injunctions and restraining orders to prevent POBR violations from occurring.

On November 23, 2015, CCPOA's State President sent a letter to the Governor and each member of the California State Legislature disparaging the OIG with various unfounded accusations of impropriety in all facets of its operations. The OIG finds the accusations baseless, devoid of any understanding of the OIG's role and function, and disruptive to the provision of independent oversight as initially ordered by the federal court in *Madrid* and later codified by the Legislature. Due to their frivolous nature, the OIG deems CCPOA's allegations unworthy of a substantive response. Rather, the letter is the latest strong-arm tactic CCPOA has elected to deploy in an effort to obstruct the OIG's Senate-authorized review and attempt to discredit the OIG in advance of the release of this report.

Finally, on November 24, 2015, CCPOA filed a lawsuit in Sacramento County Superior Court in which it claims its members' POBR rights were violated, seeking monetary damages and injunctive relief. These actions serve as an attempt to chill the transparent oversight of the correctional system that the department has worked hard to embrace in the wake of the *Madrid* federal lawsuit.

CCPOA's collective actions during the course of the OIG's review cast into doubt the genuineness of its stated organizational mission. The union's staunch opposition to the OIG's review of HDSP demonstrates a clear hostility towards transparency and independent oversight in the prison system. The culture fostered by CCPOA is one of regression to prior periods of the "green wall" and code of silence, when officers were actively encouraged to disrupt and sabotage legitimate inquiries into pressing issues of public policy. This especially exacerbates a situation in a prison with the problems and culture discovered at HDSP.

RECOMMENDATIONS TO CDCR

- Infuse HDSP supervisory and management positions with culturally diverse staff who have experience working in other institutions and do not have lifelong ties to the community.

- Consider rotating HDSP management staff to other institutions, similar to the rotation required for CDCR headquarters peace officer staff.

- Increase the frequency at which peer reviews are conducted at HDSP.

- Revise the peer review tool to include follow-up measures and tests that better assess areas that could indicate deep-seated issues, such as by adding PREA and ADA compliance components.

- Increase inmate programming, especially on the SNY facilities.

- Ensure inmates housed in enhanced program facilities meet the EPF participation criteria.

- Ensure HDSP is following the DOM requirements related to staff in high stress assignments.

- Require HDSP seek approval from the CDCR Associate Director, prior to extending staff in high stress assignments beyond the initial two years.

- Seek out opportunities to partner with organizations, such as the US DOJ, to conduct research and provide training to custody staff, starting at HDSP, on how to recognize and address implicit bias.

- Implement a mindfulness and wellness program that gives staff resiliency tools to cope with working in a uniquely stressful environment.

SEX OFFENDERS AND THE R SUFFIX

R SUFFIX

As part of CDCR's inmate classification process, inmates with a history of sex offenses are designated with an R suffix, signifying restricted custody. According to California Code of Regulations (CCR), Title 15, Section 3377.1(b), the purpose of applying an R suffix is to ensure the safety of inmates, correctional personnel, and the general public by identifying inmates with a history of specific sex offenses. Inmates with an R suffix are automatically assessed a mandatory 19 classification points, which restricts them from being housed or assigned to jobs or programs outside the prison's security perimeter (to reduce the risk of escape).

The R suffix designation follows the inmate for every subsequent incarceration, even if he has served his term on the initial sex offense and is later recommitted for a different, non-sex related offense. Regardless of an inmate's current commitment offense, if that inmate is required to register as a sex offender, pursuant to PC Section 290, for any offense committed in his lifetime, an R suffix is applied (in California, PC 290 sex offender registration is a lifetime registration). In addition, CDCR's policies require every arrest, detention, or charge for an offense that would warrant the inmate to register pursuant to PC Section 290, be evaluated for assignment of an R suffix; the policy is applied liberally.

The mandatory application of 19 classification points is the ONLY requirement tied to the R suffix. However, over the years, the R suffix has come to be automatically associated with the inmate being a sex offender, triggering bias and preconceived beliefs inmates and officers might have related to sex offenders.

In interviews conducted of former HDSP inmates, allegations were raised related to staff disclosing the commitment offense of inmates to other inmates, placing their safety at risk. These former inmates alleged that staff told inmates that other inmates were sex offenders, or had shown them classification documents or let them view the electronic inmate records retained in the Strategic Offender Management System (SOMS), showing that an inmate had an R suffix. Having an R suffix carries a major stigma in prison and can jeopardize an inmate's safety by setting the inmate up for assault or extortion for protection from assault.

The OIG was also told by former HDSP inmates and staff that, more commonly, inmates are told by other inmates to show their paperwork, which includes the inmate's commitment offense. Inmates who are celled together regularly show each other their paperwork. This occurs on general population yards, as well as sensitive needs yards. The document being shared is usually a form provided to the inmate documenting the outcome of their classification committee hearing. Previously, the information was documented on a Classification Chrono, *CDCR Form 128-G*; however, it has been replaced by a printout of the SOMS screen titled Classification Committee Chrono (Chrono). The information provided in the Chrono not only summarizes the classification committee's decisions regarding the inmate's status, such as clearance for double-celling,

and education and work assignments, but it also documents the inmate's case factors including his commitment offense and prior arrest history. It also includes any applicable custody suffix, including an R suffix.

In addition to the Chrono, many CDCR forms include an inmate's commitment offense, arrest history, or custody suffix information, including the Legal Status Summary, the Classification Scoresheet, and Crime/Incident Reports. Although staff may be mindful not to route copies of documents containing sensitive information through inmate mail, and instead hand-deliver the documents to the inmate, once an inmate is in possession of these documents he can be pressured to provide them to other inmates. The OIG recognizes that there are multiple ways inmates can find out about each other's commitment offenses; however, limiting the information provided in hard copies given to all inmates would eliminate one way in which this information is discovered and reduce the pressures faced by inmates which then lead to victimization. The department cites no penological reason that information related to R suffix, commitment offense, or arrest history must appear on the Chrono given to the inmate.

With the implementation of SOMS and staff's ability to review inmate records in real-time, it is recommended that CDCR review any forms and documents that have required the commitment offenses and R suffix information, and determine if including this information is necessary and who has a need to know. CCR, Title 15, Section 3375(h), requires that an inmate be provided a copy of all non-confidential CDCR staff-generated documentation and reports placed in the inmate's central file, unless otherwise requested in writing by the inmate. Inmates who are pressured to provide a document to verify their commitment offense may be placed in a predicament if they request that their documentation not be provided since one can then assume that the inmate is hiding something.

The dangers associated with an inmate's paperwork and R suffix are all too real. In May 2013, on an SNY facility (not HDSP), an officer discovered an inmate lying unresponsive on the floor of his cell with a sheet pulled over him and a classification document resting on top of the sheet. There was a ligature around the inmate's neck, wound tight by a connected State-issued cup, and blood near his head. The classification document found on the deceased inmate noted that his commitment offense was for lewd and lascivious acts with a child under 14 years of age.

Additionally, as recently as December 2015 on an SNY facility (not HDSP), an inmate with a history of in-cell violence and gang affiliation informed an officer that his cellmate was dead. The victim was found face down on the floor and hogtied with multiple injuries and a pen and pencil stabbed in the victim's ear. Written on the victim's t-shirt were derogatory slurs specific to his criminal history. Although the victim's current offense was not a sex offense, he had sex offenses in his history.

SOMS Access

In the last few years, CDCR has converted from a paper inmate file, to an electronic inmate record. While this has made major improvements, it has come with the unintended consequence of giving staff unfettered access to an inmate's history. In the past, staff

wanting to know if an inmate was a sex offender would have to visit the prison records office, request the inmate's hard copy file, sign in on a log sheet, and sit in the records office to review the file. Now, from just about every housing unit in a prison, with a few key strokes and no admonishment or reminder that the information contained therein is sensitive and confidential, anyone accessing SOMS can instantly know if an inmate has an R suffix. In fact, the very first screen that appears after entering the inmate's CDCR number contains the R suffix information in the header.

In addition, although these SOMS computers are considered to be out of bounds for inmates, their placement throughout the housing units can sometimes be in areas where inmates can see the information on the screen. While the OIG recognizes that there are legitimate penological reasons that custody staff may need to access some information from an inmate's electronic record, for instance, to verify an inmate has no enemy concerns before rehousing him on another yard, custody staff must be mindful of the sensitive information being displayed on the computer monitors. Additionally, most custody officers do not have a need to know most information regarding inmates' commitment offenses.

RECOMMENDATIONS TO CDCR

- Develop a policy authorizing staff to access an inmate's electronic record on a "need to know" basis only. The policy should add admonishment language to the SOMS login screen, advising against misuse, and the consequence thereof.

- Develop a method of tracking and recording staff access to records in SOMS and other inmate records, and periodically audit access history to identify potential misuse.

- Remove the R suffix information from the SOMS header, as any staff specifically needing this information can find it on another screen.

- Conduct an in-depth review of every form and document that currently requires commitment offense information and R suffix notations, and remove this requirement from all forms and documents where it no longer serves a legitimate purpose.

- Consider providing inmates with only hard copies of certain portions of non-confidential documentation from SOMS or other inmate records, to exclude commitment offenses, R suffix notations, and any other information that may put an inmate at risk.

SENSITIVE NEEDS YARDS

When sensitive needs yards were first conceptualized in the late nineties, they were developed with the expectation that inmates would volunteer to be housed on a yard where they would pledge to program, in return for a "violence free" environment. There are no policies or procedures related to SNY housing, only a loose set of placement consideration guidelines outlined in a single memo from 2002. Essentially, the department did not want to establish rigid criteria for SNY placement, but rather a case-by-case review of each inmate would be conducted by the classification committee. SNYs do not have additional programming or anything different than general population facilities, as they were perceived to be truly a GP placement for inmates who simply wish to live in a nonviolent environment. The memo grouped inmates appropriate for SNY housing as falling into one of the following general categories:

- Prison Gang Dropout – these inmates had to be validated by CDCR's Office of Correctional Safety as a gang dropout.
- Victim of Assault – these inmates may have been assaulted because of a commitment offense or failure to commit an ordered assault on another inmate.
- Significant Enemy Concerns – these inmates may have provided testimony in open court, or their status as snitches or informants may have become known to the general inmate population.
- Other Safety Concerns – these inmates may be high notoriety, public interest cases, or sex offenders. These inmates might also include those that refuse to recognize inmate-imposed racial or cultural lines and other safety concerns not specifically listed.

The memo instructed staff to take a liberal approach to placing an inmate in an SNY and a conservative approach on any considered action to remove an inmate from an SNY. Additionally, the department foresaw that as the number of inmates receiving and requesting SNY housing grew, so would the need for SNY beds. These facilities "simply become housing for *programming* inmates who are willing not to prey upon other inmates in exchange for a feeling that they are less likely to be preyed upon" [emphasis added].

Because CDCR considers SNY facilities to be no different than GP facilities, SNY staff have never received any training in supervising vulnerable populations. However, unlike GP facilities, CDCR does not require SNY facilities to have an ethnic balance for inmate program and job assignments, leading many SNY inmates to complain that other races are receiving the best job assignments.

The demand for sensitive needs housing has grown to over 37,000 inmates being designated SNY. CDCR staff no longer wait for inmates to volunteer or request SNY housing. It is common now for classification staff to recommend SNY housing to inmates who have committed a sex offense or other crimes that make them targets for violence. Many vulnerable inmates who accept SNY housing do so expecting a protective environment and it is not always explained to them by classification staff that sensitive

needs yards are still violent, have programming no different from GP yards, and once they are assigned to an SNY, it is very difficult to ever return to a general population yard.

The growing numbers of gang dropouts being placed in SNYs has resulted in numerous new gangs forming and warring with rivals on the SNYs. Gang violence has grown so bad that some SNY inmates have asked to return to mainline yards rather than continue to face the gangs on the SNYs. However, once an inmate has been housed on an SNY facility, he then becomes a target or is labeled as soft, making it very difficult to ever transfer out. In fact, CDCR's SNY guidelines acknowledge that SNY housing in itself adds a label or stigma to the inmate and under no circumstances will an SNY inmate be returned to a GP if it is believed that the inmate's safety would be threatened by such housing, not even inmates who repeatedly assault other SNY inmates.

As one former HDSP staff member stated, *inmates take a very dim view of other inmates who have committed various crimes, mostly sex offenses. And they tend to target them for assaults, for extortion, for a whole variety of negative actions. Many of the assaults that happen, you could probably break down into a couple of categories, inmate-on-inmate assaults that are debts, generated from drugs or protection or bribery or blackmail. Then there's the gang-related assaults that happen when somebody is not toeing the line where they are supposed to, and they need to be removed from the picture from the inmate point of view. And so it's really hard to say the frequency of assaults– it happens all the time.*

To further gauge the amount of violence occurring on sensitive needs yards compared to general population yards, the OIG analyzed CDCR's COMPSTAT[18] reports for the 13-month period from June 2014 through June 2015. The OIG compared the data reported for the *Average Number of Incidents per 100 Inmates* and found that, of the ten facilities with the highest number of incidents per 100 inmates, 80 percent of the institutions housed SNY inmates. The OIG then compared the data reported for the *Average Number of Inmate Disciplinary Actions, per 100 Inmates* and found that of the twenty facilities with the highest number of inmate disciplinary actions per 100 inmates, 70 percent of the institutions housed SNY inmates.[19]

Finally, the OIG compiled the COMPSTAT data for the number of inmate disciplinary actions for specific violent offenses[20] issued at each institution.[21] Unfortunately, CDCR's COMPSTAT data is not broken down by individual facility within a prison, so the OIG is unable to compare individual SNYs within a prison to GP or other yards. However, as indicated in the following table, institutions housing SNY inmates (highlighted in green) have violence prevalence similar to institutions housing GP inmates.

[18] COMPSTAT data can be found at www.cdcr.ca.gov
[19] See Appendices H and I for number of incidents and disciplinary actions.
[20] The violent offenses included: assault on staff, battery on staff, assault on inmate, battery on inmate, attempted murder, and murder.
[21] Data was unavailable for the California Health Care Facility and the California City Correctional Facility. Additionally, there are no SNYs at female institutions.

Inmate Disciplinary Actions (115's) for Specific Violent Acts, June 2014 through June 2015

Institution	Total 115s for Violent Acts	Monthly average	June 2015 Inmate Count	June 2015 SNY Pop	All Levels	SNY Levels	Mission
WSP	672	51.69	4881	N/A	I, III, RC	N/A	RC
NKSP	612	47.08	4365	N/A	I, III, RC	N/A	RC
SAC	572	44.00	2319	N/A	I, IV, PSU, SHU	N/A	HS
LAC	562	43.23	3494	896	I, III, IV	IV	HS
SOL	430	33.08	3866	N/A	II, III	N/A	GP
CAL	420	32.31	3774	922	I, IV	IV	GP
CCI	326	25.08	3931	3186	I, II, III, IV, SHU	I, II, III, IV	HS
HDSP	324	24.92	3300	1009	I, III, IV	III, IV	HS
SVSP	323	24.85	3678	1468	I, III, IV	III, IV	HS
SATF	318	24.46	5581	3156	II, III, IV	II, III, IV	HS
COR	287	22.08	4405	1850	I, III, IV, SHU, PHU	III, IV	HS
KVSP	286	22	3638	1578	I, IV, THU	IV	HS
DVI	235	18.08	2117	N/A	I, II, RC	N/A	RC
SCC	222	17.08	4345	788	I, II, III	III	RC
CCC	212	16.31	4089	N/A	I, II, III	N/A	RC
PVSP	209	16.08	2271	1274	I, III	III	GP
CMF	184	14.5	2269	N/A	I, II, III	N/A	FOPS
PBSP	177	13.62	2742	N/A	I, IV, PSU, SHU	N/A	HS
CEN	173	13.31	3489	871	I, III, IV	III	GP
CIM	173	13.31	3802	1810	I, II, RC	II	RC
MCSP	165	12.69	2941	2778	I, III, IV	I, III, IV	GP
CMC	154	11.85	3809	N/A	I, II, III	N/A	RC
ISP	154	11.85	3401	1561	I, III	I, III	GP
RJD	142	10.92	3148	2118	I, III, IV	III, IV	RC
SQ	121	9.31	3687	N/A	II, RC	N/A	RC
FSP	114	8.7	2876	N/A	I, II, FWF	N/A	FOPS
ASP	112	8.62	2766	2324	II	II	GP
CRC	89	6.85	2434	784	II	II	RC
VSP	79	6.08	3379	3326	II	II	GP
CTF	72	5.54	5167	2668	I, II	II	GP
CVSP	50	3.85	2264	1178	I, II	I, II	GP

Also indicative of the increased violence in SNYs is the proportion of inmate homicides that occur involving victims assigned to SNY housing. In the OIG's October 2014 Semi-Annual Report, Volume II, it reported on the homicides that took place on sensitive needs yards. Of the 11 inmate-on-inmate homicides reported, 10 occurred on Level IV sensitive

needs yards, 8 of which were in-cell homicides. In addition to the 11 homicides, another case reported was an in-cell great bodily injury case that also occurred on an SNY facility, but did not result in death.

In addition to the cases noted above, a 2012 SNY homicide at HDSP involved an inmate strangling his cellmate to death in their cell. The aggressor was convicted for murder and the victim for multiple violent sex offenses. The aggressor had been placed on the sensitive needs facility because he had been attacked during intake, upon his arrival at HDSP. The question later arose as to why a violent murderer had been celled together with a sex offender. Subsequent investigation determined that CDCR has no policies requiring an analysis of housing compatibility on sensitive needs yards.

Also at HDSP, a 2013 SNY homicide involved an inmate with a history of in-cell violence strangling his cellmate to death in their cell. The aggressor was convicted for murder and rape in 1994 and the victim for sex offenses against minors in 2011. They had only been celled together for 16 days.

In the OIG's assessments of these events, it became clear that there are steps that the department can take to lessen such risks. The assumption that placement in SNY housing includes an implied agreement by SNY inmates to co-exist peacefully is no longer a viable premise, especially in light of the fact that CDCR staff no longer wait for an inmate to volunteer before designating him for SNY housing. CDCR does not complete a double-cell housing compatibility review form for SNY inmates. This form is intended to ensure that inmates are properly placed with compatible cellmates and that potential cellmates are given the opportunity to document their agreement to house together or expose reasons why they should not be housed together. Similar forms are not used on GP yards either, but the inherent volatility created by mixing a sex offender and violent gang member (albeit a dropout) does not typically exist on a GP yard.

The OIG further determined that the department's policy for changing an inmate from single-cell to double-cell status is insufficient. The policy states in part*: A classification committee may consider whether an inmate with single-cell designation has since proven capable of being double-celled.* The policy does not provide specific guidelines or examples of how an inmate that previously assaulted cellmates can prove capable of transitioning back to double-cell status. As a result of these findings, in the OIG's October 2014 Semi-Annual Report, Volume II, the OIG issued CDCR the following recommendations:

- Institute compatibility guidelines requiring the completion of *CDCR Form 1882-A, General Population Double Cell Review* and completion of the *CDCR Form 1882-B, Administrative Segregation Unit/Security Housing Unit Double-Cell Review* to help ensure that inmates are properly housed with compatible cellmates.
- Require potential cellmates to document their agreement to house together.
- Provide clear guidelines for transitioning single-cell designated inmates to double-cell status on SNY facilities.

- Require that SNY inmates' central files be reviewed for propensity for violence and prior assaultive behavior before double-celling, or at least prior to placement with a vulnerable cellmate (part of the *CDCR Form 1882-A* process).

The department initially declined to implement any of these recommendations, but later agreed to develop a classification system to identify inmates that are at risk of being assaulted and to identify inmates that are likely to assault other inmates. With this new system, CDCR hopes to ensure inmates from these two groups are not celled together. The new classification system is expected to be implemented in early 2016.

Finally, as heard repeatedly in interviews with former HDSP staff, the lack of quality programs at HDSP is a factor leading to inmates having nothing to do and causing tensions to rise. As stated earlier in this report, one way to mitigate criminality and violence is to increase program opportunities for the inmate population.

RECOMMENDATIONS TO CDCR

- Address the growing violence on sensitive needs yards by:
  - developing formal policies and procedures related to SNY housing;
  - considering the development of separate SNY housing criteria for vulnerable inmates at risk of assault;
  - transferring aggressors to some other type of housing;
  - re-examining the double cell policy for sensitive needs yards pursuant to previous OIG recommendations;
  - requiring completion of a compatibility review, similar to the *CDCR Form 1882-B*, *Administrative Segregation Unit/Security Housing Unit Double Cell Review*; and
  - reviewing the process for transitioning inmates from single-cell designation to double-cell status, pursuant to prior OIG recommendations.

- Add more meaningful programs to sensitive needs yards, especially Level IV SNYs such as HDSP's Facility B, where programs have been historically lacking.

- Ensure that classification staff designating inmates as requiring SNY placement, inform inmates that SNYs are still violent, have programming no different from GP yards, and once assigned to an SNY, it is very difficult to ever return to a general population yard.

- Require training for SNY staff in supervising vulnerable populations.

- Require racial balance criteria for inmate program assignments in SNY housing, at least at HDSP (similar to general population facilities), to overcome the perception of racial bias.

INMATE APPEALS AND STAFF COMPLAINTS

APPEAL COLLECTION AND PROCESSING

The OIG reviewed dozens of complaints, filed by both inmates and staff, related to the processing of inmate appeals. Some of the allegations included:

- Appeals were being destroyed or discarded, never being delivered to the Appeals Office.
- Appeals were being read by officers, and if the appeal contained a complaint against staff, the inmate was subjected to retaliation or the appeal was destroyed.
- Staff complaints were never addressed.
- Appeals were being shredded by Appeals Office staff.

As referenced earlier, the OIG published a review in September 2011 of CDCR's inmate appeals process, finding the process does not provide enough accountability to address inmate allegations that appeals are subject to intentional destruction or negligence. In response to OIG recommendations, the department issued a December 30, 2011, directive to all institutions, which, among other mandates, included the following:

- A secure appeals lock box is required on every yard and in each building, retrieval from which shall only be done by Appeals Office staff and/or staff designated by the warden.
- Reading or inspecting the contents of appeals by anyone outside of Appeals Office staff is prohibited.

At HDSP, neither of these directives were implemented. The OIG's review found that the first watch program sergeant is delegated the responsibility for collecting appeals from the lock boxes and delivering them to the Appeals Office. The key to each lock box is on each program sergeant's key ring, which is passed from the first watch sergeant to the second watch sergeant to the third watch sergeant. This of course means that throughout the course of any given day, many different people have access to read, tamper with, or destroy inmate appeals.

Appeals may also be submitted through the mail. All inmate mail not marked as legal mail, including inmate appeals, is opened, read, and examined for contraband by HDSP officers. As an aside, department managers were unable to explain why a letter addressed to the Appeals Office within the prison needed to be opened and examined for contraband. Once read and examined, instead of routing the appeals directly to the Appeals Office, officers were placing the mail into a mailbag for delivery to the mailroom, where it would once again be subject to review by mailroom staff, before finally arriving at the Appeals Office.

Additionally, inmates housed in the administrative segregation unit or on modified program during a lockdown, cannot personally deposit their appeals in a lock box in any institution. In these situations, the same staff who provide day-to-day supervision of the inmates in their assigned housing units personally collect the appeals from the inmates' cells and are then supposed to deposit them into the lock box on the inmates' behalf. HDSP's appeals collection process allows inmate appeals to pass directly through the hands of those who might have an interest in the complaint, whether that be the officer being accused of misconduct, that officer's friend (or quite possibly neighbor), or a supervisor who may be friends with the accused officer. This process decreases individual accountability and thwarts HDSP's ability to determine who is responsible if the appeals lock box has been tampered with or if an inmate's appeal goes missing.

As reported above, in 2011, the OIG found that the appeal process lacks an accountable means of verifying that appeals are made and lacks an accountable means of delivering appeals. The report recommended CDCR add a receipt feature to its appeal form so that appeals could be tracked; allow inmates to make copies of their appeals; and implement accountability measures, such as requiring Appeals Office staff to directly collect inmate appeals instead of custody staff.

The OIG reiterates its recommendations from its 2011 report, and in addition, the department must address the issue of inmates in ASU or on a modified program during lockdown who are unable to personally place their appeal into a lock box. This can be remedied by mandating Appeals Office staff personally retrieve the appeal from the inmates' cells or instituting some form of secure mobile collection process.

VOLUME OF APPEALS AT HDSP

During the 18-month period of January 1, 2014 through June 30, 2015, the HDSP Appeals Office logged 5,711 appeals. The following table indicates property complaints are overwhelmingly the most appealed issue, at more than double the amount of the next highest appeal category. Although the topic of lost or destroyed inmate property is not the focus of this review, the sheer volume of property appeals should signal to HDSP management that there are systemic issues related to its handling of inmate property that need to be addressed.

During interviews of inmates and parolees formerly assigned to HDSP, a few stated that staff would take an inmate's property and give it to another inmate in exchange for a favor. One inmate mentioned a particular staff member who was known for giving confiscated inmate property to other inmates as a reward for assaulting inmates. Another inmate said that he had seen staff take property from inmates involved in assaults, place the property on a table, and later allow other inmates to take it.

The OIG found during the course of its review that staff do not always have a clear understanding of the policies and procedures related to the processing and handling of property. In addition, the OIG is currently monitoring an internal affairs investigation related to allegations of officers tampering with inmate property as a ruse to confiscate the property. The OIG will report on the outcome of the case at the conclusion of the investigation.

HDSP Appeals January 2014 – June 2015

Facility	Appeals
HDSP-A	1246
HDSP-ASU	396
HDSP-B	1136
HDSP-C	1127
HDSP-D	1229
HDSP-E (MSF)	42
HDSP-H (CTC)	80
HDSP-Other	455
Grand Total	5711

Appeal Issue	Appeals
PROPERTY	1539
CUSTODY/CLASS.	580
DISCIPLINARY	510
ADA	412
LEGAL	410
STAFF COMPLAINTS	384
LIVING CONDITIONS	318
FUNDS	305
WORK INCENTIVE	256
MAIL	253
CASE RECORDS	228
PROGRAM	220
TRANSFER	148
VISITING	58
MEDICAL	43
SEGREGATION	39
RE-ENTRY/PAROLE	8
Grand Total	5711

In addition to the appeals above, during this same timeframe, over 2,000 health care related appeals were responded to by HDSP's health care services department. The most appealed health care issues were related to medication, disagreements regarding treatment decisions, issues related to reasonable accommodations for ADA inmates, access to care, referrals, and issues related to reasonable accommodation medical devices. Unlike regular appeals, which are stored in an inmate's electronic file, health-care-related appeals, due to HIPAA laws, are kept in the Health Care Appeals Tracking System. If a health care appeal is received in the Inmate Appeals Office by mistake, it is re-routed to the Health Care Appeals Office for response.

STAFF COMPLAINTS

When an inmate wants to file a complaint against a staff person, it is handled by Appeals Office staff in a manner similar to a regular appeal, with a few exceptions. The policy for processing a staff complaint can be found in CCR, Title 15, Section 3084.9(i), titled *Exceptions to the Regular Appeal Process*. Basically, the policy requires the inmate alleging staff misconduct by a departmental employee to forward the appeal to the appeals coordinator who in turn must forward it to the hiring authority (at a level not below chief deputy warden) with a recommendation on whether to process as a regular appeal or handle as a staff complaint.

If the hiring authority determines it should not be handled as a routine appeal, the hiring authority has the following options:

(1) If the hiring authority determines the alleged conduct would likely lead to adverse personnel action, the case will be referred for an internal affairs investigation by CDCR's Office of Internal Affairs.

(2) If the hiring authority determines the alleged conduct does not warrant a request for an internal affairs investigation, a confidential inquiry shall be completed by whomever at the prison the hiring authority designates.

The staff complaint process can be very frustrating for the appellant inmate, as the confidential nature of the proceedings give little feedback to the inmate. The inmate is only informed whether or not the complaint is being referred for an investigation or confidential inquiry and then the final outcome of the investigation or inquiry. The inmate does not receive a copy of the confidential report; however, the accused staff may review the confidential report in the Appeals Office upon approval of the prison's litigation coordinator.

The OIG reviewed the HDSP logs for staff complaints filed at HDSP from January 1, 2014, through June 30, 2015. The OIG found that of the 807 staff complaints filed, only 282 were referred for investigation. This is not uncommon in CDCR, as individual staff complaint determinations tend to come down to the inmate's word versus the word of staff, and allegations of misconduct can be difficult to prove.

HDSP Staff Complaints - January 1, 2014 - August 18, 2015	
807	Total number of staff complaints processed by the HDSP Appeals Office.
34	Cancelled. Usually due to the issues being identified as duplicative of another appeal.
491	Processed as a routine appeal after being deemed not to meet the criteria for assignment as a staff complaint.
267	Processed as a staff complaint. Referred to an Associate Warden for inquiry, due to adverse action being unlikely.
5	Referred to HDSP's Investigative Services Unit for an allegation review to gather additional information.
10	Referred to CDCR's Office of Internal Affairs for investigation, based on a reasonable belief that misconduct occurred.

As illustrated in the table above, in all but ten of the HDSP staff complaints, the hiring authority decided to handle the complaints internally. Only about one percent of all the staff complaints filed were ever reviewed by anyone outside of HDSP. Additionally, in one of the ten cases where HDSP reported it had been referred for an outside investigation, there is no evidence that the complaint ever actually left the institution.

The OIG noted that there were several staff who had multiple staff complaints filed against them from several different inmates. The alarming number of complaints should have triggered HDSP management staff to look more closely at the totality of the

circumstances surrounding the complaints, such as deficiencies in supervision; however, management never correlated multiple complaints against officers.

HDSP is not consistently logging its allegations of misconduct, which is required by DOM Section 31140.13; therefore, it cannot accurately track the status of complaints referred for inquiry or investigation, nor can it easily recognize potential areas of concern related to allegations being lodged repeatedly against the same staff or in the same work area.

DISINCENTIVES TO FILING STAFF COMPLAINTS

The appeal collection process places inmate appeals directly in the hands of the officers being accused of misconduct. This creates a significant disincentive for inmates to file appeals; knowing that the officers they are accusing of misconduct will be handling or reading the appeals will likely dissuade an inmate from filing a complaint. When an inmate does file a complaint against staff, the inmate is often placed in administrative segregation for their own "protection," which is yet another disincentive.

However, even if the appeals collection process is changed in a manner that precludes custody staff from reading or handling inmate appeals, the CCPOA MOU contains a provision that mandates that officers who are accused of misconduct by inmates be immediately notified of the contents of all inmate complaints filed against them. Section 9.09 of the Bargaining Unit 6 MOU states:

> (D) Whenever a ward/inmate/parolee/patient files or submits a grievance, a 602 (Inmate Appeal), any written complaint, or verbal complaint which is later reduced to writing by either the inmate or the State, which, if found true, could result in adverse action against the employee or contain a threat against the employee, the Department agrees to immediately notice the employee of said filing. The State agrees to provide the affected employee a copy of said document if the employee so requests. This is not intended to preclude the informal level response procedure in the current CDCR Operations Manual. Upon the employee's request, a copy of the outcome of the ward/inmate/parolee/patient's complaint shall be provided, if the complaint has progressed beyond the informal stage. The Employer and CCPOA agree that all video tapes, audio tapes or any other kind of memorialization of an inmate/ward/parolee/patient statement or complaint shall be treated as a writing within the meaning of this subsection. The tapes or writings shall be turned over, regardless of whether the complaint/statement is deemed inmate/ward/ parolee/patient initiated or not.

The department's appeal process fails to protect the identity of the inmate accusing an officer of misconduct and unjustifiably exposes the inmate to retaliation for filing a complaint. The appeal process is the inmate's main avenue for resolving issues and the OIG was repeatedly informed that inmates choose to no longer file appeals for fear of

reprisal. CDCR's own peer review found additional deficiencies in HDSP's appeal processing.

CDCR's headquarters Appeals Office has responsibility for ensuring institutions have the necessary training and assistance needed relative to the appeal system; conducting audits of appeals units; and meeting with CDCR administrators to review policy and procedure needs as revealed by inmate appeals. It does not appear that the headquarters Appeals Office has done any of these related to High Desert State Prison, which could greatly benefit from oversight, training, and assistance.

RECOMMENDATIONS TO CDCR

- Create a formal policy that reflects the contents of the December 30, 2011, memo titled: ***Secure Appeal Collection Sites and Related Matters***, but require appeals in lock boxes be retrieved by Appeals Office staff only.
- Add a receipt feature to the *CDCR Form 602, Inmate/Parolee Appeal*, or assign a log number to all appeals at the point of collection.
- Immediately reiterate that initial appeal content is to be read by Appeals Office staff only, until assigned out for response.
- Provide HDSP staff with training relating to the processing and handling of inmate property and hold officers accountable for failing to abide by the relevant policies and procedures.
- Require institutions to conduct a management review into an employee's performance and worksite when multiple staff complaints are filed by multiple inmates against an individual employee.
- Revisit DOM Section 31140.14, and develop a procedure to ensure staff completing allegation inquiries have received approved internal affairs investigation training, prior to being designated and/or approved by CDCR's OIA or OIA investigators.
- Require staff performing allegation inquiries into staff complaints receive formal internal affairs investigations training prior to conducting allegation inquiries.
- Ensure hiring authorities and managers reviewing allegation inquiry reports are trained to recognize complete, thorough, and adequate allegation inquiry reports.
- Develop an accountability process for ensuring hiring authorities are keeping accurate and complete *CDCR Form 2140*, *Internal Affairs Allegation Logs*, in accordance with DOM Section 31140.13, which requires each allegation of employee misconduct be logged, regardless of whether the allegation is referred for investigation.
- Renegotiate Section 9.09 of the Bargaining Unit 6 MOU to treat inmate appeals in the same manner as any other allegation of staff misconduct.

- Remedy the inability of inmates in ASU or on a modified program to personally place their appeal into a lock box, by mandating Appeals Office staff personally retrieve the appeal from the inmates' cells or instituting some form of secure mobile collection process.
- Dispatch staff from the Appeals Office to conduct an in-depth audit of HDSP's appeal process, provide any remedial training necessary, and report back to CDCR administrators any policy or procedure deficiencies revealed by a review of HDSP inmate appeals, such as property issues and the handling of staff complaints.

USE OF FORCE INCIDENTS

HDSP USE OF FORCE FREQUENCY

As part of this review of High Desert State Prison, the Senate Committee specifically requested the OIG review practices related to excessive use of force against inmates, internal reviews of incidents involving excessive use of force against inmates, and protection of inmates from assault and harm by others.

The OIG analyzed and compared a variety of use of force documents and data points, spanning, unless otherwise noted, the 18-month period of January 1, 2014, through June 30, 2015. This included several dozen use-of-force incident packages, staff complaints alleging excessive or unnecessary use of force, disciplinary logs and rules violation reports, confidential inmate files related to force allegations, complaints filed directly with outside stakeholders, and internal affairs investigations. In addition, the OIG interviewed several inmates formerly housed at HDSP.

From the data gathered by the OIG, it developed the following tables to get a snapshot of how HDSP compares to other similar facilities, and how the facilities within HDSP compared to each other.

The table below compares the total number of incidents to the total number of incidents involving use of force, and the percentage of incidents involving use of force, that occurred on Level IV SNY facilities.

Incident Data, Level IV SNY Facilities[22]

Facility	Total # of Incidents	Total # of Incidents Involving Use of Force	Percent of Incidents Involving Use of Force
HDSP-B	227	173	76%
CAL-D	91	49	54%
COR-03B	343	176	51%
KVSP-C	226	118	52%
KVSP-D	204	141	69%
LAC-C	217	134	62%
MCSP-A	334	214	64%
RJD-C	209	98	47%
SATF-D	128	80	63%

[22] SVSP and CCI also have a Level IV SNY; however, they went through their conversions during this timeframe, so comparable data was not available.

This data demonstrates that HDSP's Level IV SNY Facility B had the highest percentage of incidents involving the use of force, compared to other Level IV SNY facilities.

The next table compares the number of inmate disciplinary actions for a variety of serious or violent offenses to the total number of all inmate disciplinary actions, for each yard at HDSP.

HDSP Inmate Disciplinary Actions

Inmate Disciplinary Actions January 1, 2014-July 31, 2015	HDSP-A	HDSP-B (SNY)	HDSP-C	HDSP-D
Inmate Disciplinary Actions for Serious or Violent Offenses	337	805	354	387
All Inmate Disciplinary Actions	643	1076	486	548
Percent of Disciplinary Actions for Serious or Violent Offenses	52%	75%	73%	71%

This data demonstrates that a significantly higher number of disciplinary actions occurred on Facility B, with a higher percentage involving serious or violent offenses, compared to the other HDSP facilities.

In addition to reviewing incident data, the OIG has been reviewing every use of force incident package and attending every Institutional Executive Review Committee[23] (IERC) meeting since March 2015,[24] where the warden and executive staff review every use of force incident package. Reviews conducted by the OIG find that the majority of the incident packages and staff reports are thorough and the IERC conducts a fair review. It should be noted that IERC reviews are only as thorough as the reports available for review. If fights are instigated or staff are not fully reporting the force used, this will not be apparent in the reports. Additionally, unlike institutions with yard cameras, staff reports are the only source of information related to HDSP use-of-force incidents for the IERC to review.

In the OIG's 2012 report related to sex offender abuses at High Desert State Prison, some of the officers interviewed indicated that they believed there were officers at HDSP who would provoke inmates into physical altercations to necessitate the use-of-force. The inmate interviews conducted by the OIG are consistent with the picture the data paints of High Desert State Prison as an institution with a high level of violence. The interviews are also consistent with inmate complaints the OIG read in appeals and also in letters written to the OIG and received from outside stakeholders.

[23] IERC requirements can be found in CCR, Title 15, Section 3268, Use of Force.
[24] Prior to March 2015, the OIG would attend at least one IERC meeting at HDSP per month.

The following excerpts are summarized from individual inmate interviews, conducted separately over the course of this review:

.. officers are slow to respond to incidents.

.. always concerned that an incident could erupt at any time.

.. had safety concerns due to his commitment offense.

.. officers at times were slow to respond during riots.

.. felt less safe than other prisons.

.. an officer sent an inmate to attack him, and then the officer and his buddies sat and watched.

.. constantly afraid at HDSP, and had never been afraid at any other prison. It was the officers he was afraid of, and not the inmates.

Additionally, the OIG was told that staff who had previously worked at HDSP and then transferred to CCC were heavy-handed and quicker to "jump" to using force.

The OIG is also currently monitoring a number of internal affairs investigations related to excessive or unnecessary force which are detailed in the ***Internal Affairs Investigations*** portion of this report. The OIG will report on the outcome of these cases at the conclusion of the investigations. All of these incidents currently being monitored allegedly occurred between October 2014 and September 2015.

With an appeals process that is fatally flawed and a staff complaint process that results in only about one percent of complaints getting referred for an outside investigation, coupled with staff's unwillingness to report misconduct for fear of reprisal, it is very difficult to prove excessive or unnecessary use of force. However, inmates continue to utilize all available avenues to report alleged abuses, including writing letters to the CDCR Ombudsman, the OIG, the Prison Law Office, the Legislature, and the Governor. Until the department takes steps to address these issues, outside stakeholders will continue to place a heightened level of scrutiny on HDSP.

The Need For Cameras in All Inmate Areas

In the OIG's September 2015 Semi-Annual Report, it was noted that one area where the department agrees but has yet been unable to address, is the placement of cameras on all yards and in all housing units. Such surveillance is invaluable in capturing misconduct, documenting inmate activity, and exonerating employees who have been wrongly accused of misconduct. The OIG monitors all incidents involving the use of deadly force, as well as incidents involving lesser force that may not have complied with departmental policy. Often times there are conflicting accounts of what transpired, making it difficult

to assess whether the force used complied with policy. High quality visual recordings of incidents can serve to resolve these conflicting accounts. In addition, there are many rule violations and crimes inmates commit that visual recordings could memorialize for just resolution. However, most institutions still lack cameras, including HDSP.

Installing cameras at High Desert State Prison should be the department's number one fiscal priority. Allegations of excessive and unnecessary use of force, inmate abuse, and staff misconduct have been relentlessly lodged at HDSP for years, and with evidence of lax supervision and sustained cases of officers failing to report use of force that they observed, cameras are the absolute best tool for CDCR to curtail misconduct and exonerate staff falsely accused of using unnecessary or excessive force.

When deciding on a camera system to install, the OIG recommends that the department look to the system installed at the California Health Care Facility or the California City Correctional Facility, and ensure the cameras are installed in all inmate areas.

The Need to Pilot a Program Using Body Cameras

In addition to installing cameras in all inmate areas, CDCR should pilot a program similar to the program piloted by the Wisconsin Department of Corrections (WDOC). According to the WDOC, it partnered with a company known as Taser International to conduct a pilot program using body cameras in its Waupun Correctional Institution (WCI). The pilot was designed to enhance staff professionalism, reduce sexual assault allegations, staff assaults, inmate complaints regarding staff, and use of force incidents. At the conclusion of the pilot, WCI found that there was a reduction in the number of use of force incidents; however, PREA allegations and inmate complaints remained consistent.

WCI found the body cameras to be very effective for interactions at cell doors and when speaking to inmates. They were not effective while escorting inmates; however, the audio provided perspective as to what was taking place.

In the beginning of the pilot, WDOC reported that staff were apprehensive about wearing the cameras, while the inmate population appeared to be playing to the camera, attempting to provoke an unprofessional response from staff. Training regarding professional communication skills was conducted with all staff involved in the pilot and after a couple of weeks, staff were comfortable wearing the cameras and the inmates had adjusted as well. The pilot showed that the cameras enhanced the professionalism of staff and how they communicated with inmates.

Although the number of complaints and PREA allegations did not decrease during the pilot, the camera footage made it easier to review the allegations and determine if an incident occurred. The use of body cameras by police departments has also had a positive

impact of enhanced officer safety and reduced liability, and as the WDOC pilot shows, it appears that similar benefits can also be achieved within correctional settings.[25]

In piloting the use of body cameras, the OIG recommends that CDCR choose at least one building on HDSP Level IV SNY facility. This will enable the department to compare incident and disciplinary data, among other things, to other buildings housing similar inmates. The OIG further recommends that the body cameras be equipped with GPS (global positioning satellite) geotagging technology, which is a common feature in body cameras. This feature could be important to determine the location of staff during incidents at any particular point in time, improving officer safety and possibly disproving staff misconduct allegations.

Allegations That Staff Are Slow to Respond to Incidents

Although the earlier table shows that HDSP has a high percentage of incidents involving the use of force, several inmates previously housed at HDSP said that staff would pick and choose which incidents to respond to with force. Inmates stated officers were sometimes deliberately slow to respond to incidents and intervene when inmates assaulted one another. Two recent incidents occurred at HDSP, where staff reports suggest a delayed response and failure to use force when it appears force was necessary to stop serious injuries to the victims from multiple attackers. The details of these incidents are as follows:

> Staff observed three inmates attacking another inmate on the yard by punching the victim with their fists. One officer reported that it took ten minutes before the inmates finally complied with staffs' orders to get down into a prone position. As staff finally approached the incident, the combatants ceased their attack. Staff reports state that the victim lost consciousness during the incident and was transported to an outside hospital for serious bodily injuries, including a broken nose, broken orbital socket, and stitches to his left eye. Force was not used to stop the attack.
>
> Staff observed four inmates attacking another inmate on the yard by punching the victim with their fists, while one of them stabbed the victim multiple times with an inmate manufactured weapon. Staff reports state that staff gave multiple orders for the inmates to get down, but the combatants continued their assault. As staff finally approached, the combatants ceased their attack. Staff reports state that the victim was transported to an outside hospital for serious bodily injuries, including more than 30 lacerations and puncture wounds to his face, neck, stomach, head, and back areas. Force was not used to stop the attack.

Allegations that officers are slow to respond to incidents are exceedingly difficult to adjudicate. There is no system currently in use that documents where officers are within

[25] A copy of WDOC's pilot report at WCI can be found in the Appendix J.

the prison. One solution would be to use GPS or RFID (radio frequency identification) type tags to document where officers are in the prison. Not only would these types of allegations be easy to resolve, but the use of this type of technology would be a significant enhancement to the safety and security of the individual officers. No officer could ever be isolated without someone knowing their location.

RECOMMENDATIONS TO CDCR

- Immediately install cameras in all inmate areas, including, but not limited to, the exercise yards, rotundas, building dayrooms, patios, and program offices of HDSP.

- Implement a pilot program in at least one building on HDSP's Level IV SNY facility, requiring custody staff to wear body cameras, similar to the pilot conducted at Wisconsin's Waupun Correctional Institution. Ensure the body cameras are equipped with GPS geotagging technology. Collect, compare, and report the resulting incident, disciplinary, and other relevant data for the buildings with body cameras and the similar buildings without body cameras, for possible statewide pilot program expansion.

- Ensure that HDSP custody supervisors are scrutinizing all incidents where inmates receive serious injuries, and hold accountable officers who fail to timely respond to incidents and fail to use force when appropriate to stop potential deadly attacks.

- Consider using GPS or RFID type technology to document where within an institution an officer is located.

ARMSTRONG REMEDIAL PLAN – ADA INMATES

DISABILITY PLACEMENT PROGRAM

In 1994, a class action lawsuit (known as *Armstrong*) was brought against the department under the Americans with Disabilities Act and the Rehabilitation Act on behalf of inmates and parolees with disabilities. The resulting court-ordered *Armstrong* Remedial Plan[26] is the department's framework for ensuring inmates are not excluded from programs, services, or activities, and are not discriminated against, due to a disability.

The Disability Placement Program (DPP) is the department's set of plans, policies, and procedures related to *Armstrong*. Inmates with permanent mobility, hearing, vision, and speech impairments, or other disability or compound conditions severe enough to require special housing and programming, are to be placed in a designated DPP facility. HDSP has been a designated DPP facility since at least 1997. Inmates with a permanent impairment of lesser severity may be assigned to any of the department's institutions consistent with their existing classification factors.

The number of DPP inmates at any institution varies from day to day. In October 2015, of the more than 3,000 inmates housed at HDSP, approximately five percent (165) were DPP inmates, who were housed on various yards throughout the institution based on their classification factors.

HDSP DPP Inmates	
Mobility Impaired (not impacting placement)	58
Full Time Wheelchair User	30
Hearing Impaired (not impacting placement)	28
Mobility Impaired	19
Intermittent Wheelchair User	17
Vision Impaired	10
Hearing Impaired	3
Total DPP Inmates[27]	165

At the designated facilities, the department is required to provide reasonable accommodations or modifications for known physical or mental disabilities of qualified inmates. Examples of reasonable accommodations include: special equipment (such as

[26] A copy of the Plan can be found on CDCR's website, at: www.cdcr.ca.gov
[27] In addition, 19 of the 165 DPP inmates also had a secondary disability.

readers, sound amplification devices, or Braille materials), inmate or staff assistance, bilingual or qualified sign language interpreters, modified work or program schedules, or grab bars installed for mobility impaired inmates who require such.

Ultimately, when an inmate requests a durable medical device or an accommodation, custody staff must initially provide the device or accommodation to the inmate and then refer the inmate to a physician to determine whether the accommodation or device is needed for the disability. Custody staff does not have the authority to deny an accommodation or medical device unless there is a demonstrated security concern.

CALLOUS TREATMENT OF DPP INMATES

During the OIG's review, allegations surfaced that staff callously disregarded an inmate's claimed disability and that a general culture of indifference to the plight of severely disabled inmates exists at HDSP. The OIG is currently monitoring three investigations that illustrate this culture of indifference. HDSP referred one of these investigations on its own; the other two cases would not have been referred for investigation, but for this review.

Case Number 1

In this case, an inmate who had mobility impairment was virtually ignored by staff for hours. The *Armstrong* issues arose after a use-of-force incident. The inmate, who wore a leg brace to prevent foot drop due to an injury that occurred prior to his commitment to State prison, was confronted about alleged contraband shoes that he was wearing. When he refused to voluntarily relinquish the shoes, the shoes were forcibly removed. When the shoes were removed, custody staff also confiscated his leg brace. During that incident, the inmate received a head injury and a leg injury which required him to be taken to an outside hospital for a higher level of care.

When he returned from the hospital, he was in a wheelchair and was dressed in an orange jumpsuit (the type of jumpsuit inmates wear when outside the prison). He was directed to remove the jumpsuit and to return to his housing unit to pick up his issued blue prison clothing. His wheelchair was also taken from him. He protested that, because of his injuries, he could not walk and needed the wheelchair. By this time, he was only dressed in boxer briefs. He was told by custody staff that he did not have an authorization for a wheelchair and that he needed to walk back to his housing unit to get dressed. It should be noted that prior to the altercation he did walk with a cane and with a leg brace. The inmate protested that he could not walk and needed the wheelchair and was told by custody staff "when you get tired of sitting here you will get up and walk back to your housing unit." He remained outside the housing unit for an extended period of time while custody staff simply ignored him sitting there in his boxer briefs. At some point, a lieutenant noticed him sitting there and asked him why he was simply sitting there. The inmate explained that he could not walk back to the housing unit and, at this point, the lieutenant retrieved a wheelchair and had the inmate delivered to a medical clinic.

The inmate remained in the medical clinic for several more hours, sitting in a holding cell in his boxer briefs. Again, there is no evidence that staff inquired as to what his condition was and why he was sitting there. Finally, the same lieutenant who had delivered him to the medical clinic observed him sitting there and again inquired as to why he was just sitting in the medical clinic. The inmate again informed the lieutenant that he needed help getting back to his housing unit and at that point the lieutenant made arrangements for the inmate's cellmate to take the inmate back to his housing unit in a wheelchair. After finally arriving at his cell, the inmate remained for several days without a wheelchair and was unable to participate in programming. There is no evidence that custody checked on the inmate until he was transferred to another institution several days later.

There appears to have been a complete disregard for this inmate during the hours that he was simply sitting trying to get back to his housing unit and further disregard after he was in his cell.

Case Number 2

In this case, a wheelchair-bound inmate resisted being placed in a cell, claiming that he had safety concerns with the other occupant of the cell. The officers disregarded his safety concerns and physically picked him up out of the wheelchair and threw him into the cell. The door to the cell was then closed and the wheelchair was thrown against the door, damaging the wheelchair. Neither the use of force nor the damage to the wheelchair was reported. In addition, an inmate who could not ambulate was left in the cell without his wheelchair.

Case Number 3

In this case, a hearing impaired inmate who was wearing a vest noting that he was hearing impaired was slightly injured during a use-of-force incident. The inmate was receiving a package through Receiving and Release and for reasons still not clearly understood; the inmate became upset regarding his package. There was no sign language interpreter and it does not appear that the officer ever tried to establish effective communication.

The account of what happened becomes somewhat confused at this point with officer witnesses claiming that the inmate took a bladed stance and raised his fists while inmate witnesses consistently claim that this inmate turned around to leave and was tackled from behind. What is clear is that no reasonable attempt was made to establish effective communication with an inmate who has been deaf and speechless since birth.

INTERNAL COMPLIANCE REVIEWS AND PLAINTIFF TOURS

As part of this authorized review, the OIG reviewed CDCR internal *Armstrong* compliance reviews and the reviews done by plaintiffs' counsel. The department has not done an internal compliance review since 2013, while plaintiffs' counsel has done a review within the past few months.

CDCR's 2013 internal *Armstrong* compliance review showed a decrease in compliance from the prior review done in 2011. After the 2013 compliance review, a final corrective action plan was required; however, the corrective action plan was not submitted until March 24, 2015.

In contrast, the most recent plaintiffs' counsel tour and document review at HDSP was conducted from August 18 – 21, 2015. Plaintiffs' counsel conducts yearly tours of each CDCR institution. The most recent Plaintiff *Armstrong* monitoring tour found HDSP significantly out of compliance in several areas. Many of the serious violations identified in this report have been previously identified by Plaintiffs, but never effectively addressed or remedied by the institution. The areas of noncompliance found by Plaintiffs are broadly documented in the following areas:

I. MANAGEMENT FAILURES PREVENT THE INSTITUTION FROM RECOGNIZING AND REMEDYING VIOLATIONS

Plaintiffs believe that management has not embraced the reforms mandated by the *Armstrong* remedial orders. Plaintiffs allege that prison management fails to identify or stop violations from occurring. Plaintiffs report that inmates who were interviewed have claimed that staff retaliate against prisoners who request disability accommodations. These reports have remained consistent from year to year. What is most troubling is that the department has not investigated these complaints, seemingly dismissing them because they come from inmates.

For several years, a consistent complaint has been that appeals "disappear" or "go missing." Interviews of inmates by Plaintiffs' counsel have been consistent with complaints received by the OIG about appeals that have gone missing or are not acted on. The OIG's review of the appeals system at HDSP noted that the institution is not collecting appeals as directed by a memo authored by a former Director of Adult Institutions, which directed institutions to collect appeals with personnel other than officers who may be subjects of staff complaints. HDSP tasks housing officers on first watch to collect the appeals. This practice sets the department up for allegations that officers who may be the subject of a complaint are interfering with the complaint process.

II. THE YARDS ARE INACCESSIBLE AND PRISON STAFF DO NOT BELIEVE THERE IS ANY DURABLE REMEDY

Plaintiffs allege that the paths of travel throughout the yards at HDSP are inaccessible to people with mobility and vision impairments. Cracks that appear two or three inches wide and one-half to two inches deep run throughout each of the prison yards, making the yards unsafe for prisoners with significant mobility and vision impairments. Path of travel problems throughout the yards are longstanding, and are the subject of numerous reports and appeals as documented in the Plaintiffs' March 2014 HDSP report.

There appears to be no immediate ongoing remedial plan to improve accessibility of all paved areas at the prison and at all times of year. Although CDCR expects to complete "master plan" repairs to HDSP, those repairs are not expected to begin until mid-2016.

Again, it appears that there is no management emphasis on making the yards accessible in the near term.

III. VIOLATION OF STATE MOBILITY IMPAIRED VEST POLICY

Prison staff confirmed that the policy at HDSP is to require everyone to sit down on the ground when there is an alarm – including those wearing mobility vests. This is contrary to the statewide policy stated in a February, 25, 2014, Memorandum from the Director of Adult Institutions and the Director of Health Care Operations at the California Correctional Health Care Services (CCHCS) to all wardens, which states that "inmates wearing a MI [Mobility Impaired] Vest are not required to attain a seated position" during alarms. This violation of policy is particularly concerning because the *identical* violation was identified in the Plaintiffs' March 2014 HDSP report.

IV. LACK OF EFFECTIVE INMATE DISABILITY ASSISTANT PROGRAM

The Inmate Disability Assistant Program (IDAP) is not functioning adequately at HDSP, as IDAP workers are not allowed out of their cells during their work hours unless they are specifically called by a correctional officer to provide help; IDAP workers are not trained; and IDAP workers were instructed to perform inappropriate tasks including carrying canteen items for prisoners and, more troubling, one IDAP worker was instructed to place his cellmate in waist-chain restraints.

V. FAILURE TO ACCOMMODATE PRISONERS WITH HEARING IMPAIRMENTS

Class members reported that staff failed to allow the use of telecommunication devices for the deaf (TDD) phones, failed to provide sign language interpretation, and failed to communicate alarms and announcements.

VI. OTHER CUSTODY STAFF FAILURES ALLEGED BY PLAINTIFFS' COUNSEL

Failure to maintain ADA cells in working order
There was water leaking from the ceiling in numerous wheelchair-accessible cells on facility B and the ADA staff had been unaware of these leaks until Plaintiffs raised them. If prison staff had been conducting the safety checks and ADA features checks required by the local operating procedures, staff would have identified and remedied these leaks earlier.

Failure to provide orientation materials
Numerous class members who had recently arrived to the prison reported that they had not received orientation, including information regarding the purpose of the DPP; availability of the CCRs, ARP, and similar printed materials in accessible formats; reasonable accommodations or modifications available to qualified inmates; access to readers or scribes and availability of specialized library equipment.

Lack of access to day room showers
Numerous inmates with disability placement wheelchair (DPW) status throughout B yard reported that they have difficulty accessing the ADA showers because so many non-disabled

prisoners use that shower, and because prisoners with disabilities who have mobility devices, prostheses, or incontinent supplies, often require additional time to complete their showers. This issue has been raised in numerous appeals, and in numerous prior reports.

Laundry
Incontinent prisoners throughout the institution reported to Plaintiffs' counsel that when they have accidents, they are unable to get clean clothing or laundry. That complaint has been relayed to management with no evidence of management action.

Lack of knowledge of the new durable medical equipment (DME) policy
Interviews with class members suggest that custody staff still demand Chronos for hygiene supplies, such as toilet paper. Numerous prisoners throughout the institution who are incontinent as a result of their disability also reported that they are denied access to a shower when they have an accident. The same issues were reported last year.

Failure to provide restroom accommodations in the library
Library staff confirmed that prisoners are not allowed to access restrooms while in C or D facility libraries. This poses a problem for class members who, because of their disability, are incontinent and may need immediate access to a bathroom.

Mismanagement of prisoner property
Plaintiffs received a number of complaints from class members claiming that prison staff allow other prisoners go through their personal property and, as a result, items are stolen. The OIG has also received the same type of complaints.

VII. HEALTH CARE STAFF FAILURES ALLEGED BY PLAINTIFFS' COUNSEL

Delayed provision of durable medical equipment
A number of prisoners complained of improper delays in receipt of ordered durable medical equipment. A review of the DME logs and receipts indicate additional delays.

Wheelchair repair problems
Although the local operating procedures require HDSP staff to evaluate each wheelchair each day to determine if it is in safe working order, it is apparent that this is not occurring. Nor are staff taking appropriate steps to ensure that broken wheelchairs are repaired. This same problem was reported last year.

Erroneous charges for durable medical equipment supplies
Plaintiffs identified numerous instances where class members were inappropriately charged for wheelchair gloves and hearing aid batteries.

Failure to provide needed toileting supplies
Monitors received reports that disabled inmates had not received needed toileting supplies, such as colostomy supplies, gloves, chux, tape, or bio bags.

Confusing or incomplete documentation of disabilities and failure to ensure effective communication
Plaintiffs received reports that medical staff failed to ensure effective communication with hearing impaired prisoners.

VIII. APPEALS STAFF RESPONSIBILITIES

HDSP recently implemented the Reasonable Accommodation Panel (RAP) process for addressing requests for disability accommodations and/or allegations of disability discrimination.

Inappropriately identifying requests as "non-ADA"
RAP responses continue to include language inappropriately identifying ADA accommodation requests as "non-ADA". For example; an inmate reported that R&R staff made him choose whether to transfer with his wheelchair or with his property. The RAP response inappropriately states that this issue is "non-ADA related" even though failing to transfer prisoners with their ADA assistive devices is a violation of the ADA and Remedial Plan.

Failure to identify accountability issues raised in appeals
Multiple appeals alleged *Armstrong* violations on the part of staff members were not flagged for *Armstrong* accountability investigations.

Improperly construing access issues
Plaintiffs' counsel identified a tendency on the part of the RAP to narrowly construe the definition of equal access to programs, services, and activities. For example, one inmate stated that he was in special education previously and is now "unable to focus on things or take knowledge in." He requests transfer to a prison that will help him learn properly. The RAP response form inappropriately states that "no issues were identified with access to program, services, or activities." Access should not be construed as physical access only; it also includes barriers resulting from communication and learning difficulties.

IX. ACCOUNTABILITY

This report and prior tour reports allege violations of the ADA, the *Armstrong* Remedial Plan, and *Armstrong* Court orders. Pursuant to the August 22, 2012, order, CDCR must "track any allegation that any employee of the Department of Corrections and Rehabilitation was responsible for any member of the Plaintiff class not receiving access to services, programs, activities, accommodations or assistive devices required by" the ADA, the Court's Orders, or the Remedial Plan. "All such allegations shall be tracked, even if the non-compliance was unintentional, unavoidable, done without malice, done by an unidentified actor or subsequently remedied." The order contains detailed requirements regarding the timing and content of investigations and investigation reports. Plaintiffs' counsel reviewed the CDCR and CCHCS "Employee Non-Compliance Logs" for the months of January – May 2015. Defendants recorded a total of 423 incidents during those months. Of those, investigations are still ongoing in 76 cases. Of the cases where investigations were completed, employee non-compliance was confirmed in 325 (or 77 percent of) cases. In

addition, Plaintiffs' counsel found seven allegations of non-compliance in appeals that did not appear in the logs, but should have.

DEPARTMENT RESPONSE

After the Plaintiff tour and report, the department provided a response that, for the most part, acknowledges the deficiencies found by Plaintiffs. The almost universal response by the institution management to these deficiencies is that "staff will be trained."

This response does not address the underlying concerns about why staff has not already been trained, and who is accountable for the lack of training. For example, one deficiency found in the August 2015 tour was that mobility-impaired inmates were being required by HDSP custody staff to prone out on the yard when an alarm was sounded. The directive excusing mobility impaired inmates from this requirement was published by the Director of Adult Institutions in February 2014. The underlying concern is why staff is not already trained in this area and who should be held accountable for the lack of training. Prison managers have not been held accountable for these lapses.

The above information documents a profound lack of management and custody staff emphasis on ADA issues in a facility designated to house disabled inmates. Staff is not sensitive to the needs of disabled inmates nor does staff appear to consider ADA accommodation to be an important aspect of custody duties.

The OIG's review found evidence that insensitivity to these issues still exists.

RECOMMENDATIONS TO CDCR

- Move the DPP inmates to another *Armstrong*-designated institution, if paths of travel and accessibility cannot be immediately fixed at HDSP.
- Revise the ADA tab in the SOMS computer system to:
    - Better capture details of an ADA inmate's accommodation needs. For instance, instead of only stating that an inmate has an accommodation for "shoes," insert a detailed description, or even a picture of the shoes.
    - Include a place to record the doctor's name.
    - When applicable, describe the specific restraint accommodation needed, such as "waist restraint."
- Train staff on *Armstrong* Remedial Plan and ADA requirements, document the training, and when new violations occur, hold both the offending officers and their supervisors accountable for failure to follow or enforce the training.

INTERNAL AFFAIRS INVESTIGATIONS

Over the past few years there have been a significant number of misconduct complaints levied against staff at High Desert State Prison. However, especially over the last 12 months, there have been numerous instances in which the hiring authority has failed to refer cases of serious misconduct to CDCR's Office of Internal Affairs for investigation. Additionally, a concern has arisen regarding CDCR's assignment of "resident special agents," particularly at High Desert State Prison. Resident agents are OIA special agents, but they do not work out of the Office of Internal Affairs; instead their office is located within the prison they are assigned to investigate. Thus, they are enmeshed into the culture of the prison and not in an independent office at a centralized location away from the prison, like the majority of the other OIA special agents.

HIRING AUTHORITY REFERRALS AND INTERNAL ALLEGATION INQUIRIES

DOM Chapter 3, Article 14 sets forth the department's policies regarding internal investigations. Section 31140.14 gives the hiring authority the discretion to direct "locally designated investigators approved by the OIA or OIA investigators [special agents]" to conduct an allegation inquiry when there is an allegation of misconduct, which if true could lead to adverse action, and the subject(s), allegation(s), or both are not clearly defined or more information is necessary to determine if misconduct may have occurred.

The locally designated investigator is often times a sergeant or higher ranking member of the institution's Investigative Services Unit (ISU).

The hiring authority is required to maintain a log on a *CDCR Form 2140*, of all allegations of staff misconduct, regardless of whether the allegation is referred for investigation. The log must also state whether or not an allegation inquiry is being conducted and the resulting action from the allegation inquiry (e.g., referred to OIA for investigation, processed as a *CDCR Form 602*, *Inmate/Parolee Appeal Form*, or found to not have merit).[28]

If sufficient evidence is known or obtained through an allegation inquiry to warrant an internal investigation, the hiring authority is to refer a *CDCR Form 989, Confidential Request for Internal Affairs Investigation*.[29] Upon receipt of a referral, the Office of Internal Affairs decides whether to open an investigation, refer the case to another entity for an investigation, return the case to the hiring authority without an investigation for direct disciplinary or corrective action, return the case for further inquiry, or determines that no action is necessary. Pursuant to PC Section 6133, the OIG is responsible for the

[28] DOM, Chapter 3, Article 14, Section 31140.13.
[29] DOM, Chapter 3, Article 14, Sections 31140.4.10 and 31140.4.14, and 31140.4.15.

contemporaneous public oversight of the investigations conducted by the Office of Internal Affairs and for advising the public regarding the adequacy of each investigation and whether discipline of the subject of the investigation is warranted.

During the review of HDSP, several areas of concern arose related to allegation inquiries. First, HDSP is not keeping a consistent *CDCR Form 2140, Internal Affairs Allegation Log*. This makes it very difficult for HDSP to identify staff who have repeated allegations of misconduct made against them and this lack of transparency makes it difficult to determine what action, if any, High Desert State Prison management has taken regarding specific allegations of misconduct made against HDSP staff.

Second, when allegation inquiries are conducted, one route that can be taken is to close the case, without referring the case to OIA for an investigation, if the person conducting the allegation inquiry finds that the allegation has no merit and the hiring authority agrees. Unfortunately, there actually is no process for OIA to appoint "a locally designated investigator," so the persons conducting allegation inquiries are appointed by the hiring authority with no "designation" from the Office of Internal Affairs. Additionally, there is no required training for persons conducting allegation inquiries, and there is no training for hiring authorities to recognize what is an adequate enough allegation inquiry to deem it unnecessary to refer to OIA for an investigation. Therefore, the quality of allegation inquiries varies widely, and without a consistent Allegation Log, it is difficult to determine what the hiring authority has decided to do when allegations of misconduct become known. One thing we do know for sure is that there were many allegations of staff misconduct that HDSP management chose not to refer for investigation (please refer to the following).

ALLEGATIONS OF MISCONDUCT INVOLVING HDSP STAFF

The OIG learned of several allegations of misconduct involving HDSP staff and urged both HDSP and CDCR's Office of Internal Affairs to take action. The cases described below are examples of staff misconduct allegations the HDSP hiring authority did not refer for investigation, and would not have been investigated, but for this review.

- An officer allegedly directed expletives at inmates including derogatory language and racial slurs. The officer's misconduct placed inmates and staff in a dangerous situation, and as inmates became agitated, two additional officers heard the statements and failed to report the officer's misconduct. The Office of Internal Affairs concluded its investigation and is in the process of forwarding its report and investigative materials to the hiring authority for a decision on whether or not to sustain the charges.

- An officer allegedly threatened an inmate that he would be assaulted if the inmate refused to sign a form declaring that the inmate did not have enemy concerns on the yard. The officer allegedly had the inmate assaulted by other inmates. The Office of Internal Affairs investigation is still in progress.

- An officer allegedly called an inmate a "baby killer" and disclosed the inmate's criminal history to other inmates, creating a serious security risk for the inmate. The same officer allegedly pulled an inmate's pants and underwear up to the middle of his back during a routine search. The officer also attempted to humiliate the inmate in front of others, and threatened him. In retaliation for the inmate's complaint regarding this incident, that officer and another officer allegedly conducted a search of the inmate's cell and wrote false rules violations reports against the inmate and his cellmate for possession of inmate manufactured alcohol. The second officer also allegedly falsely attested that a sergeant confirmed that alcohol was found in the cell. The sergeant allegedly neglected his duty when he signed the rules violation report before completing a review of the document. The Office of Internal Affairs concluded its investigation and is in the process of forwarding its report and investigative materials to the hiring authority for a decision on whether or not to sustain the charges.

- Officers allegedly provided confidential criminal history about an inmate to other inmates, after which the inmate was assaulted. The Office of Internal Affairs concluded its investigation and forwarded its report and investigative materials to the hiring authority for a decision on whether or not to sustain the charges.

- An officer allegedly yelled abusive comments toward an inmate and then directed the control booth officer to turn the power off on the lower tier. The control booth officer allegedly turned the power off on the lower tier, and placed the inmate in jeopardy when he announced to the other inmates that the power outage was due to the inmate. The Office of Internal Affairs concluded its investigation and is in the process of forwarding its report and investigative materials to the hiring authority for a decision on whether or not to sustain the charges.

- Two officers allegedly falsely claimed that an inmate's property had another inmate's name on it and confiscated it as contraband. An officer allegedly removed security screws from an inmate's television as a ruse to confiscate the property as contraband. The Office of Internal Affairs investigation is still in progress.

- An officer allegedly used physical force to take a hearing-impaired inmate to the ground and repeatedly slammed his head onto a concrete floor. The Office of Internal Affairs concluded its investigation and is in the process of forwarding its report and investigative materials to the hiring authority for a decision on whether or not to sustain the charges.

- A nurse issued non-standard shoes to an inmate as a medical accommodation. The shoes had a red stripe. A captain, without resolving the medical accommodation needs of the inmate, allegedly determined the shoes were contraband and ordered officers to seize the shoes from the inmate. The officers also seized a leg brace from the inmate. When the officers attempted to seize the shoes, the inmate resisted and officers used physical force and allegedly injured the inmate during

the incident. The inmate suffered an injury to his pre-existing disabled leg and a cut to his forehead necessitating medical attention at an outside hospital. When the inmate was returned to the institution the same day, officers initially refused to assist him to his cell with a wheelchair. The inmate was left to remain on a patio and then in a medical holding cell for several hours without proper attire considering the weather conditions. The Office of Internal Affairs concluded its investigation and is in the process of forwarding its report and investigative materials to the hiring authority for a decision on whether or not to sustain the charges.

- Prison officials allegedly failed to respond to safety concerns expressed by an inmate. Subsequently, the inmate was assaulted. The Office of Internal Affairs concluded its investigation and forwarded its report and investigative materials to the hiring authority for a decision on whether or not to sustain the charges.

- Two officers and a sergeant allegedly solicited an inmate to commit assaults on another inmate who had masturbated in front of a female sergeant. The Office of Internal Affairs investigation is still in progress.

- Several officers allegedly disclosed an inmate's confidential criminal history to other inmates. Subsequently, the officers allegedly approached the inmate's cell, cursed at him, discussed his case, and said that he "deserves to die." An officer then allegedly arranged for the inmate to be assaulted. The Office of Internal Affairs investigation is still in progress.

In the following instances, the hiring authority identified possible misconduct and referred the cases to the Office of Internal Affairs:

- An officer allegedly told an employee, she should join the green team, inmates are not human, and that the institution is a zoo. The officer also allegedly slammed his baton onto the counter and stated, "I have my own version of progressive discipline." The Office of Internal Affairs determined that an investigation was not necessary, as there was sufficient evidence of misconduct, and returned the case to the hiring authority to take direct action. The hiring authority imposed a salary reduction.

- An officer allegedly taunted an inmate in a mental health crisis bed, banged the door to the inmate's cell with his baton, and then covered the inmate's window with paper. The Office of Internal Affairs investigation is still in progress.

- Six officers allegedly responded to an inmate's safety concerns by physically picking him up out of his wheelchair, throwing him into a cell, and then damaging the wheelchair by throwing it against the closed cell door. The six officers also allegedly failed to report their use of force. A seventh officer who was working in the control booth in the building failed to report the force that he observed. The Office of Internal Affairs investigation is still in progress.

- An officer allegedly failed to report a second officer's use of force. During the incident, the control booth officer allegedly failed to maintain observation of the officers and inmates. The Office of Internal Affairs investigation is still in progress.

- An OIA resident agent released confidential information regarding multiple internal investigations, including information regarding a pending criminal investigation. The hiring authority demoted the special agent, who returned to his former lieutenant position at High Desert State Prison. Shortly after his return, the HDSP acting warden at the time placed him in an acting captain position.

- An employee relations officer allegedly failed to report that an OIA special agent had improperly divulged confidential information. The special agent allegedly falsely advised the employee relations officer that he had reported his misconduct to a senior special agent. The employee relations officer allegedly withheld information during an interview with the Office of Internal Affairs. The OIA concluded its investigation and the hiring authority imposed a salary reduction against the employee relations officer, who resigned before the penalty was served.

- Two non-custody staff allegedly released confidential information pertaining to the internal investigations of several employees. One of the employees was allegedly dishonest during an interview with the Office of Internal Affairs and allegedly discussed the interview with another employee after being ordered not to do so. The hiring authority sustained the allegations, dismissed the dishonest employee, and imposed a salary reduction against the other.

- An officer allegedly subjected another officer to threats and intimidation for failing to use lethal force on inmates during a prior incident when the inmates assaulted custody staff. The Office of Internal Affairs investigation is still in progress.

Several of these investigations involve allegations meriting dismissal if sustained. It should be noted that there are some officers involved in multiple cases.

OFFICE OF INTERNAL AFFAIRS RESIDENT AGENTS

CDCR's Office of Internal Affairs has started assigning "resident agents" to institutions located in hard-to-reach areas. In addition to the recent retirement of the resident agent assigned to the California Men's Colony (CMC) in San Luis Obispo, resident agents were assigned to the following institutions:

- Chuckawalla Valley State Prison – Blythe, CA
- California State Prison, Centinela – Imperial, CA
- High Desert State Prison – Susanville, CA
- California Correctional Center – Susanville, CA
- Pelican Bay State Prison – Crescent City, CA
- Salinas Valley State Prison – Soledad, CA
- San Quentin State Prison – San Quentin, CA

As part of the regular monitoring of the discipline process, the OIG has previously criticized this practice, and the OIA responded by ending the San Quentin assignment, and does not plan to assign a resident agent to CMC in San Luis Obispo. However, the others have remained in place.

Routinely, resident agents have an office physically located within the prison they are tasked with investigating. In all of the current assignments, the resident agent worked at least part of their career, if not their entire career, at one of the institutions they now "reside" at for work. While the OIG understands the department is attempting to remedy a recruiting issue, the assignment of resident agents can lead to bias or the perception of bias. In addition, the assignment of resident agents runs counter to the recently codified[30] *Madrid* mandate, which to facilitate contemporaneous oversight and transparency, requires OIG staff be physically co-located with OIA staff.

Recent events at High Desert State Prison highlight the problems that assigning a resident agent can cause, not only for the resident agent, but also for the friends and coworkers the agent encounters. As described in a previous section, a special agent assigned to HDSP was demoted after he released confidential information regarding multiple internal investigations, including information regarding a pending criminal investigation. His demotion caused him to be placed back at HDSP. Shortly thereafter, he was promoted. This leaves the perception that he was being rewarded by HDSP management for his actions as an OIA special agent, and his loyalty to HDSP.

Additionally, an officer from CCC was disciplined for receiving confidential information from the resident agent pertaining to another employee's internal investigation and then failing to report that he had received the information. Staff from HDSP released confidential information pertaining to the internal investigations of several other employees.

[30] PC Section 6133.

On a separate but similar note, the OIA routinely assigns investigations to non-resident agents at institutions where they recently worked. While special agents are required to sign a conflict of interest form, disclosing any conflict in the cases they are assigned to investigate, the Office of Internal Affairs assigns an overly narrow interpretation to the concept of a "conflict of interest." While OIA contends it can be valuable for a special agent to be familiar with a prison (in particular, its processes, layout, etc.) when conducting investigations, it is important that all possible conflicts be duly considered, as an effective investigation and employee discipline process must be free from bias or the perception of bias. OIA's conflict form requires only a self-assessment by the assigned agent with little or no additional scrutiny by a supervisor unless the agent indicates a potential conflict.

RECOMMENDATIONS TO CDCR

- Revisit DOM Section 31140.14, and develop a procedure to ensure staff completing allegation inquiries have received approved internal affairs investigation training, prior to being designated and/or approved by CDCR's OIA or OIA investigators.

- Require allegation inquiries be conducted only by staff who have received formal internal affairs investigation training.

- Ensure hiring authorities and managers reviewing allegation inquiry reports are trained to recognize a complete, thorough, and adequate allegation inquiry report.

- Develop an accountability process for ensuring hiring authorities are keeping accurate and complete *CDCR Form 2140*, *Internal Affairs Allegation Logs*, in accordance with DOM Section 31140.13.

- Cease the practice of assigning resident agents.

- Carefully review and consider conflict of interest forms completed by special agents prior to assigning investigations, especially when contemplating assigning investigations to special agents who formerly worked at the institution where the misconduct allegations arose.

FINDINGS AND RECOMMENDATIONS

FINDING 1 – ENTRENCHED CULTURE

There is evidence that a perception of insularity and indifference to inmates exists at High Desert State Prison, exacerbated by the unique geographical isolation, the high stress environment, and a labor organization that opposes oversight.

RECOMMENDATIONS TO CDCR

1.1 Infuse HDSP supervisory and management positions with culturally diverse staff who have experience working in other institutions and do not have lifelong ties to the community.

1.2 Consider rotating HDSP management staff to other institutions, similar to the rotation required for CDCR headquarters peace officer staff.

1.3 Increase the frequency at which peer reviews are conducted at HDSP.

1.4 Revise the peer review tool to include follow-up measures and tests that better assess areas that could indicate deep-seated issues, such as by adding PREA and ADA compliance components.

1.5 Increase inmate programming, especially on the SNY facilities.

1.6 Ensure inmates housed in enhanced program facilities meet the EPF participation criteria.

1.7 Ensure HDSP is following the DOM requirements related to staff in high stress assignments.

1.8 Require HDSP seek approval from the CDCR Associate Director, prior to extending staff in high stress assignments beyond the initial two years.

1.9 Seek out opportunities to partner with organizations, such as the US DOJ, to conduct research and provide training to custody staff, starting at HDSP, on how to recognize and address implicit bias.

1.10 Implement a mindfulness and wellness program that gives staff resiliency tools to cope with working in a uniquely stressful environment.

FINDING 2 – SEX OFFENDERS AND THE R SUFFIX

The R suffix has served as a bull's-eye target on some inmates at HDSP and other prisons, some of whom have never been convicted of a sex offense.

RECOMMENDATIONS TO CDCR

2.1 Develop a policy authorizing staff to access an inmate's electronic record on a need-to-know basis only. The policy should add admonishment language to the SOMS login screen, advising against misuse, and the consequence thereof.

2.2 Develop a method of tracking and recording staff access to records in SOMS and other inmate records, and periodically audit access history to identify potential misuse.

2.3 Remove the R suffix information from the SOMS header, as any staff specifically needing this information can find it on another screen.

2.4 Conduct an in-depth review of every form and document that currently requires commitment offense information and R suffix notations, and remove this requirement from all forms and documents where it no longer serves a legitimate purpose.

2.5 Consider providing inmates with only hard copies of certain portions of non-confidential documentation from SOMS or other inmate records, to exclude commitment offenses, R suffix notations, and any other information that may put an inmate at risk.

FINDING 3 – SENSITIVE NEEDS YARDS

Based upon this review and observations in prior OIG reports, the use of sensitive needs yards merits a complete overhaul.

RECOMMENDATIONS TO CDCR

3.1 Address the growing violence on sensitive needs yards by:

a) developing formal policies and procedures related to SNY housing;

b) considering the development of separate SNY housing criteria for vulnerable inmates at risk of assault;

c) transferring aggressors to some other type of housing;

d) re-examining the double cell policy for sensitive needs yards pursuant to previous OIG recommendations,

e) requiring completion of a compatibility review, similar to the *CDCR Form 1882-B*, *Administrative Segregation Unit/Security Housing Unit Double Cell Review*; and

f) reviewing the process for transitioning inmates from single-cell designation to double-cell status, pursuant to prior OIG recommendations.

3.2 Add more meaningful programs to sensitive needs yards, especially Level IV SNYs such as HDSP's Facility B, where programs have been historically lacking.

3.3 Ensure that classification staff designating inmates as requiring SNY placement, inform them that SNY yards are still violent, have programming no different from GP yards, and once assigned to an SNY, it is very difficult to ever return to a general population yard.

3.4 Require training for SNY staff in supervising vulnerable populations.

3.5 Require racial balance criteria for inmate program assignments in SNY housing, at least at HDSP, similar to general population facilities, to overcome the perception of racial bias.

FINDING 4 – INMATE APPEALS AND STAFF COMPLAINTS

The inmate appeals system at HDSP is not functioning adequately and the staff complaint process is broken.

RECOMMENDATIONS TO CDCR

4.1 Create a formal policy that reflects the contents of the December 30, 2011, memo titled: ***Secure Appeal Collection Sites and Related Matters***, but require appeals in lock boxes be retrieved by Appeals Office staff only.

4.2 Add a receipt feature to the *CDCR Form 602, Inmate/Parolee Appeal*, or assign a log number to all appeals at the point of collection.

4.3 Immediately reiterate that initial appeal content is to be read by Appeals Office staff only, until assigned out for response.

4.4 Provide HDSP staff with training relating to the processing and handling of inmate property and hold officers accountable for failing to abide by the relevant policies and procedures.

4.5 Require institutions to conduct a management review into an employee's performance and worksite when multiple staff complaints are filed by multiple inmates against an individual employee.

4.6 Revisit DOM Section 31140.14, and develop a procedure to ensure staff completing allegation inquiries have received approved internal affairs

investigation training, prior to being designated and/or approved by CDCR's OIA or OIA investigators.

4.7 Require staff performing allegation inquiries into staff complaints receive formal internal affairs investigation training prior to conducting allegation inquiries.

4.8 Ensure hiring authorities and managers reviewing allegation inquiry reports are trained to recognize complete, thorough, and adequate allegation inquiry reports.

4.9 Develop an accountability process for ensuring hiring authorities are keeping accurate and complete *CDCR Form 2140*, *Internal Affairs Allegation Logs*, in accordance with DOM Section 31140.13, which requires each allegation of employee misconduct be logged, regardless of whether the allegation is referred for investigation.

4.10 Renegotiate Section 9.09 of the Bargaining Unit 6 MOU to treat inmate appeals in the same manner as any other allegation of staff misconduct.

4.11 Remedy the inability of inmates in ASU or on a modified program to personally place their appeal into a lock box by mandating Appeals Office staff personally retrieve the appeal from the inmates' cells or instituting some form of secure mobile collection process.

4.12 Dispatch staff from the Appeals Office to conduct an in-depth audit of HDSP's appeal process, provide any remedial training necessary, and report back to CDCR administrators any policy or procedure deficiencies revealed by a review of HDSP inmate appeals, such as property issues and the handling of staff complaints.

Finding 5 – Use of Force Incidents

There are statistical trends, continued complaints, and recent misconduct allegations that cause alarm about the use of force at HDSP.

Recommendations to CDCR

5.1 Immediately install cameras in all inmate areas, including, but not limited to, the exercise yards, rotundas, building dayrooms, patios, and program offices of HDSP.

5.2 Implement a pilot program in at least one building on HDSP's Level IV SNY facility, requiring custody staff to wear body cameras, similar to the pilot conducted at Wisconsin's Waupun Correctional Institution. Ensure the body cameras are equipped with GPS geotagging technology. Collect, compare, and report the resulting incident, disciplinary, and other relevant data for the

buildings with body cameras and the similar buildings without body cameras, for possible statewide pilot program expansion.

5.3 Ensure that HDSP custody supervisors are scrutinizing all incidents where inmates receive serious injuries, and hold accountable officers who fail to timely respond to incidents and fail to use force when appropriate to stop potential deadly attacks.

5.4 Consider using GPS or RFID type technology to document where within an institution an officer is located.

FINDING 6 – *ARMSTRONG* REMEDIAL PLAN – ADA INMATES

In light of the *Armstrong* federal court's ongoing monitoring, the OIG expressly refrains from making findings in this area, and has reserved comment to those areas where OIG's review has supported the Plaintiffs' last review and the department's inadequate responses. We make the following recommendations in light of these comments.

RECOMMENDATIONS TO CDCR

6.1 Move the DPP inmates to another *Armstrong*-designated institution, if paths of travel and accessibility cannot be immediately fixed at HDSP.

6.2 Revise the ADA tab in the SOMS computer system to:

a) Better capture details of an ADA inmate's accommodation needs. For instance, instead of only stating that an inmate has an accommodation for "Shoes," insert a detailed description, or even a picture of the shoes.

b) Include a place to record the doctor's name.

c) When applicable, describe the specific restraint accommodation needed, such as "waist restraint."

6.3 Train staff on *Armstrong* Remedial Plan and ADA requirements, document the training, and when new violations occur, hold both the offending officers and their supervisors accountable for failure to follow or enforce the training.

FINDING 7 – INTERNAL AFFAIRS INVESTIGATIONS

The use of resident agents is a poor practice and should be discontinued, especially at HDSP in light of the issues that arose from the placement of a resident agent at that institution. Additionally, the processes in place for allegation inquiries at HDSP are inadequate, and could be improved statewide. The OIG is monitoring several misconduct investigations that, but for this review may not have been opened or investigated to the broadest extent appropriate.

RECOMMENDATIONS TO CDCR

7.1 Revisit DOM Section 31140.14, and develop a procedure to ensure staff completing allegation inquiries have received approved internal affairs investigation training, prior to being designated and/or approved by CDCR's OIA or OIA investigators.

7.2 Require allegation inquiries be conducted only by staff who have received formal internal affairs investigation training.

7.3 Ensure hiring authorities and managers reviewing allegation inquiry reports are trained to recognize a complete, thorough, and adequate allegation inquiry report.

7.4 Develop an accountability process for ensuring hiring authorities are keeping accurate and complete *CDCR Form 2140*, *Internal Affairs Allegation Logs*, in accordance with DOM Section 31140.13.

7.5 Cease the practice of assigning resident agents.

7.6 Carefully review and consider conflict of interest forms completed by special agents prior to assigning investigations, especially when contemplating assigning investigations to special agents who formerly worked at the institution where the misconduct allegations arose.

CONCLUSION

First, we want to note that there are dedicated, hardworking, and conscientious staff that make up the vast majority of the workforce at HDSP. They come to work every day and do the best they can in a very difficult job. However, as a famous quote states:

"*All that is necessary for the triumph of evil is that good men do nothing*."
-Edmund Burke

Many of the specific instances of misconduct and even some of the pervasive indifferent treatment of inmates can be narrowed down to a small percentage of active participants, many of whom are currently under investigation. But how is it that they have been able to continue this conduct without interference by others or management? How is it that the sister institution CCC does not have the same problems and complaints? The answers may lie in the very design and mission of HDSP and the environment in which it has been placed.

HDSP has a myriad of missions and houses the highest security level of inmates. The same is not true at CCC. Officers at HDSP are constantly on high alert, and enter the prison with an "us versus them" mindset. This translates into a culture where "if you aren't for us, you're against us." Add to that a labor organization that values the brotherhood of silence over the professionalism of its members, and you add another level of legitimacy to a negative culture. The irony is that this very culture endangers the staff working at HDSP as much as anything else. When you deprive inmates of procedural justice, and there is no recourse for mistreatment because the appeals process is broken and there is a perception that staff misconduct is not addressed, there should be no surprise that violence erupts.

Unlike any other locale, HDSP staff live in a true "prison town" where they cannot disassociate from the job. The pressure to conform to the prevailing norm is tremendous. One of the differences in a lower security prison such as CCC is that staff see the inmates trying to make a difference, and "deserving" of a chance to do so. There is less violence, more programs, less stress, and therefore not the same negative mentality.

The department could change the population of HDSP, and concede that the other forces at work prevent it from ever curing its dysfunction in the current mode. That would be the most drastic of solutions.

However, with the support of the CDCR Administration, and the right leadership from management and in the ranks, HDSP can change these perceptions, if they choose to do so. The department can implement recommendations from this review, weed out the problem individuals, and provide hope for the future.

The department is now being presented with yet another opportunity to fix the problems at HDSP that have plagued the institution for over a decade. Otherwise, this review will

have been for naught and another review will almost assuredly follow in the very near future.

To their credit, CDCR leadership had staff conduct a peer review, which was a start. The department has now instituted additional *Armstrong* training at HDSP, as well as a comprehensive management review and training plan, to be led in December and January by the newly placed acting warden. The OIG has met with CDCR's OIA to discuss the use of resident agents, and while CDCR has not agreed to discontinue their use, OIG's concerns were heard, and the department agreed in theory that hiring agents from the prisons they are assigned to is not a best practice. The OIA is considering steps to mitigate bias, such as moving agents to offices outside the institution. But even that measure will not cure the problems with using a resident agent at HDSP.

Nonetheless, these recent efforts signal that a desire for change exists within CDCR leadership. The OIG has a sincere hope that they will be successful.

APPENDICES

SENATE RULES COMMITTEE

KEVIN DE LEÓN
CHAIR

June 25, 2015

Robert A. Barton
Inspector General
Office of the Inspector General
10111 Old Placerville Road, Suite 110
Sacramento, CA 95827

Dear Inspector General Barton:

The Senate Rules Committee authorizes the Office of the Inspector General to review the practices at High Desert State Prison (HDSP) in Susanville with respect to (1) excessive use of force against inmates, (2) internal reviews of incidents involving the excessive use of force against inmates, and (3) protection of inmates from assault and harm by others. We also request that you consult with, and recommend appropriate actions to, the Office of Internal Affairs within the Department of Corrections and Rehabilitation regarding your review and that you provide this Committee with a written report detailing the results of your review.

A number of allegations have surfaced that raise concern about whether some members of HDSP staff are engaged in a pattern or practice of using inappropriate and excessive force against inmates and whether there is adequate protection of inmates from harm at the prison. The following allegations have prompted this authorization for a review:

- A March 2015 incident involving a mobility-impaired inmate who was reportedly assaulted by staff, and consequently required outside medical treatment, for refusing to remove and relinquish footwear worn to assist with his medical condition.

- A March 2015 incident involving a hearing- and speech-impaired inmate who was reportedly wrestled to the ground and severely assaulted after noncompliance with oral instructions from custodial staff even though the inmate was wearing a brightly-colored vest identifying his impairments.

- A March 2015 incident involving an inmate who was attacked by his cellmate after custodial officers allegedly told other inmates that he was a sex offender. Prior to the incident, the

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inmate who was attacked allegedly reported to staff that he was being extorted by other inmates and feared harm from his cellmate.

- The assault of an inmate in late 2014 and early 2015 after he was denied a request to be placed in protective administration segregation because of rumors that he was a sex offender.

In addition to the specific incidents noted above, there have been general allegations asserted that some members of custodial staff refer to inmates as "sodomites" or sex offenders in the presence of other inmates and disclosed inmates' commitment offenses to others; actions which would place inmates at risk of harm from other inmates.

Ensuring the safety of both inmates and staff in our state prison system is amongst the paramount objectives of the Department of Corrections and Rehabilitation. It is vital that the Senate determine, through a review by the Office of the Inspector General, whether there is a pattern or practice among members of the custodial staff at HDSP that contradicts that objective.

The Senate Rules Committee looks forward to working with you on this matter.

Sincerely,

KEVIN DE LEÓN
President Pro Tempore
Twenty-Fourth Senate District

State of California Department of Corrections and Rehabilitation

Memorandum

Date : December 31, 2013

To : Associate Directors, Division of Adult Institutions
Wardens

Subject: **ENHANCED PROGRAM FACILITY INSTITUTIONS/FACILITIES**

As part of the California Department of Corrections and Rehabilitation (CDCR) Blueprint, we are designating certain General Population (GP) and Sensitive Needs Yard (SNY) institutions/facilities as Enhanced Program Facility (EPF). EPF will offer incentives for inmates who, based on their own behaviors and choices, are ready to take full advantage of programming opportunities.

Effective January 1, 2014, the following institutions/facilities will be designated as an EPF:

- Kern Valley State Prison, Level IV GP 180, Facility B
- High Desert State Prison, Level IV GP 180, Facility C
- Salinas Valley State Prison, Level IV GP 270, Facility B
- Pleasant Valley State Prison, Level III GP 270, Facility C
- California State Prison, Corcoran, Level IV SNY 270, Facility B
- Substance Abuse Training Facility, Level III SNY 270, Facility E
- Valley State Prison, Level II SNY

Program Options

Program enhancements will be primarily volunteer based and self help options intended to incentivize and reinforce positive life choices. These options may include, but are not limited to:

- Access to college degree programs
- Additional Self Help Groups
- Hobby craft programs

Recreational and enhanced privilege options may include, but are not limited to:

- Technology based privileges, as they are approved
- Microwave in the dayroom
- Increased canteen draw
- Increased canteen list
- Expansion of property matrix (see attached matrix)
- Yard photo programs

- Food sales (more frequent basis)
- Sports and game tournaments
- Self-Help/volunteer sponsored events (concerts, guest speakers etc.)

Placing Inmates into the Program

Initial Activation: The EPF implementation process will not require mass screening or transfer of inmates from a designated facility. Inmates currently residing on a designated EPF institution/facility will remain, provided they are willing to meet the program's expectations.

Ongoing: EPF placement will be based on their behavior and willingness to meet programming expectations. Inmates who have been identified as possible EPF participants shall be evaluated via the facility's classification process at the inmate's annual or program review. Inmates identified for transfer to an EPF shall be reflected in the Institution Classification Committee/Unit Classification Committee CDCR Form 128G and Classification Staff Representative endorsement CDCR Form 128G.

Exclusionary factors are as follows:

- Security Housing Unit (SHU) Term within the past 12 months. (Imposed SHU term)
- Rules Violation Reports (RVR) for Security Threat Group related behavior within the past 12 months.
- RVR for controlled substance and alcohol related behavior within the past 12 months. This shall include:
    1. Possession of any controlled substance, alcohol or paraphernalia.
    2. Use/under the influence of any controlled substance or alcohol.
    3. Production of alcohol.
    4. Refusal to provide a urine sample for the purpose of testing for the presence of controlled substance or alcohol.
- C/C status within the past 12 months.

Removing Inmates from the Program

To ensure program viability, participants are required to strictly adhere to the following behavioral and programming expectations in order to remain on an EPF. EPF participants must:

- Program with all inmate groups.
- House according to their current integrated housing code.
- Participate in random drug testing.
- Participate in assigned work, education, training, and self help programs.
- Continually work to resolve enemy concerns or conflicts.
- Comply with rules and regulations.

- Participate in the Correctional Offender Management Profiling for Alternative Sanctions risk and needs assessment.

Initial Activation: Inmates who do not wish to participate in the EPF shall be transferred using existing transfer protocols to a non EPF institution/facility. This may or may not require endorsement or transfer to an alternate institution.

Ongoing: Removing an EPF participant shall be the responsibility of the facility's Captain. Inmates who fail to meet the behavioral criteria shall be removed from the EPF program. Removal from the EPF program shall not mandate Administrative Segregation placement. A classification committee shall evaluate the inmate's programming needs and transfer him to an alternate non EPF institution/facility accordingly. Housing pending transfer shall be determined based on the inmate's individual case factors.

If you have any questions, please contact Ron Davis, Warden, Valley State Prison, at (559) 665-6169 or via email at ron.davis@cdcr.ca.gov.

M. D. STAINER
Director
Division of Adult Institutions

Attachment

cc: Kelly Harrington
Terri Gonzalez
Ron Davis

State of California Department of Corrections and Rehabilitation

Memorandum

Date December 30, 2011

To: Associate Directors, Division of Adult Institutions
Wardens

Subject: **SECURE APPEAL COLLECTION SITES AND RELATED MATTERS**

The Office of Inspector General (OIG) conducted a review of the revised inmate appeal process which became effective January 28, 2011. The OIG identified the concerns that led the Department to changes its inmate appeal process and assessed whether the revised inmate appeal process addressed those concerns. Pursuant to Inspector General recommendations, no later than April 30, 2012 each housing unit and every program office will ensure that a secure appeal collection site (lock box) is provided on every yard and in each building for use by inmates for submission of appeals directly to the Appeals Office.

- Retrievals from these collection sites will be performed by Appeals Office staff and/or staff designated by the Warden.
- By April 30, 2012 each institution/facility shall formulate an Operational Procedure identifying the collection sites, staff responsibilities in collection and the manner in which deposited appeals will be transmitted to the Appeals office.

In addition, inmates who desire a receipt for a submitted appeal are permitted the option of placing the appeal in an unsealed envelope addressed to the Appeals Office accompanied by a CDCR Form 22.

- Staff accepting the appeal will first confirm the presence of an appeal in the envelope and then on the CDCR Form 22, note the date and time they were given the appeal and provide the inmate with his/her receipt (Goldenrod copy) noting that the appeal is being forwarded to the Appeals Office.
- Reading or inspecting the contents of the appeal will be conducted only by the Appeals Office; therefore other staff shall not attempt to do this at the time of receipt. They will, however, date, initial and seal the envelope and deposit it at a secure collection site.
- No further response to the inmate shall be required on the CDCR Form 22 as their Inmate Appeals Tracking System (IATS) printout will serve to verify the acceptance of the appeal by the Appeals Office. If the appeal is rejected appellants receive a CDC Form 695 from the Appeals Office along with their returned appeal detailing each and every reason why it was rejected and what action(s) need to be taken for it to be accepted.

Appeals Coordinators shall, effective January 2012, meet at least quarterly with their local Inmate Advisory Councils (IAC) either independently or in conjunction with scheduled Warden Meetings in order to receive input on appeal and written request processing matters. Information developed during such meetings shall be shared with the Chief, Office of Appeals.

Associate Directors, Division of Adult Institutions
Wardens
Page 2

Each institution is hereby directed to conduct a self-certification audit to ensure revised appeal regulations are available in the prison law library with proof a practice being forwarded to their respective Associate Director as well as the Office of Appeals by January 23, 2012.

If you have any question regarding this matter, please contact Dean Foston, Office of Appeals at (916) 255-0182 or Captain Tom Emigh at (916) 255-4950.

GEORGE J. GIURBINO
Director (A)
Division of Adult Institutions

Attachment

cc: Dean Foston
Tom Emigh

California Department of Corrections and Rehabilitation
Zero Tolerance Regarding the "CODE OF SILENCE"

The California Department of Corrections and Rehabilitation (CDCR) is only as strong as the values held by each of its employees, sworn and non-sworn. How we conduct ourselves inside our institutions and in the Central Office is a reflection of those values.

The "Code of Silence" operates to conceal wrongdoing. One employee, operating alone, can foster a Code of Silence. The Code of Silence also arises because of a conspiracy among staff to fail to report violations of policy, or to retaliate against those employees who report wrongdoing. Fostering the Code of Silence includes the failure to act when there is an ethical and professional obligation to do so.

Every time a correctional employee decides not to report wrongdoing, he or she harms our Department and each one of us by violating the public's trust. As members of law enforcement, all Correctional Officers must remain beyond reproach. The public's trust in this Department is also violated by retaliating against, ostracizing, or in any way undermining those employees who report wrongdoing and/or cooperate during investigations. There is no excuse for fostering a Code of Silence.

Your hard fought efforts to protect the public deserve recognition and the public's trust must be maintained while we take steps to ensure the Department exemplifies integrity and instills pride. Part of this effort is the immediate implementation of a zero tolerance policy concerning the Code of Silence. We will not tolerate any form of silence as it pertains to misconduct, unethical, or illegal behavior. We also will not tolerate any form of reprisal against employees who report misconduct or unethical behavior, including their stigmatization or isolation.

Each employee is responsible for reporting conduct that violates Department policy. Each supervisor and manager is responsible for creating an environment conducive to these goals. Supervisors are responsible for acquiring information and immediately conveying it to managers. Managers are responsible for taking all appropriate steps upon receipt of such information, including initiating investigations and promptly disciplining all employees who violate Department policy.

Any employee, regardless of rank, sworn or non-sworn, who fails to report violations of policy or who acts in a manner that fosters the Code of Silence, shall be subject to discipline up to and including termination.

State of California Department of Corrections and Rehabilitation

Memorandum

Date: May 8, 2015

To: Sandra Alfaro
Associate Director (A)
High Security Mission
Division of Adult Institutions

Subject: **PEER REVIEW – HIGH DESERT STATE PRISON**

The primary mission of High Desert State Prison (HDSP) is to provide for the Housing and Programming of general population and sensitive needs high security (Level IV) and medium security (Level III) inmates. HDSP inmate population consists of three (3) Level IV yards, two of which are 180 design buildings (Facility C and Facility D), and one 270 design building (Facility B). The 270 design yard, Facility B, was converted to a Sensitive Needs Yard (SNY) in October 2007, which houses Level IV SNY inmates. Facility A is a 270 design medium security facility which houses Level III inmates. Facility A is also the home of our Reentry Hub Facility, which provides relevant training and services to eligible and interested inmates in order to facilitate the successful transition back to their communities and reduce their likelihood of reoffending. HDSP's Reentry programs are comprised of Academics, the California Identification Card Program, Pre-Employment Transition, and Cognitive Behavioral Treatment, which includes Substance Abuse Treatment, Anger Management, Family Relationships and Criminal Thinking. The Minimum Support Facility (MSF) houses non camp eligible Level I inmates who perform job duties in various areas of the institution outside the secure perimeter, such as the warehouse, garage, outside grounds, staff snack bar, etc. HDSP Administrative Segregation Unit (ASU) is located on Facility D, 180 design housing and consists of two buildings, D7 and D8. HDSP also has a standalone ASU named Facility Z which was activated in September 2004. HDSP houses inmates with the lowest level custody, Minimum B, all the way up to Maximum custody (ASU inmates).

This Peer Review of HDSP was conducted from April 27-30, 2015. Representatives from various areas of the Division of Adult Institutions (DAI) and the Office of the Ombudsman were assigned to review the overall operations at HDSP and to interview staff and inmates in order to determine the overall health of the institution. This review team utilized the California Penal Code (PC), California Code of Regulations (CCR), Title 15, the California Department of Corrections and Rehabilitation's (CDCR) Department Operations Manual (DOM), and their combined training and experience as the primary sources of operational standards.

Random sampling techniques were employed as an intrinsic part of the review process. In addition, facilities were toured, union representatives, line staff from all disciplines, and inmate advisory council Members (IAC) were interviewed and documentation related to the areas toured were reviewed. Throughout the tour, on-duty staff at all levels as well as inmates were interviewed to gather an overall

perception of the institution. The review team members were briefed prior to conducting this review regarding the nature and mission of the assignment.

Review team members assigned:

Jared Lozano, Correctional Administrator, DAI, High Security Mission
Michael Romero, Captain, DAI, High Security Mission
Theodore Verras, Captain, Folsom State Prison
U Chang, Correctional Counselor II Specialist, DAI, General Population Mission
Brian Unden, Ombudsman, Office of the Ombudsman

Overall, findings presented in the attached report represent the consensus of the entire review team.

General Operations

The Inmate Family Council (IFC) is active at HDSP. The review team received the minutes from the meeting with the IFC dating back to October of 2014. The Warden and/or the CDW have been active participants in these meetings.

The HDSP Daily Activity Report (DAR) was provided to the team during this review. The review team noted HDSP has only one DAR for the entire prison, the report is basic and mainly addresses operation division issues. The DAR fails to address facility security operations and daily inmate programs. This is an important tool for the management team to monitor and manage the inmate program on each facility (e.g., ensuring facility security checks are being completed, yard and dayroom programs are meeting their expectations).

Staff Interviews

Interview of Labor Relations Analyst (LRA):

On April 27, 2015, an interview was conducted with the LRA. During the interview, the review team asked general questions concerning the overall relationship between staff and administration, between the inmate population and administration, between staff and the inmate population, and overall staff morale. Currently, the LRA is a correctional sergeant, as the permanent LRA at HDSP has been temporarily reassigned. The LRA stated he thought the relationship between the inmate population and the administration is very positive. The LRA characterization of the various relationships within the administration is positive, and did not reveal any specific issues or major concerns. In fact, he believed that acting Warden Peery has brought positive change to the institution as the staff morale from the past warden had caused morale to go down. The LRA expressed the staff's appreciation and belief that acting Warden Peery's efforts in this area enabled the line supervisors to better perform their job duties. The LRA stated he has worked at HDSP for many years, and worked well with the current administration as he worked for them during previous assignments.

Interview of Employee Relations Officer (ERO):

On April 27, 2015, an interview was conducted with the ERO. During the interview, the review team asked general questions concerning the overall relationship between staff and administration, between the inmate population and administration, between staff and the inmate population, and overall staff morale. The ERO has been assigned in this office for many years, including working as an analyst while acting Warden Peery was the ERO. The ERO stated she thought the relationship was positive between the inmate population and the administration, even though she is not really exposed to it in her position. The ERO characterization of the various relationships with administration was positive and did not reveal any specific issues or major concerns. The ERO stated the previous warden was hard to work for and it was hard to repair relationships with staff whom he had disciplined. The ERO further stated the staff referred to the previous warden as "Five for Freddie," insinuating he was always trying to take money from staff during the disciplinary process. The ERO believes that acting Warden Peery has brought positive change to the institution as the staff morale from the past warden had caused morale to go down.

Interview of Managers

Between April 27-29, 2015, interviews/discussions were conducted with multiple managers. During the interviews, the review team asked general questions concerning the overall relationship between staff and administration, between the inmate population and administration, between staff and the inmate population, and overall staff morale. The managers all stated they thought the relationship was very positive between the inmate population and the administration. The managers all characterized the various relationships with administration as positive and did not reveal any specific issues or major concerns. In fact, they believed that acting Warden Peery has brought positive change to the institution as the staff morale from the past warden had caused low morale with line staff and supervisors. Some managers expressed thoughts that differed from the rest of the group. One suggestion was that the acting Chief Deputy Warden (CDW) assignment should be rotated through multiple associate wardens so more than one person could gain experience, albeit the team recognizes that the acting CDW assignment has only been in place for a couple of months, and a rotation normally would not occur until around 90 days.

Interview of California Correctional Supervisor's Organization (CCSO) Union Representative

On April 28, 2015, an interview was conducted with CCSO representatives. During the interview, the review team asked general questions concerning the overall relationship between staff and administration, between the inmate population and administration, between staff and the inmate population, and overall staff morale. The representatives' characterization of the various relationships with administration was positive and did not reveal any specific issues or major concerns. They believe that acting Warden Peery has brought positive change to the institution, she has it headed in the right direction, and she is not "micro-managing" everyone in the institution. The

CCSO representatives expressed the staff's appreciation and belief that acting Warden Peery's efforts enable the line supervisors to better perform their job duties. CCSO is attending the monthly meetings.

Interview of Service Employees International Union (SEIU) Union Representative

On April 28, 2015, an interview was conducted with SEIU Representatives. During the interview, the review team asked general questions concerning the overall relationship between staff and administration, between the inmate population and administration, between staff and the inmate population, and overall staff morale. The representatives' characterization of the various relationships with administration was positive and did not reveal any specific issues or major concerns. Specifically, the representatives stated the relationship between acting Warden Peery and all staff at HDSP is very positive. The representatives did express concerns with the changes in standardized staffing and the expectation of Division of Rehabilitative Programs that an inmate be able to test 10.0 on the test of adult basic education before they are able to take the GED test. In addition, they stated the relationship between custody, medical, and education staff and at HDSP is very good and they have no issues. SEIU is attending the monthly meetings.

Interview of California Correctional Peace Officer Association (CCPOA) Union Representatives

On April 28, 2015, an interview was conducted with the CCPOA Chapter Vice President, and two attorneys from CCPOA, as the vice president stated he did not know what we wanted to discuss, and he has a pending potential disciplinary action. The review team explained the interview had nothing to do with his personal issue; we would ask questions about the CCPOA chapter as a whole. During the interview, the review team asked general questions concerning the overall relationship between staff and administration, between the inmate population and administration, between staff and the inmate population, and overall staff morale. The vice president characterization of the various relationships with administration was positive and did not reveal any specific issues or major concerns. The vice president did feel that recently the completed and pending personnel actions against him and the president of CCPOA has brought morale down. He stated morale as a whole is improving since the change in wardens. He also stated the previous warden was severe in punishments against staff. He further stated "the jury's still out" on acting Warden Peery but he is confident she will do the right thing and not always go out of her way to look for ways to discipline staff members. The CCPOA vice president feels morale is improving. He stated that HDSP has a high staff suicide rate and this may be an issue in which HDSP would benefit from more training and resources.

Interview of Inmate Advisory Council (IAC) Representatives (All Facilities)

On April 29, 2015,an interview was conducted with IAC representatives from all facilities at HDSP. During the interview, the review team asked various open ended questions, leaving the IAC open to reveal what they believed to be the most pressing issues at HDSP. The IAC on facilities A, C, and D volunteered their most pressing

issues were related to visiting vending machines, leaking roofs, television reception, more quality meat options (not just bologna) and syrups (not just sugar free) served in the culinary, and the D-7 conversion from ASU to GP delay. The issues related to visiting vending machines were universal among the facilities (it is noted according to the management team, HDSP is receiving new vending machines for their visiting rooms as the machines they have need replacing).

Facility B IAC was much more detailed and were concerned with more issues regarding operations. Specifically, the Facility B IAC stated some staff relate well with the inmate population, and others do not (specifics were provided to the warden and chief deputy warden). The Facility B IAC stated the acting captain on the yard has created a better working relationship with the IAC and staff. They also stated the inmate population packs other inmate property instead of the officers when the inmates go out to the hospital or are placed in administrative segregation. The Facility B IAC went on to state that cell searches are completed only in mass search operations and as retaliation measures by staff. Additionally, they stated that officers in the buildings are closing the dayroom program on their own if an inmate is "passing" items from cell to cell. Staff will recall the dayroom and identify the inmate that caused the action. The Facility B IAC stated the supervisors are not part of the issue as they do not believe the supervisors are even consulted about the closure.

The review team members then asked the IAC why they believed so many incidents of violence were occurring on Facility B. The universal response identified the actions of a few staff members as well as an inmate in building 2 who has been "the enforcer."

The Facility B IAC also expressed their belief that more programs, job assignments, and inmate receiving disciplinary reports via the CDCR 115 and ASU/SHU time may help the prison population deal with these conditions by incentivizing good behavior.

The previous warden was not regularly participating in the quarterly IAC council meetings; however, acting Warden Peery has started meeting with the IACs.

The review team noted acting Warden Peery did meet with Facility E IAC for the first quarter on March 18. The minutes supplied to the review team show that few issues were resolved, and many issues are "still being looked into." The review team noted, some questions that were not answered at the IAC meeting were basic facility operations questions that should have been easy to answer and resolve the issue (e.g. Agenda Item #1; Is the inmate population on Facility E required to go to the dining room for breakfast and dinner? The response was "Will look into the matter."). The review team notes this may be so because this was the first IAC meeting the new acting warden had facilitated. The second quarter meetings are scheduled with every facility. Agendas have been received from all facility IACs so more issues may be resolved at the meetings, thus avoiding as many items being left open at their conclusion. Minutes for the IAC meetings with the facility management are not being kept; however, based on our conversations with all IACs and staff, it is apparent that these meetings are occurring on a regular basis (some occur weekly). The facility managers were instructed by the warden to ensure minutes are kept as proof of

practice that these meetings have occurred. It is also noted HDSP is not following their DOM supplement as to how the IAC meeting minutes are documented.

The review team notes that acting Warden Peery has begun a process to address these meeting deficiencies. As stated above, a process has already been put in place to meet with the IACs every quarter and to ensure the meetings with the facility managers are memorialized via meeting minutes.

Housing Units (General Conditions and Observations)

In this report, the review team has highlighted the overall facility/housing units needing attention. The facility/housing attachment has been provided for the detail of the cases used to arrive at these conclusions. The review team met with all Facility Captains, Lieutenants and Sergeants. Custodial staff was advised that the review team was there to inspect several areas of security and custodial operations. They were also informed that based on the information obtained, each facility would subsequently be evaluated for efficiency. The tour also consisted of dialogs with random officers and inmates on all facilities to determine the level of staff morale and the level of communication between staff and inmates. A meeting was scheduled with the IAC on Facilities A, C, and D. All the IACs were advised that the team was there to conduct a review, and that this was an opportunity for them to bring up any major concerns with inmate programs, Daily Activities Schedules, inmate staff relations, and anything else that was of major importance and concern to them.

Facility A:

The Facility A Captain, Lieutenant, and Sergeant were very polite and expressed a joyful demeanor. They were asked how they felt about their superiors and it was immediately obvious based on their positive responses, that they all support the management team at HDSP.

The IAC was assembled in the Facility Chapel without the presence of facility staff. The IAC's major concerns were the current laundry exchange program.

The IAC simply stated that they liked the one for one exchange and did not like the current method used (the review team notes the new process is temporary due to the HCFIP construction project currently occurring on Facility A). They also stated that quarterly packages were not delivered in a timely manner. The question was posed to the IAC, "Do you get released for yard and dayroom on time?" The IAC stated that they do get released on time for the most part for both, and are only occasionally released late. The IAC was asked how they are treated by staff and they all stated that they are mostly treated with dignity and respect but do occasionally run into the rude officer. They also stated that it was never serious enough to make an issue of it. The IAC could not identify or name a specific staff member.

The Facility A Yard staff were very helpful and assisted the review team by gathering requested documents and answering questions. Some of the newer officers who are not from the area expressed their desire to stay at HDSP, stating that they are

extremely happy with how they are treated and with the willingness of local staff to help them with whatever they need. The yard staff conducted clothed body searches of all inmates before allowing them into their respective work areas.

A review of the disciplinary log for the month of January and February revealed CDCR 115 disciplinary logs are reviewed and signed by management; however, it does not appear the logs are reviewed in accordance with DOM. The logs supplied to the review team for January and February were signed by the management staff on April 22, yet they should have been signed before then. Also, the managers signed pages that were incomplete. In addition, the log is not signed by the registrar stating he/she has received a copy of the CDCR 115. The disciplinary register did not include void memorandums for the voided Rules Violations Reports (RVRs). In review of the disciplinary logs, there are voided RVRs but the disciplinary log fails to identifiy who authorized the voiding of the RVRs. It appears no void memorandums are being generated by the CDO. There was a total of 16 RVRs for February and a total 64 RVRs for January, 36 of which related to a riot.

A medical emergency was observed by the review team. During the emergency, staff were responding to A5 for an inmate down call in cell 103. Medical and Custody staff responded without delay and immediately transported the inmate to the Facility Satellite Clinic. It was very refreshing to see all staff understood the importance of medical emergencies within their facility.

Facility B:

The Facility B Captain, Lieutenant and Sergeant were very polite and expressed a joyful demeanor. They were asked how they felt about their superiors and it was immediately obvious based on their positive responses that they all support the management team at HDSP.

The Facility B Yard staff were very helpful and assisted the review team by gathering requested documents and answering questions. Some of the newer officers who are not from the area expressed their desire to stay at HDSP, stating that they are extremely happy with how they are treated. The yard staff conducted clothed body searches of all inmates before allowing them into their respective work areas. The acting captain assigned to this facility was very engaged with the inmate population and staff. The acting captain was extremely responsive to the review teams' needs during this evaluation.

A review of the disciplinary log for the month of January and February revealed the CDCR 115 disciplinary logs are reviewed and signed by management; however, it does not appear the logs are reviewed in accordance with DOM. The logs supplied to the review team for January and February were signed by the management staff on April 28, yet they should have been signed before then. Also, the managers signed pages that were incomplete. The disciplinary register did not include void memorandums for the RVRs that were voided. In review of the disciplinary logs, there are voided RVRs but the disciplinary log fails to identifiy who authorized the voiding of the RVRs. It appears no void memorandums are being generated by the CDO. In

addition, the log is not signed by the registrar stating he/she has received a copy of the CDCR 115.

Facility B Housing Unit staff indicated that the inmate mail is rerouted daily, if necessary utilizing SOMS to locate the inmate and ensure the mail is routed appropriately by having it taken to the program office for proper distribution.

The review team observed the evening (third watch) and the morning (second watch) meal release. The inmates were released on time and in a safe manner. Officers were strategically placed in positions to provide safety during both meals.

It should be noted the inmates on Facility B complained of not having jobs or inmate programs. Some inmates stated they have been on a work waiting list for over a year. The Facility B Captain expressed similar concerns and stated it is very difficult to obtain inmate programs at HDSP. The Facility B Captain conveyed concerns relative to the lack of program availability on Facility B.

Facility C:

Facility C appeared to be extremely clean. The program areas were very clean and it was apparent the floors had been polished to a shine. The Facility C Captain, Lieutenant and Sergeant were confident about what happens in the housing units due to consistent inspections and tours of those areas. They were asked how they felt about their superiors and it was immediately obvious based on their positive responses they all support the management team at HDSP. The captain appeared to be very organized and involved with the daily operations of his assigned facility. The control booths all had the same equipment boards and they were very neat and organized.

The IAC was assembled in the program office committee room without the presence of facility staff. The IAC had no major concerns and expressed that they were happy with the leadership on the yard. The IAC also stated they have a great relationship with custody staff on the facility.

The Facility C yard staff were very helpful and assisted the review team by gathering requested documents and answering questions. The captain had a yard officer escort us around and answer questions we had about custodial programs. The yard staff conducted clothed body searches of all inmates before allowing them into their respective work areas.

A review of the disciplinary log for the month of January and February revealed the CDCR 115 disciplinary logs are not reviewed and signed by management in accordance with DOM. The logs supplied to the review team for January and February were not signed by the management staff. The disciplinary register did not include void memorandums for the RVRs that were voided. In review of the disciplinary logs, there are voided RVRs but the disciplinary log fails to identifiy who authorized the voiding of the RVRs. It appears no void memorandums are being

generated by the CDO. In addition, the log is not signed by the registrar stating he/she has received a copy of the CDCR 115.

Facility C Housing Unit staff indicated the inmate mail is re-routed daily if necessary utilizing SOMS to locate the inmate and ensure the mail is routed appropriately by having it taken to the program office for proper distribution.

Facility D:

The Facility D Captain was unavailable at the beginning of the audit due to ICC. The lieutenant and sergeant were very polite and expressed a joyful demeanor. They were asked how they felt about their superiors and it was immediately obvious based on their positive responses they all support the management team at HDSP. The lieutenant escorted the review team and was instrumental in explaining current programs, as well as a brief history of HDSP since he has been at the institution.

The IAC was assembled in the program office without the presence of facility staff. The IAC's major concern is Facility A becoming a SNY facility and having their food contaminated with feces and other things in central kitchen. The review team noted the administration has a plan in place to mitigate these concerns from the inmate population at HDSP.

The IAC stated there were several inmates have been disciplinary free for years and there was no time frame given to them for transfer to a Level IV 270 design facility. The IAC also complained the roofs leak water in the second tier cells during the winter.

The Facility D yard staff were very helpful and assisted the audit team by gathering requested documents and answering questions. The yard staff conducted clothed body searches of all inmates before allowing them into their respective work areas.

A review of the disciplinary log for the month of January and February revealed the CDCR 115 disciplinary logs are not reviewed and signed by management in accordance with DOM. The logs supplied to the review team for January and February were not signed by the management staff. The disciplinary register did not include void memorandums for the RVRs that were voided. In review of the disciplinary logs, there are voided RVRs but the disciplinary log fails to identifiy who authorized the voiding of the RVRs. It appears no void memorandums are being generated by the CDO. In addition, the log is not signed by the registrar stating he/she has received a copy of the CDCR 115. As the review team looked through the log, it appeared some CDCR 115s should have been completed, yet the log does not reflect whether or not they have been completed.

ASU (Standalone Unit/Z Unit):

The ASU Lieutenant was very knowledgeable about ASU procedures and assisted the audit team in gathering necessary documentation to complete our review of the standalone ASU. The sergeant was very polite and expressed a joyful demeanor. The staff were asked how they felt about their superiors and it was immediately obvious based on their positive responses that they all support the management team at HDSP.

The Z ASU staff were very helpful and assisted the audit team by gathering other requested documents and answering questions.

A review of the disciplinary log for the month of January and February revealed the log was completed. Signatures indicating the logs are being reviewed by staff were present. However, the signatures belonged to the sergeant and not the manager, as required. The disciplinary register did not include void memorandums for the RVRs that were voided. In review of the disciplinary logs, there are voided RVRs but the disciplinary log fails to identifiy who authorized the voiding of the RVR. It appears no void memorandums are being generated by the CDO. It appears no void memorandums are being generated by the CDO authorizing the voiding of RVRs.

The control booth officer requested identification before entering the unit. All floor officers were wearing their respective personal alarm device (PAD) and required equipment. Housing unit common areas were very clean. CDCR 602, 602-A, 602-G, Forms 22 and 7362 inmate request for medical sevices forms are available for inmates upon request or on supply days. Cell Search logs were inspected and were well maintained. Cell Search Receipts were properly documented by officers.

A review of random cells indicated staff allows the inmates to clean their respective cells consistently. A thorough review of the control booth officer's inventory revealed an accurate accounting of equipment and appropriate use of the chit method.

The floor officers conducted inmate showers and documented them in the CDCR 114-A Segregation File as the inmates completed showering. A review of the ethnic balance report indicated the inmates in Z ASU are ethnically balanced. No maintenance issues were observed nor reported.

Cold weather clothing was available for inmates. The sergeant and the officers were familiar with the collection of appeals and sick call slips.

Review of Classification

The review team randomly chose inmates by pulling reports from the "SOMS>Reports>Population Tracking Report>Unlock Report" for each building. The review team reviewed the inmate's Initial Classification, last Annual Classification review at HDSP, their Double Cell status, and C/C status inmates.

The review team inspected the Initial Classification Chronos (CDCR 128-G) and checked to see if the inmates were being seen by the Unit Classification Committee within 14 days after arriving at HDSP. The review team also checked to see if the inmates were given a copy of the Notice of Classification Hearing (CDCR 128-B1) ensuring the inmates were given at least a 72 hour notice prior to committee, and the notices were placed in the inmates' Electronic Records Management (ERMS) file. On the CDC 128-B1, the review team checked to see if the Correctional Counselors were documenting the type of committee the inmates were seeing. While reviewing the Initial Classification Chronos, the review team also checked to ensure the committee discussed the inmate's cell status (single cell or double cell) and whether the committee thoroughly documented how they made the decision of single cell or double cell.

For the Annual Review, the review team checked to ensure inmates were seen by committee within 30 days (prior or after) of their Annual Review and were not more than 30 days overdue.

Upon review of Work Group C/Privilege Group C (C/C) inmates, the review team asked the classification staff who tracks the RVRs, and whether or not an inmate's electronic appliances are removed when placing an inmate on C/C status. The review team randomly went to C/C inmate cells and performed a cursory search inside the cells. The review team spoke with floor staff and asked what privileges C/C inmates received.

In this report, the review team has highlighted the overall classification processes needing attention. The classification attachment has been provided for the detail of the cases used to come to these conclusions.

A review was conducted of HDSP's overdue Committee Actions. A list prior to April 30 was generated from SOMS. Within all the facilities, HDSP has a total of 46 overdue initial Unit Classification Committees (UCC), 25 overdue Annual Reviews (A/R) and one overdue Institutional Classification Committee (ICC). Filtering the overdue committees down to facilities: Facility A has 10 overdue initial UCC and two overdue A/R; Facility B has five overdue initial UCC and five overdue A/R; Facility C has 20 overdue initial UCC and six overdue A/R; Facility D has 10 overdue initial UCC, 11 overdue A/R and one overdue ICC; Z Unit has one overdue ICC; and MSF has one overdue UCC.

Facility A:

Facility A has seven inmates on C/C status. The inmates are not clustered in one area. When the review team spoke with staff, their understanding of C/C status inmates was: electronic appliances are removed from the inmate's cell; allowed one hour of morning yard, a shower and emergency telephone calls only. During the audit of five out of the seven inmates on C/C status, two inmates were found to have portable CD players in their cells, with another or no inmate's name on the CD player. After the discovery, staff removed the electronic appliances per policy and procedure.

Facility A inmate intake is closed for level three general population due to the conversion schedule; however, it is open for MSF inmates. The MSF orientation inmates are coming to their initial UCC within 14 days after arriving to HDSP.

In speaking with counseling staff, most A/Rs are being seen within the 30 days; however, some are out to March, e.g., in May, they will be out 60 days.

During this review, the team randomly selected two to three inmates from each building for a total of 14 inmates on Facility A, and reviewed their cases. Upon review, it was noted counseling staff are not consistently issuing the Notice of Classification Hearing (CDCR 128B-1) and ensuring it is scanned into the inmate's ERMS file. Counselors are not consistently documenting the reason for clearing/approving an inmate for D/C status. When an inmate is more than 14 days from his initial UCC, counseling staff should document the reason for the late committee.

Facility B:

Facility B has 12 C/C status inmates and they are not clustered. Most inmates on C/C status are inmates who have been established by Facility B committees. The CC-Is are given a copy of the RVRs to track and determine when an inmate is to be placed on C/C. The CC-II has expectations; the inmates are being held accountable for their actions. A search of seven C/C status inmates was conducted. Of the seven, two inmates had electronic appliances in their cells. After the discovery, the floor staff removed the property per policy and procedure.

All orientation inmates are being seen for their initial UCC within 14 days after arriving. CC-I's Annual Reviews are backlogged to March. As of May, they will be out 60 days.

During this review, the team randomly selected two inmates from each building for a total of ten inmates on Facility B, and reviewed their cases. Upon review, it was noted that staff needs to be more consistent with their reason for clearing an inmate for D/C status and ensuring the CDCR 128B-1 is scanned into the inmate's ERMS file.

Facility C:

Facility C has two inmates on C/C status. The inmates are not clustered in one area. When I talked to Captain Lewis, he indicated all C/C inmates are moved to Facility D due to Facility C being an enhanced programming facility. The two inmates on Facility C were made aware of this and that they were going to being moved to Facility D. Captain Lewis also indicated when an inmate is placed on C/C, he does not go into his cell until the staff inventories the inmate's property to be transferred, and removes electronic appliances which are sent to Receiving and Release.

During this review, the team randomly selected two inmates from six buildings for a total of 12 inmates on Facility C, and reviewed their cases. Upon review it was noted that the Counseling staff are not consistently ensuring the CDCR 128B-1 is being scanned into the inmate's ERMS file. The recorder is not documenting the reason for placing an inmate on D/C status. In addition, counseling staff are not consistently

issuing the CDCR 128B-1s and ensuring they are scanned in the inmate's ERMS file. All initial UCCs are completed within the 14 days.

Facility D:

Facility D has seven C/C status inmates and they are not clustered. When the review team spoke with staff, their understanding was was: electronic appliances are removed from the inmate's cell; allowed one hour of morning yard, a shower and emergency telephone calls only. Most inmates on C/C status are inmates that are transferred from other institutions or facilities. The CC-II indicated he gives a copy of the RVR to the CC-Is and they track the RVRs to determine if the inmate needs to be reviewed by UCC for placement on C/C status or not.

The CC-II indicated the orientation inmates are seen by UCC within 14 days after arriving at HDSP. Some CC-I's Annual Reviews are out to March; e.g., in May, they will be out 60 days.

During this review, the team randomly selected two inmates from each general population building for a total of 12 inmates on Facility D, and reviewed their cases. Upon review it was noted that the counseling staff are not consistently ensuring the CDCR 128B-1s are in inmates' ERMS files. So far, the initial Classification Committees are getting completed on time. They should ensure when placing an inmate on D/C or S/C status to clearly document the reason. When issuing the CDCR 128B-1s, counseling staff must ensure they mark the box of the appropriate committee type.

ASU (Facility D and Z Unit):

The team reviewed six inmates' "flimsy" files. The inmates' CDC 114As were fully completed, indicating the staff offered ten hours of yard, three showers, cell searches, supplies and meals given, and trash removed. The "CDCR 114 Audit Worksheets" are not being completed on a regular basis for upper and lower tiers and sections, for all the audit periods. For example, for the Audit Worksheet period from 3/29/2015 to 4/4/2015, A section upper tier, B section lower tier and all of C section upper and lower tiers were missing.

During this review, the team randomly selected six inmates from ASU including both the stand alone "Z" unit and Facility D, Building 8 , and reviewed their cases. Upon review it was noted that the CDCR 128B-1s are not consistently being scanned into the inmate's ERMS file. Inmates are being seen within ten days after being placed in ASU. Only one inmate was seen by ICC passed the 10 day requirement for his Initial ICC.

The team reviewed up to three inmates' "flimsy" files, per pod/section for the period 4/12/2015 to 4/18/2015. The inmates' CDCR 114As were fully completed, showing the staff offered yard, showers, cell searches, supplies and meals given, and trash removed.

However, during this review, under the column for "Yard Total Hrs F/WK," the auditors entered "Y" for yes. This was not consistent with Facility D, Building 8's ASU audit and was not truly indicative of how many hours the inmates had or refused yard. In contrast, the Building 8 auditors entered the total hours the inmate had yard, and also indicated if there was a refusal. For example, on inmate Williams (K29648), the auditor documented "Y" making it appear inmate Williams had received yard; however, inmate Williams had a loss of privileges (LOP) so he did not get yard that audit period. Also discovered were two entries under the column "Cell Search." The auditor documented inmates Williams' (K29648) and Parrack's (AC1038) cells were searched in that period; however, the CDCR 114A does not indicate a cell search was conducted.

Review of Appeals Office

The review team interviewed appeals office staff and viewed supporting documents, finding that the Appeals office is operating at a marginal level. There were 38 overdue modification orders and no overdue first or second level appeal responses. According to staff, the largest inmate appeal issue is property. This appears to stem from inmates being placed into ASU with a subsequent release to a different facility or transfer, and finding his television is no longer operational. HDSP is screening a lot of appeals out (54%-70% per the last COMPSTAT report). Upon review, the appeals staff is resolving issues (e.g., Lost ID), and then the appeals office is screening the appeals out as they had no "adverse effect" since the issue had been resolved. However, the appeals office should be granting these appeals in part if the inmate does not wish to withdraw his appeal. Further, HDSP is not following the collection process for appeals articulated in the DOM Supplement (the facility staff are sending the appeals to the mailroom instead of directly to the appeals office). According to appeals staff, the greatest number of screen outs of inmate appeals is due to lack of supporting documentation. This issue should be resolved in a meeting between appeals staff and facility IACs which provides training for appeals staff to assist the inmate population on the facility. The appeals coordinators are not meeting with the IAC on a quarterly basis as required. It is very important that the review team identify the staff complaint attachment C forms (appeal inquiries) are thorough and are approved by the CDW or Warden. This is vital to protect HDSP and department staff against future litigation.

Review of Mailroom

The review team found the acting Mailroom Supervisor to be outstanding. The mailroom is up to date and operating extremely efficiently. The mailroom is processing mail within the department's expectations. Mailroom staff are very upbeat and have great working relationships with their supervisors and managers. The acting mailroom supervisor stated that if they are close to being outside the timeframes set forth by the department, she asks for assistance from other areas, and she gets it. It is apparent to the review team the acting mailroom supervisor has good knowledge of the Title 15 and DOM. The mailroom at HDSP is very clean and well organized.

Review of In Service Training (IST)

The IST department at HDSP appears to be an extremely well run operation. The IST Lieutenant at HDSP is new to the unit as the previous IST manager took a position with the Office of Internal Affairs. The Office staff appeared friendly, helpful, and knowledgeable of their duties.

AOD training is being accomplished in a condensed manner over two days. HDSP has implemented a wonderful program of videotaping the training so new AODs may watch the videos to get them up to speed. This is done just until the next AOD training, as this training requires a lot of resources from many different areas to complete. Block training was scheduled and HDSP has a good process to ensure staff are completing this training. Custody staff may only "swap" their training with someone attending the training during the same month. Non custody block continues on, and according to the list supplied to the review team, staff are getting access to the training. RBART training is scheduled and occurs as required. The pride staff takes in explaining the thorough and in depth level of their training was outstanding. Staff at HDSP take training very seriously, and it starts with the expectation from the warden and the IST Manager.

Supervisors were also receiving training and being sent to both Basic and Advanced supervision, as well as Sergeant and Lieutenant Academies, when allowed by departmental scheduling, and travel exemption approval. It is noted the supervisor training at HDSP is delinquent -- like many of the institutions -- due to fiscal constraints and lack of available room in classes. However, training is important to HDSP, and they are constantly advocating for their staff to attend these trainings. HDSP has many staff scheduled for these classes in the near future, including one they are hosting at HDSP for CCC and HDSP later this month. It is also noted according to the IST manager, that HDSP is approximately 70% completed with the new UOF training that is required to be completed by June 12. The biggest issue found in the HDSP is they have not completed an escape drill in the past two to three years. It is noted the CDW and warden said they are working on facilitating the drill shortly.

Review of Use of Force (UOF) Incident Reports

Team members reviewed ten incident reports involving staff's use of force on inmates. The team found no issues with the UOF in these cases. These incident reports met the department's overall standard for clarity, completeness and accuracy. The overall product met departmental standards. During the review, the team asked general questions concerning the overall relationship between staff and administration, between the inmate population and administration, between staff and overall staff morale. The UOF staff characterization of the various relationships with administration was positive and did not reveal any specific issues or major concerns with staff members. The UOF staff also noted they have no knowledge of inmate and administrative relationships, and limited knowledge of the staff members' relationships outside their processes. HDSP meets the time requirements as expected by the department; their incident packages are initially reviewed by IERC within 30 days of

the incidents. It is noted at the time of the review, the IERC had about five incidents still open while clarification questions were sent back to the divisions from the IERC. The process and expectations of staff regarding reportable incidents is as follows: the division has three weeks to submit the completed incident to the UOF analyst; the UOF analyst has to review the incident package and present it in IERC. If the analyst finds required clarification questions, she will present in IERC, and if agreed upon by the IERC, the case will remain open and the questions will be returned to the division for clarification. It was noted that 49% of the UOF incidents this calendar year occurred on Facility B. This is the only level 4 SNY 270 design facility at HDSP. To determine whether or not these numbers are high, the review team reached out to other institutions with level 4 SNY 270 design facilities (see attachment A for number comparisons).

Officer Sick Leave Review

The Officer Sick Leave monitoring Program is being underutilized. The AW BS is the person coordinating and "chairing" this task. HDSP monitors every officer each 60-180 days, which is not consistent with expectations. The process seems unorganized and the CDW and/or the Warden need to be a part of this process as it involves employee discipline.

Inmate Assignments

According to the last COMPSTAT report, HDSP has over 400+ inmate job assignment vacancies with more than 1200 inmates on the job assignment waiting lists. In speaking with the inmate assignments lieutenant, 49 vacancies are on their level one and are not filled due to the reduction in level 1 population. The lieutenant stated they are not assigning inmates to the Facility A vocations vacancies. In addition, HDSP is not assigning inmates to Facility A support services positions due to the conversion. The lieutenant stated HDSP also has four teacher positions vacant. This is also causing a high number of vacant positions with the inmate population. It appears HDSP needs to review their need for some of these assignments.

Summary/Conclusion

The review team's overall consensus of HDSP appearance is very positive. We found the prison to be clean and orderly. HDSP's staff expressed a hopeful attitude toward the future of HDSP. The High Security (HS) Mission staff will continue to work with HDSP on their deficiencies as identified in this report. In addition, HS mission will also provide some recommended proactive processes to the executive management team to assist them in managing HDSP.

If you have any questions regarding the information contained in this report, please contact me via email or by telephone at (916) 327-2725.

J. LOZANO
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POLICE RACIAL VIOLENCE: LESSONS FROM SOCIAL PSYCHOLOGY

*L. Song Richardson**

INTRODUCTION

The recent rash of police killing unarmed black men has brought national attention to the persistent problem of policing and racial violence. These cases include the well-known and highly controversial death of Michael Brown in Ferguson, Missouri,[1] as well as the deaths of twelve-year-old Tamir Rice in Cleveland, Ohio;[2] Eric Garner in Staten Island, New York;[3] John Crawford III in Beavercreek, Ohio;[4] Ezell Ford in Los Angeles, California;[5] Dante Parker in San Bernardino County, California;[6] and Vonderrit D. Myers Jr. in St. Louis, Missouri.[7] Data reported to the FBI indicate that white police officers killed black citizens almost twice a week

* Professor, The University of California, Irvine School of Law. J.D., Yale Law School; A.B., Harvard College. I wish to thank Professors Kimani Paul-Emile and Robin Lenhardt for the opportunity to participate in this symposium entitled *Critical Race Theory and Empirical Methods Conference* held at Fordham University School of Law. I am also appreciative of the excellent research assistance provided by Sierra Nelson and Ariela Rutkin-Becker. For an overview of the symposium, see Kimani Paul-Emile, *Foreword: Critical Race Theory and Empirical Methods Conference*, 83 FORDHAM L. REV. 2953 (2015).

1. *See, e.g.*, Jonathan Cohn, *Darren Wilson Walks: No Indictment for Michael Brown's Killer*, NEW REPUBLIC (Nov. 24, 2014), http://www.newrepublic.com/article/120395/ferguson-grand-jury-makes-issues-no-charges-officer-wilson.

2. *See, e.g.*, Emma G. Fitzsimmons, *Video Shows Cleveland Officer Shot Boy in 2 Seconds*, N.Y. TIMES, Nov. 27, 2014, at A25, *available at* http://www.nytimes.com/2014/11/27/us/video-shows-cleveland-officer-shot-tamir-rice-2-seconds-after-pulling-up-next-to-him.html.

3. *See, e.g.*, J. David Goodman & Al Baker, *Wave of Protests After Grand Jury Doesn't Indict Officer in Eric Garner Chokehold Case*, N.Y. TIMES (Dec. 3, 2014), http://www.nytimes.com/2014/12/04/nyregion/grand-jury-said-to-bring-no-charges-in-staten-island-chokehold-death-of-eric-garner.html.

4. Catherine E. Shoichet & Nick Valencia, *Cops Killed Man at Walmart, Then Interrogated Girlfriend*, CNN (Dec. 16, 2014, 10:28 PM), http://www.cnn.com/2014/12/16/justice/walmart-shooting-john-crawford/.

5. Jennifer Medina, *Man Is Shot and Killed by the Police in California*, N.Y. TIMES, Aug. 14, 2014, at A16.

6. Philip Caulfield, *Father of 5 Dies After Getting Tased by Police During Attempted Burglary Arrest*, N.Y. DAILY NEWS (Aug. 15, 2014), http://www.nydailynews.com/news/national/father-5-dies-tased-police-arrest-article-1.1904577.

7. Alan Blinder, *New Outcry Unfolds After St. Louis Officer Kills Black Teenager*, N.Y. TIMES, Oct. 10, 2014, at A18.

between 2005 and 2012.[8] This number is underinclusive because the FBI database is based on self-reports by departments that choose to participate and only includes deaths that the police conclude are justifiable.[9]

Many accounts attempt to explain these instances of racial violence at the hands of the police, ranging from arguments that the police acted justifiably to arguments likening these killings to Jim Crow lynchings.[10] Certainly, it is tempting to blame racial violence on either the racial animus of officers or the purportedly threatening behaviors of victims because it simplifies the problem; either the individual officer or citizen is at fault.

However, reducing the problem of racial violence to the individual police-citizen interaction at issue obscures how current policing practices and culture entrench racial subordination and, thus, racial violence. This is because as a result of our nation's sordid racial history, white supremacy and racial subordination have become embedded not only within social systems and institutions but also within our minds. As a result, unless corrective structural and institutional interventions are made, racial violence is inevitable regardless of whether officers have malicious racial motives or citizens engage in objectively threatening behaviors.

This Essay proceeds in three parts. Part I discusses how unconscious racial biases and implicit white favoritism can result in racial disparities in police violence. Part II moves beyond unconscious biases and focuses instead on how the personal insecurities of police officers in the form of stereotype threat and masculinity threat also can lead to racial violence. Finally, Part III argues that when considered in combination, these psychological processes powerfully demonstrate why racial violence is inevitable and overdetermined given current policing practices and culture, even when conscious racial animus is absent. Part III concludes by discussing the need to implement institutional and structural changes to reduce instances of racial violence.

I. IMPLICIT RACIAL BIAS AND IMPLICIT WHITE FAVORITISM

Both implicit racial bias and implicit white favoritism are consequential when it comes to racial violence, but in opposite ways. Implicit racial biases typically refer to unconscious anti-black bias in the form of negative stereotypes (beliefs) and attitudes (feelings) that are widely held, can conflict with conscious attitudes, and can predict a subset of real world behaviors. For instance, implicit racial biases can influence whether black

8. Kevin Johnson et al., *Local Police Involved in 400 Killings Per Year*, USA TODAY (Aug. 15, 2014), http://www.usatoday.com/story/news/nation/2014/08/14/police-killings-data/14060357/.

9. Only 750 of the approximately 17,000 law enforcement agencies in the United States participate. *Id.* Unfortunately, this is the only national database that collects data on police use of deadly force. *Id.* (quoting Geoff Alpert, a criminologist from the University of South Carolina who studies police use of deadly force).

10. Isabel Wilkerson, *Mike Brown's Shooting and Jim Crow Lynchings Have Too Much in Common. It's Time for America to Own Up*, GUARDIAN (Aug. 25, 2014), http://www.theguardian.com/commentisfree/2014/aug/25/mike-brown-shooting-jim-crow-lynchings-in-common.

individuals receive callback interviews[11] and life-saving medical procedures,[12] as well as whether individuals exhibit nonverbal discomfort when interacting with non-whites.[13] Decades of research demonstrate that most Americans are unconsciously biased against black individuals.[14]

Two specific types of implicit racial biases are consequential when it comes to racial violence. First is the implicit association between blacks and criminality.[15] This unconscious association has led officers to misidentify blacks with more stereotypically black features such as dark skin, full lips, and wide noses as criminal suspects,[16] to engage in unconscious racial profiling,[17] and to shoot more stereotypical-looking black suspects more quickly than others in computer simulations.[18]

More recently, a second type of unconscious anti-black bias has proven consequential to racial violence. Implicit dehumanization refers to the tendency of individuals to unconsciously associate blacks with apes. Recent studies demonstrate that implicit dehumanization predicts police violence against black juveniles.[19] In one of these studies, subjects who had been subliminally primed with images of apes were more likely to find a vicious beating of a black suspect to be justified.[20] Similar effects did not occur when the victim was white or when individuals were not primed.

11. *See* Dan-Olof Rooth, *Implicit Discrimination in Hiring: Real World Evidence* 1, 4–5 (Inst. for the Study of Labor, Discussion Paper No. 2764, 2007), *available at* http://d-nb.info/98812002X/34 (discussing the difference in receiving callback job interviews between applicants with Arab or Muslim names and applicants with Swedish names); *see also* Marianne Bertrand & Sendhil Mullainathan, *Are Emily and Greg More Employable Than Lakisha and Jamal? A Field Experiment on Labor Market Discrimination*, 94 AM. ECON. REV. 991, 998 (2004) (demonstrating that job applicants with white-sounding names such as Emily or Greg were 50 percent more likely to receive callback job interviews in Boston and 49 percent more likely in Chicago than applicants with black-sounding names like Jamal); Devah Pager et al., *Discrimination in a Low-Wage Labor Market: A Field Experiment*, 74 AM. SOC. REV 777, 788 (2009).

12. *See* Alexander R. Green et al., *Implicit Bias Among Physicians and Its Prediction of Thrombolysis Decisions for Black and White Patients*, 22 J. GEN. INTERNAL MED. 1231 (2007).

13. *See generally* John E. Dovodio et al., *Why Can't We Just Get Along? Interpersonal Biases and Interracial Distrust*, 8 CULTURAL DIVERSITY & ETHNIC MINORITY PSYCHOL. 88 (2002).

14. *See generally* Kristin Lane et al., *Implicit Social Cognition and Law*, 3 ANN. REV. L. & SOC. SCI. 427 (2007).

15. For an in-depth discussion of how this stereotype can influence judgments of criminality, see L. Song Richardson & Phillip Atiba Goff, *Self-Defense and the Suspicion Heuristic*, 98 IOWA L. REV. 293 (2012).

16. Jennifer L. Eberhardt et al., *Seeing Black: Race, Crime, and Visual Processing*, 87 J. PERSONALITY & SOC. PSYCHOL. 876, 876 (2004).

17. *See* Sophie Trawalter et al., *Attending to Threat: Race-Based Patterns of Selective Attention*, 44 J. EXPERIMENTAL SOC. PSYCHOL. 1322, 1322 (2008); Eberhardt et al., *supra* note 16, at 890.

18. *See* Kimberly Barsamian Kahn & Paul G. Davies, *Differentially Dangerous? Phenotypic Racial Stereotypicality Increases Implicit Bias Among Ingroup and Outgroup Members*, 14 GROUP PROCESSES & INTERGROUP REL. 569, 573 (2011).

19. *See generally* Phillip Atiba Goff et al., *Not Yet Human: Implicit Knowledge, Historical Dehumanization, and Contemporary Consequences*, 94 J. PERSONALITY & SOC. PSYCHOL. 292 (2008).

20. *See id.* at 292–97.

Additionally, this study found that implicit dehumanization influences real world behaviors. The researchers discovered that the more closely police officers unconsciously associated black youths with apes, the more likely they were to have used force against black children throughout the course of their careers.[21]

The recognition that implicit racial biases can cause racially disparate effects, even in the absence of conscious bias, is becoming increasingly commonplace in mainstream discussions of police violence.[22] This science demonstrates that even when people are acting in identical ways, implicit racial bias places black citizens more at risk of mistaken judgments of danger and criminality. As a result, they are more likely to be shot, more likely to be dehumanized, and more likely to be seen as deserving of an officer's use of force.[23]

While significant attention has been paid to implicit anti-black racial bias, a sister concept, implicit white favoritism, has received almost no attention in the legal literature. I am only aware of one law review article on the subject.[24] In that article, Professors Robert Smith, Justin Levinson, and Zoë Robinson explain that implicit white favoritism is "the automatic association of positive stereotypes and attitudes with members of a favored group, leading to preferential treatment for persons of that group. In the context of the American criminal justice system, implicit favoritism is white favoritism."[25] While the concept of implicit white favoritism is new, critical race scholars have long identified white supremacy as a central building block of racial subordination.[26] Now, social psychological evidence provides empirical support for the theory.

Considering implicit white favoritism in tandem with implicit racial bias is important because it illuminates that racial disparities would remain in the context of racial violence even if all implicit anti-black biases were eliminated.[27] As Professor Smith and his colleagues explain, "Removing out-group derogation is not the same as being race-neutral."[28] For instance, one study found that when subjects were primed with white faces, they were slower to identify weapons than when they had not been primed with

21. *See* Phillip Atiba Goff et al., *The Essence of Innocence: Consequences of Dehumanizing Black Children*, 106 J. PERSONALITY & SOC. PSYCHOL. 526, 528–29 (2014).

22. *See* Chris Mooney, *The Science of Why Cops Shoot Young Black Men*, MOTHER JONES (Dec. 1, 2014), http://www.motherjones.com/politics/2014/11/science-of-racism-prejudice.

23. For a discussion of a recent study demonstrating this, see L. Song Richardson & Phillip Atiba Goff, *Interrogating Racial Violence*, 12 OHIO ST. J. CRIM. L. 115, 138–43 (2014).

24. Robert J. Smith et al., *Bias in the Shadows of Criminal Law: The Problem of Implicit White Favoritism*, 66 ALA. L. REV. (forthcoming 2015) (on file with author).

25. *Id.* (manuscript at 4).

26. Critical race scholars have long discussed white supremacy. *See, e.g.*, Derrick Bell, *Racial Realism*, 24 CONN. L. REV. 363, 363–379 (1998); DERRICK BELL, RACE, RACISM AND AMERICAN LAW (6th ed. 2008); DERRICK BELL, AND WE ARE NOT SAVED: THE ELUSIVE QUEST FOR RACIAL JUSTICE (1989).

27. *See* Smith et al., *supra* note 24 (manuscript at 4) (noting that "[e]ven if we could eliminate [implicit anti-black bias], . . . racial disparities would persist.").

28. *Id.* (manuscript at 28).

any faces at all.[29] Thus, while black men are associated with violence and criminality, facilitating racial violence against them, white men "are automatically and cognitively *disassociated* with violence."[30] In other words, being white protects people against racial violence. It is simply cognitively more taxing to associate whites with criminality.

Both implicit racial bias and implicit white favoritism together highlight why attempting to determine whether officers are bigots or reasonably felt threatened by the actions of victims does little to explain or address the problem of racial violence. These two processes together demonstrate that black men are at greater risk of racial violence at the hands of the police even when the officer confronting them is consciously egalitarian, and even if black men are acting identically to white men in the same situation.

Once implicit biases are activated—and simply thinking about crime is sufficient to activate them[31]—officers' attention will be drawn to black men more readily than white men, even if they are acting identically and even if officers are not engaged in conscious racial profiling. Once black men are under close police scrutiny, unconscious racial criminality can influence the way an officer interprets their ambiguous behaviors, causing the officer to be more likely to interpret their actions as being consistent with criminality even as identical behaviors engaged in by young white men would not arouse suspicion.[32] In fact, the unconscious association between blacks and criminality can explain why officers are primed to see a weapon or assume that one exists when black men reach into their pockets or the glove compartment of a car. On the other hand, implicit white favoritism illuminates why unarmed white men are significantly less likely to be shot in similar circumstances.

Implicit white favoritism explains why being white helps inoculate white men from this series of events. It is more difficult to view them as criminal. Unlike with black men, thinking about crime draws attention away from whites.[33] As Professor Smith and his colleagues write, "[S]eeing white automatically means seeing positive, law abiding behavior."[34] In fact, in one study, Professor Levinson found that subjects reading about an aggressive white defendant recalled fewer aggressive facts when relating the story than when the defendant was black.[35] Seeing white also makes it more difficult to identify weapons.[36] Thus, asking whether officers feared for their safety when confronting an individual does not address the fact that white men acting in identical ways would not trigger the same violent reaction. This is why focusing solely on the individual interaction between

29. *Id.* (manuscript at 32) (citation omitted).
30. *Id.* (emphasis added).
31. *See* Eberhardt et al., *supra* note 16, at 883.
32. For an extended discussion, see L. Song Richardson, *Arrest Efficiency and the Fourth Amendment*, 95 MINN. L. REV. 2035, 2045–48, 2052–53 (2011).
33. *See* Smith et al., *supra* note 24 (manuscript at 47).
34. *Id.*
35. *Id.* (manuscript at 21–22) (citing Justin D. Levinson, *Forgotten Racial Equality: Implicit Bias, Decisionmaking, and Misremembering*, 57 DUKE L.J. 345 (2007)).
36. *Id.* (manuscript at 36, 48).

officers and victims merely entrenches racial disparities in police use of force. Rather, the inquiry must be structural and institutional.

II. SELF-THREATS

Thus far, this Essay has focused on how police officers' unconscious perceptions can facilitate or inhibit racial violence. This part examines a different question, namely, how do officers' perceptions of themselves influence their use of force? Recent psychological evidence suggests that the self-directed insecurities of officers also can enable racial violence. This part analyzes two self-threats in particular, stereotype threat and masculinity threat.

A. Stereotype Threat

Stereotype threat refers to the anxiety that occurs when a person is concerned about confirming a negative stereotype about his or her social group.[37] I have discussed stereotype threat in depth elsewhere but provide a brief summary here.[38] Stereotype threat affects performance because concerns about being negatively stereotyped redirect cognitive resources away from the task at hand, leading to deficient performances.[39] Importantly, people do not need to believe or endorse the stereotype in order to be influenced by stereotype threat. Rather, it occurs whenever individuals care about their performance on a given task, are aware of the negative stereotype, and are concerned that failure or a deficient performance will confirm the negative stereotype.[40]

37. *See* Claude M. Steele, *A Threat in the Air: How Stereotypes Shape Intellectual Identity and Performance*, 52 AM. PSYCHOL. 613 (1997); Claude M. Steele & Joshua Aronson, *Stereotype Threat and the Intellectual Test Performance of African Americans*, 69 J. PERSONALITY & SOC. PSYCHOL. 797 (1995).

38. *See* Richardson & Goff, *supra* note 23, at 124–28.

39. *See generally* Jennifer K. Bosson et al., *When Saying and Doing Diverge: The Effects of Stereotype Threat on Self-Reported Versus Non-Verbal Anxiety*, 40 J. EXPERIMENTAL SOC. PSYCHOL. 247 (2004); Laurie T. O'Brien & Christian S. Crandall, *Stereotype Threat and Arousal: Effects on Women's Math Performance*, 29 PERSONALITY & SOC. PSYCHOL. BULL. 782 (2003); Sian L. Beilock et al., *On the Causal Mechanisms of Stereotype Threat: Can Skills That Don't Rely Heavily on Working Memory Still Be Threatened?*, 32 PERSONALITY SOC. PSYCHOL. BULL. 1059 (2006); Jim Blascovich et al., *African Americans and High Blood Pressure: The Role of Stereotype Threat*, 12 PSYCHOL. SCI. 225 (2001); Phillip Atiba Goff et al., *The Space Between Us: Stereotype Threat and Distance in Interracial Contexts*, 94 J. PERSONALITY & SOC. PSYCHOL. 91 (2008); Brenda Major & Laurie T. O'Brien, *The Social Psychology of Stigma*, 56 ANN. REV. PSYCHOL. 393 (2005); Wendy Berry Mendes et al., *Challenge and Threat During Social Interactions with White and Black Men*, 28 PERSONALITY & SOC. PSYCHOL. BULL. 939 (2002); Wendy Berry Mendes et al., *How Attributional Ambiguity Shapes Physiological and Emotional Responses to Social Rejection and Acceptance*, 94 J. PERSONALITY & SOC. PSYCHOL. 278 (2008); Toni Schmader & Michael Johns, *Converging Evidence That Stereotype Threat Reduces Working Memory Capacity*, 85 J. PERSONALITY & SOC. PSYCHOL. 440 (2003).

40. *See generally* Steele & Aronson, *supra* note 37.

In one study demonstrating the influence of stereotype threat, white men who had high SAT math scores were asked to take a difficult math test.[41] In the stereotype threat condition, they were told that the test would evaluate mathematical proficiency.[42] They also were given information suggesting that Asians typically outperformed other students.[43] In the control condition, they were only told that the test evaluated mathematical ability without any mention of Asian student performance.[44] The subjects in the threat condition performed significantly worse than the subjects in the control group.[45] In another experiment, researchers found that when white men believed that an athletic skills task required athletic intelligence rather than natural sports ability, they performed better than when the opposite was true.[46]

Across a number of studies, researchers have discovered that dominant group members' concerns with being negatively stereotyped as racist can work to the detriment of subordinated groups. In one study, researchers had white teachers read and give written feedback on an essay purportedly written by students.[47] The researchers found that when white teachers experienced stereotype threat, their fear of being judged as racist caused them to give falsely positive feedback when they believed the essay was written by black students but not when they believed the essay was written by white students. In a similar study, researchers found that when white subjects feared they would appear racially biased, they were less likely to warn black students that their workload might be unmanageable while not feeling similarly constrained with white students.[48]

Recent work by social psychologist Phillip Atiba Goff and his colleagues suggests that the fear of being evaluated as racist can also result in racial violence. In one study, ninety-nine members of the San Jose Police Department completed measures of their explicit and implicit racial attitudes as well as a measure of how concerned they were with appearing racist.[49] The researchers then obtained a copy of each officer's use of force history from the previous two years to determine whether there was any relationship between the use of force and the officer's psychological

41. *See* Joshua Aronson et al., *When White Men Can't Do Math: Necessary and Sufficient Factors in Stereotype Threat*, 35 J. EXPERIMENTAL SOC. PSYCHOL. 29 (1999).
42. *Id.* at 36–37.
43. *Id.*
44. *Id.* at 37.
45. *Id.* at 37–38.
46. *See* Jeff Stone et al., *Stereotype Threat Effects on Black and White Athletic Performance*, 77 J. PERSONALITY & SOC. PSYCHOL. 1213 (1999).
47. *See* Kent D. Harber et al., *The Positive Feedback Bias As a Response to Self-Image Threat*, 49 BRIT. J. SOC. PSYCHOL. 207, 209 (2010).
48. *See* Jennifer Randall Crosby & Benoît Monin, *Failure to Warn: How Student Race Affects Warnings of Potential Academic Difficulty*, 43 J. EXPERIMENTAL SOC. PSYCHOL. 663, 665–66 (2007).
49. *See* PHILLIP ATIBA GOFF ET AL., PROTECTING EQUITY: THE CONSORTIUM FOR POLICE LEADERSHIP IN EQUITY ON THE SAN JOSE POLICE DEPARTMENT 3–4 (2012) [hereinafter SAN JOSE REPORT].

profile.[50] Surprisingly, the researchers did not find any relationship between explicit and implicit racial bias and the use of force.[51] However, they did find an association between stereotype threat and the use of force. Higher levels of stereotype threat were associated with the greater use of force against black suspects relative to other racial groups, both in the lab and in the real world.[52] Goff also did not find significant differences between black and white officers in the level of stereotype threat they experienced.[53]

It is tempting to explain this counterintuitive result by suggesting that officers who have high levels of stereotype threat are also aversive racists. Aversive racists are individuals who are consciously egalitarian but unconsciously biased.[54] However, if this were the case, then we would expect to see a relationship between unconscious bias and stereotype threat. Yet, this relationship did not exist.

It is more likely that this response is tied to legitimacy and how officers are trained to respond to safety concerns. In his important work, Tom Tyler has demonstrated that subordinates are more willing to voluntarily defer to authorities and to follow their rules when those authorities are perceived to be trustworthy and legitimate.[55] Thus, legitimacy reduces the need to rely upon coercive force to obtain compliance.[56] While this focus on how subordinate groups judge the legitimacy of authorities is important, new evidence demonstrates that it is equally critical to attend to how dominant groups understand their own legitimacy.

In a recent study, Goff and his team examined whether officers' concerns about legitimacy would influence their sense of safety and anxiety.[57] One hundred fourteen officers from two police departments participated in the study.[58] Officers' legitimacy judgments were assessed along two dimensions: whether they viewed their actions as legitimate and their understanding of how others perceived their legitimacy.[59]

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50. *Id.* at 4.
51. *Id.* at 11.
52. *Id.*
53. *Id.* at 5. As Goff notes, this could be attributed to either the small sample size of non-white officers. *Id.* Fifty-three percent of the officers were white, 28 percent were Hispanic, 6 percent were black and 6 percent were Asian, respectively. *Id.* at 4. It also could be related to concerns white officers may have had with admitting to a fear of being judged to be racist. *Id.* at 5. However, he also observed that non-white officers frequently mentioned occasions when citizens of the same race accused them of racism. *Id.*
54. Leanne S. Son Hing et al., *Exploring the Discrepancy Between Implicit and Explicit Prejudice: A Test of Aversive Racism Theory*, *in* SOCIAL MOTIVATION: CONSCIOUS AND UNCONSCIOUS PROCESSES 274–75 (Joseph P. Forgas et al. eds., 2005).
55. Tom R. Tyler, *Trust and Law Abidingness: A Proactive Model of Social Regulation*, 81 B.U. L. REV. 361, 386 (2001); *see also* TOM R. TYLER & YUEN J. HUO, TRUST IN THE LAW: ENCOURAGING PUBLIC COOPERATION WITH THE POLICE AND COURTS 49–96 (2002).
56. *See* Tyler, *supra* note 55, at 386; *see also* TOM R. TYLER, WHY PEOPLE OBEY THE LAW 4, 8 (2006).
57. *See* Phillip Atiba Goff et al., *Illegitimacy Is Dangerous: How Authorities Experience and React to Illegitimacy*, 4 PSYCHOL. 340, 341 (2013).
58. *Id.* at 342.
59. *Id.* at 340.

To examine both of these aspects of legitimacy, the researchers asked officers about a controversial policy that required them to enforce federal immigration laws by sometimes stopping individuals suspected of being undocumented and requesting proof of lawful immigration status.[60] Officers were asked about their own perceptions of the policy.[61] Additionally, because much of the debate surrounding this policy centered on the question of whether officers would disproportionately stop Latino residents, they were asked whether they believed the Latino community would respect them while they enforced the policy.[62] The authors used respect as a proxy for legitimacy.[63] The researchers also examined whether these legitimacy judgments would influence how anxious and how safe officers would feel when approaching either white or Latino suspects on the street to enforce the policy.[64] The results demonstrated that when officers perceived that enforcing the policy would cause Latino individuals to lose respect for them, they not only experienced anxiety but also expressed concern for their safety when imagining future encounters with Latinos.[65]

This study illuminates one reason why stereotype threat can cause officers to more readily use force against black suspects. Officers who believe black citizens will evaluate them as racist also likely suspect that those same citizens do not respect them and do not view them as legitimate. As the Goff study revealed, these anxieties can translate into concerns for their safety when confronting black citizens.[66]

When confronted with potentially threatening situations, Professor Frank Rudy Cooper has observed that officers are trained to perform "command presence" which involves "tak[ing] charge of a situation [and] projecting an aura of confidence and decisiveness. It is justified by the need to control dangerous suspects."[67] Officers who anticipate a dangerous situation based on their experience of stereotype threat may enact command presence when it is unnecessary. They may interpret the ambiguous behaviors of black suspects as dangerous and threatening given not only implicit racial biases but also their expectations that the situation is potentially dangerous. However, this command and control approach may backfire. As Professor Tom Tyler observes:

> [B]y approaching people from a dominance perspective, police officers encourage resistance and defiance, create hostility, and increase the likelihood that confrontations will escalate into struggles over dominance

60. *Id.* at 342.
61. *Id.*
62. *Id.*
63. *Id.*
64. *Id.*
65. *Id.* at 343.
66. *Id.* at 341–42.
67. Frank Rudy Cooper, *"Who's the Man?": Masculinities Studies,* Terry *Stops, and Police Training*, 18 COLUM. J. GENDER & L. 671, 674 (2009); *see also* Geoffrey P. Alpert, Roger G. Dunham & John M. MacDonald, *Interactive Police-Citizen Encounters That Result in Force*, 7 POLICE Q. 475, 476 (2004) (explaining the difference between "dominating force" and "accommodating force").

> that are based on force. The police may begin a spiral of conflict that increases the risks of harm for both the police and for the public.[68]

Thus, this series of events can explain why officers are more likely to use force against black citizens as a result of stereotype threat.

Note, however, that the same concerns do not arise in dealings with white citizens. First, there is no worry about stereotype threat, here defined as the fear of being evaluated as racist. Second, because of implicit favoritism, more evidence of danger will be required before their ambiguous actions generate safety concerns. Hence, officers are unlikely to enact command presence too early, thus not triggering the cascade of conflict that leads to the use of force.

B. Masculinity Threat

Another self-threat that can lead to racial violence is masculinity threat. Masculinity threat refers to the fear of being perceived as insufficiently masculine. I have discussed masculinity threat in depth elsewhere.[69] In summary, what it means to be masculine is socially constructed and thus, how people perform their masculine identity depends upon the social context. For men, maintaining their masculine identity often feels precarious because it is not perceived "as a developmental guarantee, but as a status that must be earned."[70] Thus, masculinity threat is pervasive among men. Men often respond with action to prove their masculinity when they feel that it is under threat. Sometimes, this gender performance takes the form of violence, especially in hypermasculine environments where exaggerated displays of physical strength and aggression are glorified and rewarded as a means of demonstrating and maintaining one's masculine identity.[71]

A recent study demonstrated that police officers' level of masculinity threat predicts their use of force against black men.[72] The researchers found that masculinity threat predicted whether officers had used force against black men, relative to men of other races, in the real world.[73] The use of force against black suspects was not correlated with either explicit or implicit racial bias.[74]

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68. Tyler, *supra* note 55, at 369 (citations omitted).

69. *See* Richardson & Goff, *supra* note 23, at 128–31.

70. Johnathan R. Weaver et al., *The Proof Is in the Punch: Gender Differences in Perceptions of Action and Aggression As Components of Manhood*, 62 SEX ROLES 241, 242 (2010) (citation omitted); *see also* Joseph A. Vandello et al., *Precarious Manhood*, 95 J. PERSONALITY & SOC. PSYCHOL. 1325, 1335 (2008) (finding that "manhood is seen as more of a social accomplishment that can be lost and therefore must be defended with active demonstrations of manliness").

71. Angela P. Harris, *Gender, Violence, Race, and Criminal Justice*, 52 STAN. L. REV. 777, 785 (2000); Vandello et al., *supra* note 70, at 1327; *see* Jennifer K. Bosson & Joseph A. Vandello, *Precarious Manhood and Its Links to Action and Aggression*, 20 CURRENT DIRECTIONS IN PSYCHOL. SCI. 82, 83 (2011).

72. *See generally* SAN JOSE REPORT, *supra* note 49.

73. *Id.* at 11; *see also* Phillip Atiba Goff et al., Voices of Dominance (unpublished manuscript) (on file with author).

74. SAN JOSE REPORT, *supra* note 49, at 11; Goff et al., *supra* note 73.

What might explain these results? First, despite the fact that police departments have become more gender diverse since the 1950s,[75] hypermasculinity amongst the rank and file is still the norm.[76] This orientation persists because departments remain male-dominated and continue to highlight the importance of physical strength in recruitment materials, reinforce the hypermasculine ideal during academy training, and police it through the harassment of women and gay men.[77] The militarization of the police also strengthens the association between policing and violent masculinity.[78] In hypermasculine environments, it is foreseeable that officers would respond to masculinity threats with aggression and even violence in order to prove their masculine identity. Second, black men likely pose the greatest threat to an officer's masculinity, especially if they are disrespectful or noncompliant, because they are stereotyped, both consciously and unconsciously, as more masculine than other men.[79] Thus, both race and masculinity intersect to facilitate racial violence.

Consider the grand jury testimony of Officer Wilson alleging that Michael Brown called him "too much of . . . a pussy to shoot."[80] No doubt this statement, coupled with Michael Brown's race and physical size, challenged Wilson's masculinity and might explain why the confrontation between Brown and Wilson ended in violence. Even if Officer Wilson is not consciously racist, unconscious biases may have influenced his perceptions of the threat posed by Brown. In fact, his grand jury testimony referring to Brown as "super human" and "a demon" suggests the officer also dehumanized him.[81] Additionally, masculinity threat can explain why Officer Wilson confronted Brown in the first place instead of calling for

75. David Alan Sklansky, *Not Your Father's Police Department: Making Sense of the New Demographics of Law Enforcement*, 96 J. CRIM. L. & CRIMINOLOGY 1209, 1210 (2006).

76. JAMES W. MESSERSCHMIDT, MASCULINITIES AND CRIME: CRITIQUE AND RECONCEPTUALIZATION OF THEORY 178 (1993) (citing Jennifer Hunt, *The Development of Rapport Through the Negotiation of Gender in Field Work Among Police*, 43 HUM. ORG. 283 (1984)); Susan Ehrlich Martin & Nancy C. Jurik, DOING JUSTICE, DOING GENDER: WOMEN IN LAW AND CRIMINAL JUSTICE OCCUPATIONS 43 (2d ed. 2006).

77. Richardson & Goff, *supra* note 23, at 131–32.

78. *See* Peter B. Kraska & Victor E. Kappeler, *Militarizing American Police: The Rise and Normalization of Paramilitary Units*, 44 SOC. PROBS. 1, 2–3 (1997); U.S. Dep't of Justice, *Technology Transfer from Defense: Concealed Weapon Detection*, 229 NAT'L INST. OF JUST. J. 1, 35 (1995) (the 1981 Military Cooperation with Law Enforcement Act and the 1984 National Defense Authorization Act gave military weapons and technology to departments to aid in the drug war); *see also* National Defense Authorization Act for Fiscal Year 1997, Pub. L. No. 104-201, 110 Stat. 2422, 2639 (1996), *available at* www.nps.gov/legal/laws/104th/104-201.pdf; RADLEY BALKO, OVERKILL: THE RISE OF PARAMILITARY POLICE RAIDS IN AMERICA 27 (2006).

79. For an in-depth discussion, see Richardson & Goff, *supra* note 23, at 120–28.

80. Conor Friedersdorf, *Witnesses Saw Michael Brown Attacking—and Others Saw Him Giving Up*, ATLANTIC (Nov. 25, 2014), http://www.theatlantic.com/national/archive/2014/11/major-contradictions-in-eyewitness-accounts-of-michael-browns-death/383157/.

81. Frederica Boswell, *In Darren Wilson's Testimony, Familiar Themes About Black Men*, NPR (Nov. 26, 2014), http://www.npr.org/blogs/codeswitch/2014/11/26/366788918/in-darren-wilsons-testimony-familiar-themes-about-black-men.

backup before engaging with him. As one police veteran relates, "[O]fficers who 'call for help' are seen as weak, as vulnerable, and as feminine . . . . The subculture dictates that 'real men' will never need to call for help; those who do are often subjected to ridicule and scorn after having done so."[82]

III. IMPLICATIONS

The influence of implicit racial biases, stereotype threat, and masculinity threat on police behavior explains why racial violence is inevitable and overdetermined even in the absence of conscious racial animus. Thus, while punishing bad racial actors is important,[83] racial violence will continue unabated even if we could discover and remove all consciously racist officers from the department. That is because the major problem is not dispositional, but rather, situational.

The key to reducing racial violence is to transform current policing strategies and cultures that create an "us-versus-them" mentality between officers and the non-white communities they police. This is because positive intergroup contact is a proven method for reducing the influence of implicit racial biases[84] and getting to know people makes it more difficult to dehumanize them.[85] Furthermore, when officers are able to build relationships with non-white citizens, they are less likely to worry about being stereotyped as racist.

However, officers are rarely in situations where they interact in positive ways with non-white citizens. Rather than creating incentives for officers to work together with the community to identify and address the underlying causes of disorder, current policing practices discourage the social work aspects of policing in favor of proactive, aggressive policing strategies that prize arrests over problem-solving. Such practices make it difficult for officers and community members to have positive contacts and to build relationships that are not defined by distrust and suspicion. As a result, officers experience stereotype threat because they know the community believes they are racist. Furthermore, because of their awareness that

82. Thomas Nolan, *Behind the Blue Wall of Silence*, 12 MEN & MASCULINITIES 250, 255 (2009).

83. Strategies for holding officers liable for their misconduct is woefully inadequate. *See* Erwin Chemerinsky, Op-Ed., *How the Supreme Court Protects Bad Cops*, N.Y. TIMES, Aug. 27, 2014, at A23 (discussing how U.S. Supreme Court decisions protect officers from liability); *see also* Kevin M. Keenan & Samuel Walker, *An Impediment to Police Accountability? An Analysis of Statutory Law Enforcement Officers' Bills of Rights*, 14 B.U. PUB. INT. L.J. 185 (2005) (discussing the impact of police officer bill of rights on police accountability); Barbara E. Armacost, *Organizational Culture and Police Misconduct*, 72 GEO. WASH. L. REV. 453, 463 (2004); Rachel A. Harmon, *The Problem of Policing*, 110 MICH. L. REV. 761 (2012).

84. Calvin K. Lai et al., *Reducing Implicit Racial Preferences: A Comparative Investigation of 17 Interventions*, 143 J. EXPERIMENTAL PSYCHOL. 1765, 1772 (2014); Calvin K. Lai et al., *Reducing Implicit Prejudice*, 7 SOC. & PERSONALITY PSYCHOL. COMPASS 315, 317 (2013).

85. Richardson & Goff, *supra* note 23, at 123.

members of the community view them as illegitimate, they enact command presence, which escalates rather than defuses already tense situations.

Thus, building relationships between officers and the community can reduce racial violence. Of course, doing this is easier said than done. Although community policing is a popular philosophy, most officers remain disengaged from the communities they police and continue to denigrate aspects of the job they associate with "social work."[86] These attitudes are understandable since success continues to be measured largely by the number of arrests made and how quickly officers respond to calls for service.[87] Why would an officer expend energy on more time-consuming problem-solving activities when these are unlikely to be rewarded?

Police departments are not solely to blame for this reward structure. Some federal grants create incentives for departments to engage in aggressive, proactive policing by tying funds to the number of arrests made.[88] It is no surprise, then, that departments encourage their officers to engage in policing practices such as stops and frisks that result in arrests but which end up alienating communities. Thus, creating incentives for officers to focus more on relationship building and problem-solving rather than on arrests will require interventions at both the institutional and national level. Rewarding the problem-solving and social work aspects of policing will naturally lead to changes in the hypermasculine police culture because those individuals not interested in engaging in this type of policing will no longer be attracted to the field. Furthermore, as these problem-solving and relational skills become more important, departments will have to begin recruiting individuals who excel in these areas, again helping to slowly change the culture.

While this intervention is large-scale and long-term, a more concrete intervention is for departments to begin collecting data to determine whether any of their practices result in racially disparate impacts. Some departments are already doing this. For instance, in 2008, the police chief in Kalamazoo, Michigan, did just that. Responding to community concerns over racial profiling, he put systems in place to gather data and hired a consulting group to conduct a study within his department.[89] When the study revealed racial disparities in the policing of black citizens, he shared the report with the community and implemented changes in policy that required officers to have reasonable suspicion before asking for consent to search.[90]

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86. For an in-depth discussion, see *id.* at 143–47.

87. George L. Kelling & Mark H. Moore, *The Evolving Strategy of Policing*, *in* COMMUNITY POLICING: CLASSICAL READINGS 105–06 (Willard M. Oliver ed., 2000); George L. Kelling & William J. Bratton, *Implementing Community Policing: The Administrative Problem*, *in* COMMUNITY POLICING, *supra*, at 261.

88. MICHELLE ALEXANDER, THE NEW JIM CROW: MASS INCARCERATION IN THE AGE OF COLORBLINDNESS 75–82 (2010).

89. *See* Lorie Fridell, *Psychological Research Has Changed How We Approach the Issue of Biased Policing*, SUBJECT TO DEBATE, May–June 2014.

90. *Id.*

Another fruitful example is exemplified by the work of the Center for Policing Equity (CPE) based at UCLA.[91] CPE has been successful in working closely with police departments to identify some of the causes of racially biased policing and to implement solutions.[92] For instance, when working with the Las Vegas Police Department, the group found that many uses of force by police officers against racial minorities occurred after foot chases in non-white neighborhoods. Acknowledging that it would be difficult for officers engaged in a foot chase to stop and think about whether implicit racial biases were influencing their behaviors, CPE instead helped the department develop new rules to address the problem. Under the new policy, the officer engaged in a pursuit would no longer be allowed to lay hands on the suspect. Rather, another officer would be required to step in if force was necessary. This change resulted in a significant decline in the use of force against people of color.[93]

One challenge is that departments may be reluctant to gather racial data because of concerns that exposing their practices to outside review will subject them to liability. CPE has developed a way to overcome liability concerns. CPE researchers and departments sign a memorandum of understanding that provides legal protection against disclosure of confidential data, guarantees departments that they will be the first to learn of the results, allows departments to elect to remain anonymous when the results are published, and gives them a reasonable time to implement solutions, inform the press, or do nothing.[94]

Admittedly, it can be difficult to speak to police departments about gathering racial data because of the inevitable defensiveness that often accompanies discussions of race. This problem is exacerbated by the fact that many people employ colorblindness as a strategy to reduce racial anxiety.[95] CPE has been successful in overcoming this defensiveness and developing close, working relationships with numerous police departments. Goff relates he has achieved this in part by approaching departments guided by two assumptions. The first is "that everyone involved wants to do the right thing—that is, that the research partners are not bigots."[96] The second is that "ridding a department of racism is both a worthy goal and a difficult one."[97] These assumptions help overcome understandable defensiveness

91. CPE is "a research and action think tank that works with police departments to conduct original research in the interest of improving equity in police organizations and the delivery of police services." Phillip Atiba Goff et al., *(The Need for) A Model of Translational Mind Science Justice Research*, 1 J. SOC. & POL. PSYCHOL. 385, 391 (2013). Goff is CPE's cofounder and president.

92. *Id.* at 394.

93. Mooney, *supra* note 22.

94. Goff et al., *supra* note 91, at 392.

95. Evan P. Apfelbaum et al., *Seeing Race and Seeming Racist? Evaluating Strategic Colorblindness in Social Interaction*, 95 J. PERSONALITY & SOC. PSYCHOL. 918, 919 (2008); Phillip Atiba Goff et al., *Anything but Race: Avoiding Racial Discourse to Avoid Hurting You or Me*, 4 PSYCHOL. 335 (2013).

96. Goff et al., *supra* note 91, at 393.

97. *Id.*

that arises when issues of race are discussed as well as when racial disparities, sometimes stark, are discovered.[98]

Moving beyond a focus on conscious racial bias is another way to overcome defensiveness. The Fair and Impartial Policing (FIP) program has been successful in educating departments about the influence of implicit biases. FIP is a comprehensive program that relies on the science of implicit racial bias to help departments move toward unbiased policing practices.[99] It "addresses the ill-intentioned police who produce biased policing and the overwhelming number of well-intentioned police in this country who aspire to fair and impartial policing, but who are human like the rest of us."[100] The program involves trainings as well as issues related to recruitment and hiring, internal policies and procedures, outreach to the community, and creating accountability mechanisms and measurement tools to track data.[101] This program has been adopted by a number of police departments[102] and several states are considering statewide adoption of the program.[103] The program is being taken seriously by police leadership[104] and is gaining traction.[105] Many officers who have taken part in the program have praised it, making comments like: "It changed my perception,"[106] "I will better recognize bias and be able to address it with officers,"[107] and "could see doing this training in my retirement, would feel proud and honored to be involved in a program like this."[108]

Not only can this program help departments understand the importance of being race conscious when it comes to policing, but also, if departments begin to implement trainings such as those provided by the FIP program, they also can begin to tie promotions and other job perks to demonstrable

98. *Id.*

99. For information on this program, see Lorie Fridell, *FIP Client*, FAIR & IMPARTIAL POLICING, http://www.fairimpartialpolicing.com (last visited Apr. 23, 2015).

100. *Id.*

101. *Id.*

102. Lorie Fridell, *Press*, FAIR & IMPARTIAL POLICING, http://www.fairimpartialpolicing.com/press/ (last visited Apr. 23, 2015).

103. *See* Fridell, *supra* note 99.

104. *See, e.g.*, Tracey G. Cove, *Implicit Bias and Law Enforcement*, POLICE CHIEF, Oct. 2011, at 44, *available at* http://static.squarespace.com/static/54722818e4b0b3ef26cdc085/t/54790aece4b03c29747eb163/1417218796679/press-thepolicechief.pdf.

105. *See* Fridell, *supra* note 99.

106. UNIV. OF CAL. BERKELEY POLICE DEP'T, OFFICERS: RACIAL PROFILING, FAIR AND IMPARTIAL POLICING B, *available at* http://static.squarespace.com/static/54722818e4b0b3ef26cdc085/t/5472b283e4b0367870bd3335/1416802947888/rberkb.pdf (compiling course evaluations).

107. LORIE A. FRIDELL, FAIR AND IMPARTIAL POLICING 5, *available at* http://static.squarespace.com/static/54722818e4b0b3ef26cdc085/t/5478bbd4e4b045935f33df73/1417198548003/overview-program.pdf.

108. UNIV. OF CAL. BERKELEY POLICE DEP'T, OFFICERS: RACIAL PROFILING, FAIR AND IMPARTIAL POLICING A, *available at* http://static1.squarespace.com/static/54722818e4b0b3ef26cdc085/t/5472b245e4b081a2addcb9a9/1416802885101/rberka.pdf (compiling course evaluations); *see also* Lorie A. Fridell, *Racially Biased Policing: The Law Enforcement Response to the Implicit Black-Crime Association*, *in* RACIAL DIVIDE: RACIAL AND ETHNIC BIAS IN THE CRIMINAL JUSTICE SYSTEM (Michael J. Lynch, E. Britt Patterson & Kristina K. Childs eds., 2008).

changes in an officer's behaviors in response to what he or she learned. This is not only a way of changing incentives, but it also will help to change department culture as officers who are not motivated and committed to making the necessary adjustments will slowly be weeded out of the department.

CONCLUSION

It will not be easy to transform current policing practices and culture in order to address racial violence. Doing so will not only require changes within police departments but also in legal doctrine and legislation. This is a tall order given that the problem of policing and race is a perennial one. However, now is a particularly auspicious time to push for meaningful, groundbreaking changes to police practices and culture. The high-profile cases of police violence, intransigence, and arrogance,[109] coupled with signs of optimism[110] have brought issues of policing to the public consciousness in ways not seen in recent history. Furthermore, the public protests that have sprung up across the country in response to the failure to indict police officers for killing unarmed black men have and will continue to play a critical role in facilitating the debate over the meaning of policing and how it should be reformed. As Professors Lani Guinier and Gerald Torres explained in a recent article, social movements can play a role in facilitating "the cultural shifts that make durable legal change possible."[111] Perhaps through their activism bringing attention to and contesting current policing practices, these movements can spark changes in how our society views the police in ways that will make changes to policing seem inevitable and appropriate. Until this occurs, we can expect that racial violence against unarmed black men will continue unabated.

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109. Matt Taibbi, *The NYPD's "Work Stoppage" Is Surreal*, ROLLING STONE (Dec. 31, 2014), http://www.rollingstone.com/politics/news/the-nypds-work-stoppage-is-surreal-20141231.

110. For instance, the police chief of Richmond, California, recently took part in a protest against police brutality, holding a sign that read "Black Lives Matter." Robert Rogers, *Richmond Police Chief a Prominent Participant in Protest Against Police Violence*, CONTRA COSTA TIMES (Dec. 9, 2014), http://www.contracostatimes.com/west-county-times/ci_27102218/richmond-police-chief-prominent-participant-local-protest-against. Additionally, in December 2014, the Obama Administration created the Task Force on 21st Century Policing. *See* David Hudson, *President Obama Creates the Task Force on 21st Century Policing*, WHITE HOUSE BLOG (Dec. 18, 2014), http://www.whitehouse.gov/blog/2014/12/18/president-creates-task-force-21st-century-policing. The task force "will examine, among other issues, how to strengthen public trust and foster strong relationships between local law enforcement and the communities that they protect, while also promoting effective crime reduction." Press Release, Office of the Press Sec'y, White House, Fact Sheet: Task Force on 21st Century Policing (Dec. 18, 2014), http://www.whitehouse.gov/the-press-office/2014/12/18/fact-sheet-task-force-21st-century-policing.

111. Lani Guinier & Gerald Torres, *Changing the Wind: Notes Toward a Demosprudence of Law and Social Movements*, 123 YALE L.J. 2740, 2743 (2014).

Center for Council and Center for Mindfulness in Corrections
Draft Proposal for a Wellness & Resiliency Skills Training Pilot
California Department of Corrections & Rehabilitation

Vision: Establish an ongoing Wellness & Resiliency Skills Training program for CDCR staff designed to protect staff health and safety, enhance staff morale and provide staff with the skills they need to effectively manage job stress and build a healthy, positive and resilient CDCR staff culture in support of positive correctional outcomes.

Providers: Center for Council (C4C) and Center for Mindfulness in Corrections (CMC). C4C is a nonprofit agency providing training in council practice to organizations, business and institutions, including correctional facilities. CMC is a nonprofit agency providing evidence-based professional development training in the areas of wellness, communication, management and leadership to corrections, law enforcement, treatment agencies and personnel. This unique program combines the pioneering curriculum development that has been the hallmark of Center for Mindfulness in Corrections with the groundbreaking work Center for Council has accomplished in working with a variety of CDCR divisions and stakeholders, including rehabilitative programming and reentry support, community outreach and organizational policy development with staff leadership; C4C is currently providing services at 14 CDCR facilities.

Program: An initial 10-week pilot Wellness & Resiliency Skills Training program based on the CMC mindfulness-based wellness & resiliency (MBWR)™curriculum and designed to deliver to participants a broad range of simple and practical stress management, health maintenance, communication and resiliency building skills with which to improve performance and quality of life both on and off the job while significantly reducing the serious health risks faced by corrections professionals. Coaching to develop ongoing, council-based community of practice groups to sustain and extend the mindfulness-based wellness & resiliency (MBWR) skills learned and to provide ongoing peer-based support.

The pilot 10-week Wellness & Resiliency Skills Training would train up to sixty (60) CDCR personnel and include the following core components:

- **full-day introductory mindfulness-based Wellness & Resiliency Skills Training,** delivered by CMC Training Director Fleet Maull and C4C Director Jared Seide.

- **eight two-hour Council group sessions (ten officers in each group),** focused on the following areas (facilitated by C4C staff):

  > **Self Care Skills** for effective stress management and resilience building
  1) *Physical Resilience* – healthy nutrition, exercise, hydration, breathing, moderation
  2) *Mental Resilience* – mindfulness exercises, positive attitude, brain training & education
  3) *Emotional Resilience* – empathy, emotional literacy, emotion regulation, peer support
  4) *Spiritual Resilience* – faith & spirituality; gratitude & forgiveness, community service; nature

  > **Shift Readiness Skills** for effective stress management & optimal performance
  5) *Self-Awareness* – mindful attention, presence, reframing, positive outlook
  6) *Self-Management* – manage triggers, state shift with breathing, defuse drama
  7) *Social Awareness* – body language, empathic listening, aware of others' needs
  8) *Relationship Management* – effective communication & conflict management

- **final full-day Training, Debrief and Graduation** led by CMC Training Director Fleet Maull and C4C Director Jared Seide.

Deliverables:

- A strong foundation for a CDCR personnel/facility culture shift from stress, burnout, denial, untreated trauma exposure and the resulting emotional problems, health risks and health costs to a staff culture of healthy self-management & self-care, emotionally & socially intelligent communication, effective stress & conflict management, and overall staff wellness and safety.
- A measureable reduction in staff burnout (corrections fatigue).
- Improved staff morale and improved correctional outcomes achieved by healthier, more resilient, and more emotionally and socially intelligent and skillful corrections staff.
- Prevention of and/or measurable reduction in suicide, PTSD-related incidents, and trauma/stress-caused family discord, domestic violence, substance abuse, etc.
- Reduction in DOC costs for chronic stress or burnout related staff absences, lost-time injuries, staff turnover and related healthcare costs.
- Overall long-term health care savings through improved wellness and preventive health care programs.

Training Content:

- Mindfulness-Based Wellness & Resiliency (MBWR) skills training similar to that now being provided in many areas of U.S. society, including Fortune 500 corporations, law enforcement, K-12 education, health care, etc.
- Mindfulness-Based Emotional Intelligence (MBEI) training designed to increase capacity for self-awareness, self-management (including emotion regulation), social awareness (reading behavioral cues and empathy training), and communication and interpersonal relations management.
- Council training – basic training in the practice of council, a modern practice derived from many ancient forms of communicating in a circle. Sometimes referred to as "Listening Circles," council utilizes a center, a circle, and a talking piece to create an intentional space in which to share our stories.
- Support for sustaining these "communities of practice" beyond the completion date of this training program.
- Resiliency and stress management training
- Burnout and PTSD recovery training
- Accountability and self-empowerment training
- Psychological/emotional trauma first aid information
- Family applications: mitigating family impact of on-the-job stress and trauma, developing healthy family communication and conflict management
- Developing healthy support systems and resources

Specific skills taught include:

- Attention, focusing and mindfulness skills
- Physiology management and balancing skills
- Breath regulation and other stress management skills and practices
- Self-care and wellness practices
- Cognitive reframing skills and positive attitudinal skills
- Emotion regulation & self-management skills
- Listening – engaged, empathic and reflective listening skills
- Effective communication skills
- Difficult conversation skills
- Conflict de-escalation and conflict management skills

APPENDIX H– AVERAGE NUMBER OF INCIDENTS PER 100 INMATES, JUNE 2014-JUNE 2015.

Prison	Average # Incidents per 100 Inmates	June 2015 Inmate Count	June 2015 SNY Pop	All Levels	SNY Levels	Mission
SAC	5.13	2319	N/A	I, IV, PSU, SHU	N/A	HS
LAC	1.96	3494	896	I, III, IV	IV	HS
SVSP	1.95	3678	1468	I, III, IV	III, IV	HS
CMF	1.69	2269	N/A	I, II, III	N/A	FOPS
COR	1.50	4405	1850	I, III, IV, SHU, PHU	III, IV	HS
KVSP	1.30	3638	1578	I, IV, THU	IV	HS
CAL	1.30	3774	922	I, IV	IV	GP
MCSP	1.18	2941	2778	I, III, IV	I, III, IV	GP
RJD	1.10	3148	2118	I, III, IV	III, IV	RC
HDSP	1.07	3300	1009	I, III, IV	III, IV	HS
PBSP	0.97	2742	N/A	I, IV, PSU, SHU	N/A	HS
NKSP	0.89	4365	N/A	I, III, RC	N/A	RC
WSP	0.85	4881	N/A	I, III, RC	N/A	RC
DVI	0.81	2117	N/A	I, II, RC	N/A	RC
CRC	0.77	2434	784	II	II	RC
SATF	0.75	5581	3156	II, III, IV	II, III, IV	HS
CMC	0.72	3809	N/A	I, II, III	N/A	RC
CCC	0.71	4089	N/A	I, II, III	N/A	RC
CEN	0.67	3489	871	I, III, IV	III	GP
SQ	0.65	3687	N/A	II, RC	N/A	RC
CIM	0.62	3802	1810	I, II, RC	II	RC
SOL	0.59	3866	N/A	II, III	N/A	GP
PVSP	0.55	2271	1274	I, III	III	GP
FSP	0.53	2876	N/A	I, II, FWF	N/A	FOPS
ISP	0.50	3401	1561	I, III	I, III	GP
CCI	0.50	3931	3186	I, II, III, IV, SHU	I, II, III, IV	HS
SCC	0.44	4345	788	I, II, III	III	RC
VSP	0.35	3379	3326	II	II	GP
ASP	0.35	2766	2324	II	II	GP
CVSP	0.25	2264	1178	I, II	I, II	GP
CTF	0.21	5167	2668	I, II	II	GP

The institutions highlighted in green house the SNY inmates described in the columns.

APPENDIX I– AVERAGE NUMBER OF INMATE DISCIPLINARY ACTIONS PER 100 INMATES JUNE 2014-JUNE 2105.

Prison	Average # Inmate Disciplinary Actions, per 100 Inmates	June 2015 Inmate Count	June 2015 SNY Pop	All Levels at this Prison	SNY Levels at this Prison	Mission
LAC	16.03	3494	896	I, III, IV	IV	HS
SAC	15.05	2319	N/A	I, IV, PSU, SHU	N/A	HS
CCC	10.82	4089	N/A	I, II, III	N/A	RC
MCSP	9.89	2941	2778	I, III, IV	I, III, IV	GP
SCC	9.75	4345	788	I, II, III	III	RC
CAL	8.82	3774	922	I, IV	IV	GP
CEN	8.22	3489	871	I, III, IV	III	GP
CRC	7.77	2434	784	II	II	RC
KVSP	7.75	3638	1578	I, IV, THU	IV	HS
SVSP	7.64	3678	1468	I, III, IV	III, IV	HS
SATF	7.09	5581	3156	II, III, IV	II, III, IV	HS
RJD	7.00	3148	2118	I, III, IV	III, IV	RC
SOL	6.58	3866	N/A	II, III	N/A	GP
WSP	6.41	4881	N/A	I, III, RC	N/A	RC
COR	6.28	4405	1850	I, III, IV, SHU, PHU	III, IV	HS
PVSP	6.20	2271	1274	I, III	III	GP
CMF	5.65	2269	N/A	I, II, III	N/A	FOPS
ISP	5.60	3401	1561	I, III	I, III	GP
DVI	5.29	2117	N/A	I, II, RC	N/A	RC
CIM	5.22	3802	1810	I, II, RC	II	RC
CMC	5.00	3809	N/A	I, II, III	N/A	RC
NKSP	4.73	4365	N/A	I, III, RC	N/A	RC
ASP	4.02	2766	2324	II	II	GP
PBSP	4.01	2742	N/A	I, IV, PSU, SHU	N/A	HS
HDSP	3.97	3300	1009	I, III, IV	III, IV	HS
VSP	3.56	3379	3326	II	II	GP
FSP	3.12	2876	N/A	I, II, FWF	N/A	FOPS
CCI	2.97	3931	3186	I, II, III, IV, SHU	I, II, III, IV	HS
CVSP	2.96	2264	1178	I, II	I, II	GP
SQ	2.86	3687	N/A	II, RC	N/A	RC
CTF	2.34	5167	2668	I, II	II	GP

The institutions highlighted in green house the SNY inmates described in the columns.

APPENDIX J–WCI TASER BODY CAMERA PILOT

TASER BODY CAMERA PILOT

WCI began a pilot in conjunction with TASER International with the Institution receiving 10 units (6 AXON Flex and 4 AXON Body) the pilot also included a docking station as well as 40 staff members with accounts to Evidence.com for video review, archiving and storage purposes. During the 6 month pilot WCI staff created over 15,000 video downloads ranging from a couple of minutes to 45 minutes in duration. During this time the following areas were compared PREA allegations against staff in Segregation, Reactive use of force incidents and inmate complaints.

PREA Complaints Segregation by Month

July 2013 – 2	July 2014 – 2
August 2013 – 3	August 2014 – 1
September 2013 – 4	September 2014 – 6
October 2013 – 1	October 2014 – 2
November 2013 – 4	November 2014 – 1
December 2013 – 2	December 2014 – 9
Total – 16	Total – 21

Between January 2014 and June 2014 – 18

NCH Program PREA investigations initiated between July 2013 – July 2014 – 0 Total

NCH Program PREA investigations initiated since July 2014 – 4 Total

Staff Assaults Segregation by Month

July 2013 – 1	July 2014 – 1
August 2013 – 3	August 2014 – 3
September 2013 – 4	September 2014 – 1
October 2013 – 3	October 2014 – 1
November 2013 – 1	November 2014 – 2
December 2013 – 7	December 2014 – 1
Total – 19	Total – 9

*Between January and June 2014 – 12

APPENDIX J–WCI TASER BODY CAMERA PILOT

Staff Assaults Segregation

Between July and December 2013 – WCI had 19 staff assaults in Segregation

Between July and December 2014 – WCI had 9 staff assaults in Segregation

Inmate Complaints Segregation

From January 1, 2014 – June 30, 2014 – 549 total inmate complaints approximately 91 per month

From July 1, 2014 – October 9, 2014 – 307 total inmate complaints approximately 100 per month

From January 1, 2014 – June 30, 2014 – 57 inmate complaints regarding staff issues

From July 1, 2014 – October 9, 2014 – 34 inmate complaints regarding staff issues

From January 1, 2014 to June 30, 2014 there were 2 staff misconduct complaints from SEG

From July 1, 2014 to Present there were 4 staff misconduct complaints from SEG

From January 1, 2014 to June 30, 2014 there were 7 staff sexual misconduct complaints from SEG

From July 1 to Present, there were also 7 such complaints from SEG

At the conclusion of the pilot program WCI found that there was a difference in the amount of reactive use of force incidents however PREA allegation and inmate complaints remained consistent. WCI anticipated that the number of allegations would not change dramatically. Unlike Law Enforcement who utilize Body Cameras the pilot program was conducted strictly in a Maximum Security Segregation Building which contained approximately 180 inmates with lengthy history of assaultive and self-harm behaviors.

WCI did find the body cameras to be very effective. The AXON flex camera is the more expensive model available and can be mounted in a variety of different ways however we found that the small cord connecting the camera to the controller could be damaged/broken pretty easily. The AXON body camera is cheaper and more durable. Both cameras provided roughly the same view of an incident. They were both excellent for interactions at the cell door/trap and when speaking to inmates. They were not very effective while escorting inmates however the audio did give a perspective of what was taking place.

APPENDIX J–WCI TASER BODY CAMERA PILOT

In the beginning of the pilot staff were very apprehensive about wearing the camera while the inmate population appeared to be "playing" to the camera attempting to provoke an unprofessional response from staff. Training regarding Professional Communication Skills was conducted with all staff involved in the pilot and after a couple of weeks staff were comfortable wearing the cameras and the inmates had adjusted as well. I believe the cameras definitely enhanced the professionalism of staff and how they communicated with inmates. I could see a pretty dramatic change in the communication level of staff throughout the pilot and I was able to see which staff communicated well with inmates.

Although the amount of complaints or PREA allegations did not change it was much easier to review the allegations and determine if an incident occurred.

I believe the AXON body camera would be beneficial to a Security staff member however the degree they could be utilized would be determined by cost. The camera is very inexpensive the cost will be incurred with licensing for Evidence.com and storing data in the accounts as well as Evidence.com cold storage for long term archiving of videos.

The following is the draft policy utilized by WCI staff involved in the Taser Body Camera Pilot

PURPOSE: To insure that unexpected use of force, staff assisted strip searches and medical emergencies can be recorded and preserved in a Segregation setting.

POLICY: An inmate may be recorded by a body camera worn by Segregation staff while in Segregation. This may occur both during planned and reactive use of force incidents and will include any staff assisted strip searches as well as incident that occur at the cell door trap. The Waupun Correctional Institution requires that whenever the body camera is utilized, the subsequent outlined procedures will be adhered to.

GENERAL: Designated Segregation staff will be provided with either an Axon Flex body camera (worn either on the staff member's eyewear, hat, collar or epaulette). Or the Axon body camera (worn on the uniform shirt or jacket). Staff will utilize the body camera assigned to them and will be registered camera users with evidence.com for data collection and storage.

PROCEDURE:

Designated staff will be assigned a body camera and be entered into evidence.com for data tracking and evidence preservation purposes. The following are instances when staff will activate their body camera.

1. When responding to any type of Institution emergency.
2. Whenever interacting with a Segregation inmate at the cell door trap.
3. During any staff assisted strip search. During this type of search the staff member wearing the camera will conduct the search.

4. Anytime a staff member has physical contact with the inmate (escorting, responding to medical emergencies, restraining a disruptive inmate and dealing with a verbally disruptive inmate, etc.)

5. Staff will activate the camera by pressing the button to activate the camera as they respond to an emergency, when going onto a Segregation range where they anticipate having trap side contact or encounter a disruptive inmate.

6. Only at the completion of the incident or scene will the staff member shut off the body camera. Once a video camera has arrived on scene the body camera will continue to collect data and will not be turned off until the scene is cleared by the Shift Supervisor.

7. Staff responsible for utilizing a body camera will register with evidence.com and they will ensure they are logged into a camera at the beginning of their shift. This will occur at the start of each day. They will ensure the camera they utilize is placed in the appropriate docking station at the end of their shift.

MONITORING

1. The staff member will be responsible for monitoring their own recorded video footage/evidence. They will not be permitted access to other staff members downloads. Staff can only access or review their downloaded footage while in pay status while at the WCI.

2. Audio and video footage may be reviewed by the staff member assigned to the camera however only a system administrator will have access to delete any footage.

3. Whenever possible staff will ensure that the inmate is aware that their actions are being recorded with both audio and video footage, however there is no requirement to inform the inmate they are being monitored or recorded.

4. The body camera will be utilized for monitoring or recording inmates and their actions it is not intended to be used to record staff for disciplinary actions.

5. The Warden will determine which staff will have access to review multiple camera users.

RECORDKEEPING

1. Whenever a staff member is involved in an incident they will be required to complete all necessary documentation to include any incident reports (DOC-2466), Adult Conduct Reports (DOC-9 & 9A), Observation of Offender (DOC-112), Review of Placement of Offender in Restraints (DOC-111).

APPENDIX J–WCI TASER BODY CAMERA PILOT

2. An electronic record will be kept within evidence.com of anytime a video account is accessed and will include the date, time and who accessed the video account. Only the

3. System Administrator will have the ability to delete a video and that will be included on the evidence.com electronic record.

4. The Security Director will assign a staff member to transpose or capture date on a recordable disk for possible disciplinary action or from Law Enforcement.

2015 Special Review:
High Desert State Prison
Susanville, CA

OFFICE OF THE INSPECTOR GENERAL

Robert A. Barton
INSPECTOR GENERAL

Roy W. Wesley
CHIEF DEPUTY INSPECTOR GENERAL

STATE OF CALIFORNIA
December 2015

Exhibit AAA

SUMMARY OF MENTAL HEALTH POPULATION BY INSTITUTION AND LEVEL OF CARE (H1)

CONFIDENTIAL

Data Refreshed: 7/10/20 6:07 AM

Mental Health Summary by Level of Care

Institution	Correctional Clinical Case Management System (CCCMS)				Enhanced Outpatient Program (EOP)						Mental Health Crisis Bed (MHCB)				Intermediate Care Facility (ICF)				Acute Psychiatric Program (APP)				Total Mental Health Population
	Operational Capacity	Population	% Occupied	Vacant Beds	EOP Operational Capacities: General Population (GP)	EOP Operational Capacities: Administrative Segregation Unit (ASU)	EOP Operational Capacities: Psychiatric Services Unit (PSU)	Population	% Occupied	Vacant Beds	Design Capacity	Population	% Occupied	Vacant Beds	Design Capacity	Population	% Occupied	Vacant Beds	Design Capacity	Population	% Occupied	Vacant Beds	
ASP	1,100	958	87 %	142				5		-5		3		-3									966
CAL		16		-16				1		-1		2		-2									19
CCC		2		-2																			2
CCI	1,850	1,351	73 %	499				12		-12		1		-1									1,364
CEN		19		-19																			19
CHCF	550	644	117 %	-94	375	50		579	136 %	-154	95	9	9 %	86	356	363	102 %	-7	161	84	52 %	77	1,679
CIM	1,050	906	86 %	144				37		-37	34	1	3 %	33		18		-18		7		-7	969
CMC	750	677	90 %	73	552	100		581	89 %	71	50	15	30 %	35		16		-16		10		-10	1,299
CMF	600	456	76 %	144	391	58		500	111 %	-51	50	10	20 %	40	257	235	91 %	22	207	173	84 %	34	1,374
COR	1,000	1,095	110 %	-95	366	100		263	56 %	203	24	6	25 %	18		6		-6		14		-14	1,384
CRC	1,150	1,073	93 %	77				2		-2													1,075
CTF	1,500	1,302	87 %	198				8		-8		4		-4									1,314
CVSP		2		-2																			2
DVI	500	331	66 %	169																			331
FOL	500	512	102 %	-12				6		-6		1		-1									519
HDSP	1,050	1,042	99 %	8				11		-11	10	3	30 %	7		1		-1					1,057
ISP	0	22		-22				1		-1													23
KVSP	900	1,008	112 %	-108	96			124	129 %	-28	12	3	25 %	9		5		-5		3		-3	1,143
LAC	1,000	761	76 %	239	600	100		545	78 %	155	12	4	33 %	8		28		-28		11		-11	1,349
MCSP	1,350	1,481	110 %	-131	774	50		668	81 %	156	8	6	75 %	2		7		-7		7		-7	2,169
NKSP	1,000	413	41 %	587				15		-15	10	1	10 %	9		1		-1		1		-1	431
PBSP	300	268	89 %	32				3		-3	10	1	10 %	9									272
PVSP	700	500	71 %	200				7		-7	6			6									507
RJD	1,500	1,324	88 %	176	894	63		841	88 %	116	14	10	71 %	4		9		-9		4		-4	2,188
SAC	500	472	94 %	28	642	64	172	732	83 %	146	44	19	43 %	25		22		-22		31		-31	1,276
SATF	2,000	1,782	89 %	218	660			524	79 %	136	20	3	15 %	17		10		-10		9		-9	2,328
SCC	400	520	130 %	-120				1		-1													521
SOL	1,000	645	65 %	355				8		-8	9	2	22 %	7									655
SQ	1,250	868	69 %	382	200			259	130 %	-59	0	4		-4	31	28	90 %	3	9	3	33 %	6	1,162
SVSP	850	826	97 %	24	396			371	94 %	25	10	2	20 %	8	246	201	82 %	45					1,400
VSP	1,350	1,050	78 %	300	372			331	89 %	41		4		-4						1		-1	1,386
WSP	1,300	782	60 %	518				22		-22	6	1	17 %	5		3		-3		4		-4	812
DSH-ASH		1		-1				3		-3		1		-1	256	218	85 %	38		3		-3	226
DSH-CSH															50	45	90 %	5		1		-1	46
Male Subtotal	**27,000**	**23,109**	**86%**	**3,891**	**6,318**	**585**	**172**	**6,460**	**91%**	**615**	**424**	**116**	**27%**	**308**	**1,196**	**1,216**	**102%**	**-20**	**377**	**366**	**97%**	**11**	**31,267**
CCWF	1,350	1,156	86 %	194	120	10		105	81 %	25	12	4	33 %	8		1		-1		2		-2	1,268
CIW	750	636	85 %	114	75	10	10	49	52 %	46	29	3	10 %	26	45	29	64 %	16		1		-1	718
FWF	150	109	73 %	41				1		-1													110
DSH-PSH		1		-1				2		-2					30	10	33 %	20					13
Female Subtotal	**2,250**	**1,902**	**85%**	**348**	**195**	**20**	**10**	**157**	**70%**	**68**	**41**	**7**	**17%**	**34**	**75**	**40**	**53%**	**35**	**0**	**3**		**-3**	**2,109**
Grand Total	**29,250**	**25,011**	**86%**	**4,239**	**6,513**	**605**	**182**	**6,617**	**91%**	**683**	**465**	**123**	**26%**	**342**	**1,271**	**1,256**	**99%**	**15**	**377**	**369**	**98%**	**8**	**33,376**

NOTES:

1. This report provides operational capacities, population, and vacant beds detail by mental health level of care and institution. Level of care is based on Current Mental Health level of care code in SOMS. For each level of care, a summary of patients by SOMS housing program and institution is provided. Data Source is HCODS, as of the "Data Refreshed" time stamp.
2. Definitions:
   - Operational Capacity = indicates the number of beds available in the program based on factors such as treatment space and staffing, as determined by CCHCS headquarters.
   - Design Capacity = indicates the total number of beds available in the program Determined by Facility Planning, Construction, & Management.
   - Population = total census per SOMS as of the "Data Refreshed" time stamp shown on the report.
   - % Occupied = ([Population] / [Operational Capacity]) x 100.
   - Vacant Beds = the number of beds available after subtracting the Population from the Operational Capacity.
   - The "PIP" column in the "Psychiatry Inpatient Program (PIP) Housing" refers to programs that have the ability to provide multiple levels of care.
3. PIP capacities:
   - SQ PIP is for male condemned patients only, and has a total capacity of 40 beds reflected under ICF capacity. It is noted that these are flex beds that can accomodate ICF, APP, and MHCB level of care.
   - CIW PIP has a total capacity of 45 beds reflected under ICF capacity. It is noted that these are flex beds that can accomodate ICF and APP level of care.
   - DSH-PSH has a total capacity of 30 beds reflected under ICF capacity. It is noted that these are flex beds that can accomodate ICF and APP level of care.
4. Housing Groups:

*GP Housing Group census includes patients in the following housing programs: Camp Program Beds, Debrief Processing Unit, Family Visiting, Fire House, General Population, Institution Hearing Program, Minimum Security Facility, Non-Designated Program Facility, Protective Housing Unit, Restricted Custody General Population, Sensitive Needs Yard, SNY Fire House, SNY

MSF, Transitional Housing Unit, Unkown, Varied Use and Work Crew.

SUMMARY OF MENTAL HEALTH POPULATION BY INSTITUTION AND LEVEL OF CARE

Data Refreshed: 7/10/20 6:07 AM

Correctional Clinical Case Management System (CCCMS) Level of Care Population by Housing Program

Institution	RC Reception Center	GP* General Population	EOP Enhanced Outpatient Program	MHCB Mental Health Crisis Bed	Psychiatric Inpatient Program (PIP) Housing			Specialized Medical Beds Housing			Segregated Housing							Total CCCMS Population
					Acute	Intermediate	PIP	CTC/SNF Correctional Treatment Center/Skilled Nursing Facility	Hospice	OHU Outpatient Housing Unit	ASU Administrative Segregation Unit	Condemned	LTRH Long Term Restricted Housing Unit	NDS Non-Disciplinary Segregation	PSU Psychiatric Services Unit	SHU Security Housing Unit	STRH Short Term Restricted Housing Unit	
ASP		955								3								958
CAL		9									7							16
CCC										2								2
CCI		1,303									48							1,351
CEN		14									5							19
CHCF		212	14	1	1			152		257	7							644
CIM	89	744								15	58							906
CMC		656						4			17							677
CMF		415	1					14	5	12	9							456
COR		877	5					11		6	1		116				79	1,095
CRC		1,071								2								1,073
CTF		1,282								8	12							1,302
CVSP		1									1							2
DVI	104	192								11	24							331
FOL		495									17							512
HDSP		992						6									44	1,042
ISP		22																22
KVSP		910	1					4									93	1,008
LAC		636	19								1						105	761
MCSP		1,428	27								26							1,481
NKSP	220	173						5			15							413
PBSP		222															46	268
PVSP		489															11	500
RJD		1,273	5					1			45							1,324
SAC		335	29					1			1		32		8		66	472
SATF		1,729	1					6									46	1,782
SCC		506								1	13							520
SOL		615		1				2			27							645
SQ	141	533						5			49	140						868
SVSP		736	5					5			5						75	826
VSP		1,026								11	13							1,050
WSP	620	142						3			17							782
DSH-ASH		1																1
DSH-CSH																		
Male Subtotal	**1,174**	**19,994**	**107**	**2**	**1**	**0**	**0**	**219**	**5**	**328**	**418**	**140**	**148**	**0**	**8**	**0**	**565**	**23,109**
CCWF	116	946						18			62	14						1,156
CIW		600						4		7	10					15		636
FWF		109																109
DSH-PSH		1																1
Female Subtotal	**116**	**1,656**	**0**	**0**	**0**	**0**	**0**	**22**	**0**	**7**	**72**	**14**	**0**	**0**	**0**	**15**	**0**	**1,902**
Grand Total	**1,290**	**21,650**	**107**	**2**	**1**	**0**	**0**	**241**	**5**	**335**	**490**	**154**	**148**	**0**	**8**	**15**	**565**	**25,011**

SUMMARY OF MENTAL HEALTH POPULATION BY INSTITUTION AND LEVEL OF CARE

Data Refreshed: 7/10/20 6:07 AM

Enhanced Outpatient Program (EOP) Level of Care Population by Housing Program

Institution	RC Reception Center	GP* General Population	EOP Enhanced Outpatient Program	MHCB Mental Health Crisis Bed	Psychiatric Inpatient Program (PIP) Housing			Specialized Medical Beds Housing			Segregated Housing							Total EOP Population
					Acute	Intermediate	PIP	CTC/SNF Correctional Treatment Center/Skilled Nursing Facility	Hospice	OHU Outpatient Housing Unit	ASU Administrative Segregation Unit	Condemned	LTRH Long Term Restricted Housing Unit	NDS Non-Disciplinary Segregation	PSU Psychiatric Services Unit	SHU Security Housing Unit	STRH Short Term Restricted Housing Unit	
ASP		4								1								5
CAL		1																1
CCC																		
CCI		11									1							12
CEN																		
CHCF			403	4	1	19		41		89	22							579
CIM	32	1									4							37
CMC		3	523	1				2			52							581
CMF		1	428	9	2	4		11	2	7	36							500
COR		1	193					18		3	48							263
CRC		2																2
CTF		8																8
CVSP																		
DVI																		
FOL		5									1							6
HDSP		4															7	11
ISP		1																1
KVSP		2	96					2									24	124
LAC			478					1			66							545
MCSP		3	610					1			54							668
NKSP	10										5							15
PBSP		3																3
PVSP		7																7
RJD			777					7			57							841
SAC			545	1							67				119			732
SATF		13	491					7									13	524
SCC		1																1
SOL		1		4							3							8
SQ	14	41	122					1			19	62						259
SVSP		27	306			5		1									32	371
VSP		9	319								3							331
WSP	19							1			2							22
DSH-ASH			1			2												3
DSH-CSH																		
Male Subtotal	**75**	**149**	**5,292**	**19**	**3**	**30**	**0**	**93**	**2**	**100**	**440**	**62**	**0**	**0**	**119**	**0**	**76**	**6,460**
CCWF	2	33	63					1			6							105
CIW			44								3				2			49
FWF		1																1
DSH-PSH		2																2
Female Subtotal	**2**	**36**	**107**	**0**	**0**	**0**	**0**	**1**	**0**	**0**	**9**	**0**	**0**	**0**	**2**	**0**	**0**	**157**
Grand Total	**77**	**185**	**5,399**	**19**	**3**	**30**	**0**	**94**	**2**	**100**	**449**	**62**	**0**	**0**	**121**	**0**	**76**	**6,617**

SUMMARY OF MENTAL HEALTH POPULATION BY INSTITUTION AND LEVEL OF CARE

Data Refreshed: 7/10/20 6:07 AM

Mental Health Crisis Bed (MHCB) Level of Care Population by Housing Program

Institution	RC Reception Center	GP* General Population	EOP Enhanced Outpatient Program	MHCB Mental Health Crisis Bed	Psychiatric Inpatient Program (PIP) Housing			Specialized Medical Beds Housing			Segregated Housing							Total MHCB Population
					Acute	Intermediate	PIP	CTC/SNF Correctional Treatment Center/Skilled Nursing Facility	Hospice	OHU Outpatient Housing Unit	ASU Administrative Segregation Unit	Condemned	LTRH Long Term Restricted Housing Unit	NDS Non-Disciplinary Segregation	PSU Psychiatric Services Unit	SHU Security Housing Unit	STRH Short Term Restricted Housing Unit	
ASP										3								3
CAL										2								2
CCC																		
CCI		1																1
CEN																		
CHCF				8	1													9
CIM				1														1
CMC				15														15
CMF				10														10
COR		1		5														6
CRC																		
CTF		4																4
CVSP																		
DVI																		
FOL											1							1
HDSP				3														3
ISP																		
KVSP				3														3
LAC			2	1							1							4
MCSP		4		2														6
NKSP				1														1
PBSP				1														1
PVSP																		
RJD			2	5				1			2							10
SAC				15										4				19
SATF				3														3
SCC																		
SOL				2														2
SQ					2		2											4
SVSP		2																2
VSP		4																4
WSP				1														1
DSH-ASH				1														1
DSH-CSH																		
Male Subtotal	0	16	4	77	3	0	2	1	0	5	4	0	0	4	0	0	0	116
CCWF				4														4
CIW				3														3
FWF																		
DSH-PSH																		
Female Subtotal	0	0	0	7	0	0	0	0	0	0	0	0	0	0	0	0	0	7
Grand Total	0	16	4	84	3	0	2	1	0	5	4	0	0	4	0	0	0	123

SUMMARY OF MENTAL HEALTH POPULATION BY INSTITUTION AND LEVEL OF CARE

Data Refreshed: 7/10/20 6:07 AM

Intermediate Care Facility (ICF) Level of Care Population by Housing Program

Institution	RC Reception Center	GP* General Population	EOP Enhanced Outpatient Program	MHCB Mental Health Crisis Bed	Psychiatric Inpatient Program (PIP) Housing			Specialized Medical Beds Housing			Segregated Housing							Total ICF Population
					Acute	Intermediate	PIP	CTC/SNF Correctional Treatment Center/Skilled Nursing Facility	Hospice	OHU Outpatient Housing Unit	ASU Administrative Segregation Unit	Condemned	LTRH Long Term Restricted Housing Unit	NDS Non-Disciplinary Segregation	PSU Psychiatric Services Unit	SHU Security Housing Unit	STRH Short Term Restricted Housing Unit	
ASP																		
CAL																		
CCC																		
CCI																		
CEN																		
CHCF					34	328		1										363
CIM				18														18
CMC			7	4							5							16
CMF			1	8	21	205												235
COR			5								1							6
CRC																		
CTF																		
CVSP																		
DVI																		
FOL																		
HDSP				1														1
ISP																		
KVSP			5															5
LAC			15	1				1			11							28
MCSP			5								2							7
NKSP	1																	1
PBSP																		
PVSP																		
RJD			4	5														9
SAC			7	4							1			1	9			22
SATF			6	2													2	10
SCC																		
SOL																		
SQ					5		23											28
SVSP		3				198												201
VSP																		
WSP	1							1			1							3
DSH-ASH		2	49	28	80	56		2		1								218
DSH-CSH		1	15	7	18	4												45
Male Subtotal	**2**	**6**	**119**	**78**	**158**	**791**	**23**	**5**	**0**	**1**	**21**	**0**	**0**	**1**	**9**	**0**	**2**	**1,216**
CCWF											1							1
CIW							29											29
FWF																		
DSH-PSH		4	2	1			3											10
Female Subtoal	**0**	**4**	**2**	**1**	**0**	**0**	**32**	**0**	**0**	**0**	**1**	**0**	**0**	**0**	**0**	**0**	**0**	**40**
Grand Total	**2**	**10**	**121**	**79**	**158**	**791**	**55**	**5**	**0**	**1**	**22**	**0**	**0**	**1**	**9**	**0**	**2**	**1,256**

SUMMARY OF MENTAL HEALTH POPULATION BY INSTITUTION AND LEVEL OF CARE

Data Refreshed: 7/10/20 6:07 AM

Acute Psychiatric Program (APP) Level of Care Population by Housing Program

Institution	RC Reception Center	GP* General Population	EOP Enhanced Outpatient Program	MHCB Mental Health Crisis Bed	Psychiatric Inpatient Program (PIP) Housing			Specialized Medical Beds Housing			Segregated Housing							Total APP Population
					Acute	Intermediate	PIP	CTC/SNF Correctional Treatment Center/Skilled Nursing Facility	Hospice	OHU Outpatient Housing Unit	ASU Administrative Segregation Unit	Condemned	LTRH Long Term Restricted Housing Unit	NDS Non-Disciplinary Segregation	PSU Psychiatric Services Unit	SHU Security Housing Unit	STRH Short Term Restricted Housing Unit	
ASP																		
CAL																		
CCC																		
CCI																		
CEN																		
CHCF				3	75	3		3										84
CIM				7														7
CMC				10														10
CMF				6	165	1		1										173
COR				14														14
CRC																		
CTF																		
CVSP																		
DVI																		
FOL																		
HDSP																		
ISP																		
KVSP				3														3
LAC				10														11
MCSP			1	6														7
NKSP				1														1
PBSP																		
PVSP																		
RJD				4														4
SAC				23				1										31
SATF				9														9
SCC																		
SOL																		
SQ					1	1	1											3
SVSP																		
VSP																		1
WSP				4														4
DSH-ASH					2	1												3
DSH-CSH					1													1
Male Subtotal	0	0	1	100	244	6	1	5	0	0	0	0	0	0	0	0	0	366
CCWF				2														2
CIW				1														1
FWF																		
DSH-PSH																		
Female Subtotal	0	0	0	3	0	0	0	0	0	0	0	0	0	0	0	0	0	3
Grand Total	0	0	1	103	244	6	1	5	0	0	0	0	0	0	0	0	0	369

Exhibit BBB

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July 15, 2019

VIA ELECTRONIC MAIL ONLY

CDCR Office of Legal Affairs
Nick Weber
Melissa Bentz
Jerome Hessick
Dillon Hockerson
Kristen Moose

Re: *Coleman v. Newsom*: Plaintiffs' Questions and Comments Re: Defendants' Proposal to Install Cages in the Inpatient Hospital at CHCF
Our File No. 0489-3

Dear All:

We write in response to two documents initially circulated by Melissa Bentz on January 25, 2019, Defendants' proposal for a six-month trial of installing cages, which Defendants refer to as therapeutic treatment modules or TTMs, at the California Health Care Facility (CHCF) Psychiatric Inpatient Program (PIP) (the Pilot), and a related draft cage policy (the Policy). We will respond soon in a separate letter to Defendants' draft Discretionary Programming Status (DPS) pilot policy.

Our comments and questions below come within the context of Plaintiffs' longstanding objections to Defendants' practice of providing mental health treatment to patients in cages, which evidence in this case has shown is inhumane and counter-therapeutic. As we have repeatedly stated, Defendants' concerns about managing potential violence can and should be addressed using the same methods employed every day by mental health professionals treating similar patient populations—by ensuring their mental health units have sufficient numbers of appropriately trained staff.

Nonetheless, Plaintiffs agreed to consider the relevant proposals in good faith and intend to do so. Our comments and questions below are offered in that vein, with the expectation that Defendants will provide additional responsive information in advance of workgroup discussions on this topic to ensure they are as productive as possible.

I. Plaintiffs' General Comments on Defendants' Proposal to Install Cages at CHCF PIP

As Defendants well know, Plaintiffs fundamentally disagree with the foundational assumption that the solution for addressing clinical and/or custodial staff's fear of patients is through the use of cages or the regular use of any other sort of restraint. Security in a hospital should come from direct observation and adequate numbers of properly trained staff, not classification scores and cages that undermine and impede desperately needed mental health treatment.

We are obviously dismayed that Defendants are seeking to formalize and expand their reliance on cages in the licensed inpatient context by installing 14 new cages in CHCF's PIP, given our longstanding objection to their use in any setting within CDCR for anything more than individualized, temporary and short-term situations to manage imminent risks of serious harm. Cages, an extreme version of restraints, are a literal and psychological barrier to both the patient seeking treatment and the treatment provider. Like any visible restraint, cages negatively affect others' perceptions of the mentally ill patient, dehumanizing the patients in the eyes of both their clinicians and other patients. *See Claiborne v. Blauser*, No. 16-16077, 2019 WL 2676900, at *1, *10 (9th Cir. June 28, 2019) (noting, in trial context, that visible restraints prejudice others against the restrained individual, as the "sight of a shackled litigant is apt to make jurors think they're dealing with a mad dog" (quoting *Maus v. Baker*, 747 F.3d 926, 927 (7th Cir. 2014)); *see also* Expert Declaration of Craig Haney, ECF No. 4378, Mar. 14, 2013 ¶¶ 82-83, 179 (class members describing how being locked in cages for treatment makes them feel like animals and impedes their access to mental health care). Cages are an affront to class members' basic human dignity, which the Supreme Court has noted is "inherent in all persons," including mentally ill prisoners, and which "animates the Eighth Amendment prohibition against cruel and unusual punishment." *Brown v. Plata*, 563 U.S. 493, 510 (2011). The Supreme Court was so offended by Defendants' practice of holding high-acuity patients "for prolonged periods in telephone-booth-sized cages without toilets," *id.* at 503-04, that it attached to its opinion in this case a photograph of some of the cages CDCR seeks now to newly install in its highest acuity licensed hospital, *see id.* at App'x C. There is simply no question that cages are destructive to the therapeutic relationship and impede clinical care, as the evidence has shown in this case. *See* Expert Declaration of Edward Kaufman, ECF No. 4379, Mar. 14, 2013, ¶ 86 ("At a minimum, the treatment modules pose a challenge to meaningful therapeutic interactions. To use them for individuals in acute distress, who may be feeling deeply isolated, even when there is no documented need for the modules is counter-therapeutic and inhumane.").

There is no question that Defendants' purported need to install counter-therapeutic cages to "manage" their acutely mentally ill patients is a direct outgrowth of their serious staffing deficiencies. CDCR's PIPs are dangerously understaffed, with nowhere near the number of allocated staff. Although intensive medication management is key to stabilizing patients, CHCF PIP has only 14.90 psychiatry positions filled out of 36.50 allocated. *See* May 2019 Filing, ECF No. 6209 at 5. With coverage provided through 2.80 registry positions, and 2.00 telepsychiatry positions, CHCF PIP is still at an abysmal 19.70 filled positions (54% filled). CMF PIP is even worse off, with only 10.00 psychiatrist positions filled out of 32.00 allocated. With 4.23 positions of registry coverage, CMF PIP still has only 44% of its psychiatry positions filled. SVSP PIP has *zero* of its 10.00 psychiatry positions filled, although its heavy reliance on registry coverage results in a 75% filled rate. (CDCR does not break out CIW or SQ PIP staffing on this monthly filing.)

CHCF PIP's psychiatry staffing has plummeted since CDCR took over the hospital program in June 2017's Lift and Shift. As of Defendants' May 4, 2017 report showing data for March 2017, CHCF PIP had 27.00 civil service staff psychiatrists out of 33.00 authorized positions. *See* May 4, 2017 Ltr. from G. Maynard to Special Master Enclosing DSH Staffing Report at 5. But as of May 2019, even though the staffing allocation had increased by 3.5 positions, CHCF had only 14.90 civil service staff (a drop of 12.10, or 44.81%). ECF No. 6209 at 5. Combined, CHCF PIP, CMF PIP, and SVSP PIP had 57.00 civil service staff psychiatrists as of March 2017, before Lift and Shift, and have now lost a combined 32.10 (56.32%) of those civil service staff psychiatrists. *Compare* May 4, 2017 DSH Staffing Report at 4-6 *with* ECF No. 6209 at 5.

Sufficient numbers of nursing staff are also critical to providing safe levels of observation and security in psychiatric units. Yet CHCF PIP also has severe nursing shortages that it makes up only through heavy use of overtime, according to Defendants' Monthly Report Data, April 2019 Enclosure 1*l*, enclosed hereto as **Attachment A**. Out of 430.00 authorized psychiatric technician positions, which Plaintiffs understand to be currently filled with medical technical assistants (MTAs), CHCF PIP had only 337 civil service positions filled, and made use of 2.83 full-time equivalent (FTE) contract positions and 61.91 FTE overtime positions, to bring the functional vacancy rate to of 28.26 positions (6.57% vacant). *See* Attachment A at PDF page 7 (internal document numbering: "Page 1 of 3"). CHCF PIP apparently attempted to make up for the nursing coverage gap through heavy use of registered nurse overtime as well, with 174.00 allocated registered nurse positions, 165 filled, 0.61 FTE contract positions, and 47.68 FTE overtime positions (-29.27% vacant). *See id.* The very high use of overtime for direct care nursing staff—109.59 positions—shows that CHCF is struggling to meet its actual nursing needs. CHCF PIP also reported severe functional vacancy rates in other

positions including psychologists (24.14% vacant), clinical social workers (15.15% vacant), and rehabilitation therapists (21.88% vacant). *See id.*

Even if Defendants filled their currently allocated PIP positions, however, Plaintiffs have long contended that their existing ratios are insufficient to provide safe and appropriate mental health care to the acutely ill patients in these inpatient psychiatric hospitals. CDCR has represented that it carried over DSH's existing staffing ratios to the PIPs with Lift and Shift. DSH's ICF ratios at the time of Lift and Shift were 1 to 35, although those staffing ratios have never been accepted by Plaintiffs or approved by the Special Master or the Court given that DSH's staffing plan is still in progress.

Indeed, DSH's Acting Director Stephanie Clendenin recently agreed with Plaintiffs that DSH's existing staffing ratios are inadequate. At a March 4, 2019 hearing before Assembly Budget Subcommittee No. 1 on Health and Human Services, and in the agenda for that hearing, Director Clendenin acknowledged that DSH is woefully understaffed and requested additional funding. She admitted that DSH's official budgeted psychiatry ratio for intermediate care is 1 to 35, whereas the average psychiatrist-to-patient ratio for the Western Psychiatric State Hospital Association's member hospitals is 1 to 25. *See* Assembly Budget Subcommittee No. 1 on Health and Human Services, Monday March 4, 2019 Hearing Video, available at https://www.assembly.ca.gov/media/assembly-budget-subcommittee-1-health-human-services-20190304/video ("Hearing Video") at 2:04:11 to 2:04:36; March 4, 2019 Hearing Agenda ("Agenda") at 25 (ratio is "well above the average of other state hospitals"). The Agenda is enclosed hereto as **Attachment B**. Notably, DSH maintained the 1 to 25 ratio until late 2011 or early 2012 when, in the midst of California's financial crisis, DSH's CRIPA consent decree requiring the 1 to 25 ratio ended and DSH increased the ratio to the present 1 to 35 level. *See* July 25, 2019 Commitments Ltr from C. Trapani to Workgroup at 5; August 3, 2018 Ltr. from J. Mupanduki to Workgroup at 1 (confirming ratio change). Director Clendenin also testified that DSH currently is budgeted for the minimum ratios required for licensing compliance, but due to the need for additional staffing, DSH delivers more nursing hours. *See* Hearing Video at 1:32:25 to 1:33:00; Agenda at 21 (budgeted ratios "do not result in enough nurses to effectively deliver adequate care"). This need for additional staff results in DSH's heavy reliance on overtime (including mandatory overtime) and registry use that exacerbates the staffing problems. *See* Agenda at 27-28. A representative for the California Association of Psychiatric Technicians echoed Director Clendenin's concerns, testifying that DSH is dramatically understaffed for the patient population it serves, including requiring psychiatric technicians to work 1.4 million hours of overtime, including 600,000 of involuntary overtime in 2016 alone. *See* Hearing Video at 1:45:10 to 1:45:36.

Moreover, Defendants' persistent claim that they cannot treat Maximum Custody or other high-custody patients without locking them in cages is belied by the fact that other inpatient programs serving similar patient populations treat their patients without cages by employing sufficient numbers of staff with sufficient training and support. This is the case, for example, in the San Francisco Veteran's Administration (VA) Psychiatric Inpatient Unit (PICU), which Plaintiffs, Defendants, and the Special Master team jointly toured in November 2018. Patients in the PICU have the same clinical diagnoses and range of mental health acuity as patients in CDCR's PIPs. The PICU is a richly staffed, locked facility that regularly treats individuals sent by the courts for treatment during criminal proceedings and patients on Section 5150 involuntary holds. As we learned on the tour, the PICU employs a variety of strategies to successfully manage this potentially disruptive inpatient population without cages, including, inter alia, hiring enough on-site psychiatrists to appropriately manage and adjust patients' medication and ensure continuity of care; hiring sufficient numbers of nurses and training them (as well as other staff) in therapeutic containment management and de-escalation tactics; and ensuring buy-in for appropriate behavioral management philosophies and techniques from the top down. As a result of these efforts, the PICU rarely resorts to the use of isolation or restrictive management methods such as restraints, which are employed only on a case-by-case basis at the order of a doctor. This approach, of course, stands in stark contrast to CDCR's routinized use of cages and cuffs to manage entire categories of patients, including the most acutely ill ones.

As seen at the PICU, and as DSH Director Clendinin testified in March, nursing staff perform a critical role in inpatient settings. We were surprised to learn recently that Defendants are planning to end the use of MTAs in the PIPs within the next six months, which Defendants did not disclose to the workgroup. To Plaintiffs' knowledge, Defendants have not yet developed a proposal for replacement of the MTAs—or at least have not come forward with one to the *Coleman* workgroup participants, despite Plaintiffs' query on June 24, 2019. *See* C. Trapani to Defs. Email, June 24, 2019. Assuming Defendants intend to replace the MTAs with psychiatric technicians, we strongly encourage significantly increasing the ratio and total number of psychiatric technicians assigned to the PIPs, as they can play a key role in increasing the level of direct observation and security within these units. We look forward to Defendants' proposal on this.

Staff in the PICU also identified the robust training they receive on appropriate de-escalation and management of assaultive behavior techniques as critical to the success of their program. Are CDCR clinical staff working in the PIPs currently trained in these techniques? If so, please provide us with the training materials. If not, have Defendants considered developing such a training in lieu of expanding the use of cages?

II. Plaintiffs' Specific Comments about Defendants' Draft Policy and Proposed Pilot

In light of the above concerns, Plaintiffs have a number of specific comments and questions regarding the particulars of Defendants' draft Policy and proposed Pilot.

A. Consideration of Alternative Options

Initially, Plaintiffs need more information on Defendants' justification for proposing the installation of cages in their inpatient psychiatric hospitals. What is the problem that this proposal is designed to address? Are Defendants aware of any published and/or peer reviewed studies of the use of cages or treatment modules in a licensed inpatient psychiatric hospital or program or any study of the use of cages at all in any mental health program? What other options, if any, did CDCR consider using before proposing to instead install cages at CHCF's inpatient unit? Did Defendants study or evaluate whether increasing staffing (or filling existing staffing vacancies) and/or providing additional training similar to that employed at the PICU and other inpatients hospitals would provide an alternative to installing cages? If so, please provide us the results. Did Defendants consider developing a step-down program permitting patients to more quickly program without restraints such as the one CDCR briefly attempted in the SAC PSU before abandoning it in 2017? *See* Special Master 27th Round Report, ECF No. 5779, at 186-87.

Plaintiffs understand that Defendants—first DSH, and then CDCR after Lift and Shift—have used cages in the inpatient program at SVSP for several years (despite Plaintiffs' objection), as well as in EOP ASU Hubs and the PSU (again, despite Plaintiffs' objection). Have Defendants ever studied their use of cages in any of these settings from a clinical perspective, e.g., to determine whether the use of caged treatment for psychiatric patients improves or impedes care? In particular, SVSP's PIP is the same level of care and security as CHCF's PIP. In lieu of expanding cages to new licensed inpatient programs without evaluating their efficacy in existing, substantially similar programs, Plaintiffs request that Defendants study and report on the clinical effects of their use in treating inpatient psychiatric patients in the SVSP PIP.

B. Existing Treatment for Maximum Custody Class Members in PIPs

With regard to Defendants' Pilot proposal, Plaintiffs are in the first instance deeply disturbed by Defendants' report that Maximum Custody patients at CHCF

currently receive no groups and potentially some limited individual therapeutic contacts,[1] and that their Maximum Custody policy interferes with the treatment of non-Maximum Custody patients at CHCF, as CDCR shuts down all programming anytime a Maximum Custody patient is outside of his or her cell even though that patient is restrained and escorted by staff. Pilot at 1-2. While Defendants blame the absence of cages at CHCF for their failure to provide constitutionally adequate—or indeed any—treatment to patients whom CDCR itself has determined need inpatient psychiatric hospitalization, *see id.* at 1, that is a Hobson's choice for the reasons outlined above. Furthermore, providing zero hours of therapy to patients at the inpatient level of care is a clear violation of the Eighth Amendment, particularly when Defendants' representatives have previously testified that the standard of care for ICF class members is between 35 and 40 hours per week of patient programming, and that failure to provide such care both threatens to violate ethical principles regarding patient care and causes acutely ill class members' mental health to further deteriorate. *See* Decl. of Victor Brewer, SVPP Executive Director, Sept. 16, 2010, ECF No. 3913-3 at ¶ 5; Decl. of Richard Lipon, CMF-VPP Acting Medical Director, October 12, 2010, ECF No. 3932-2 at ¶¶ 3, 6-9; *see also* ECF No. 3932 at 2, 5-6, 11-12.

Please provide us with information regarding how much programming, including yard and other out of cell activities plus group and individual treatment, patients on Maximum Custody status receive at CHCF PIP, and where and how they receive that treatment. Please also explain why Defendants are proposing to install 4 cages on the yard, including specifying the size of those cages and what Defendants propose to use them for. If, in fact, Defendants are failing to provide adequate outdoor exercise or mental health treatment to Maximum Custody prisoners in CHCF or other PIPs due to the lack of cages, then Defendants are in clear violation of their Eighth Amendment obligations to provide inpatient psychiatric care to these most vulnerable human beings. Plaintiffs do not and will not accept that cages are the only way class members needing inpatient care can receive treatment, given Defendants' failure to properly staff their inpatient programs and the many other methods employed by other inpatient hospitals across the country.

C. Operation of Maximum Custody Status in PIPs

Nor is it clear from Defendants' proposed Pilot and draft Policy what the precise scope of their planned use of cages would be given ambiguities surrounding their current and planned use of Maximum Custody status. Plaintiffs have a number of questions

[1] Although Defendants' policy does not clearly state whether and how Maximum Custody patients at CHCF receive individual clinical contacts, it appears that they may receive such treatment only if a walk-alone yard is available.

about Maximum Custody status generally, and about how and why it is utilized in CDCR's inpatient psychiatric hospitals. Below, Plaintiffs first summarize the relevant portions of the materials and then outline their questions.

Defendants' draft Policy would formalize the use of cages in licensed inpatient programs for the treatment of all patients designated as Maximum Custody status pursuant to Title 15, and whose status cannot be waived by committee. According to Defendants' proposed Policy, while the ICC (which contains no clinical staff and is chaired by the Warden) would ostensibly be required to consider clinical input regarding a patient's behavior, the ICC alone would decide whether a patient will be treated in a cage and/or subjected to mechanical restraints while in the inpatient program. Furthermore, the ICC would make that determination based on unspecified "custody factors," without further consideration of clinical factors.

Concurrently, Defendants' proposed six-month Pilot would install 14 new cages at CHCF PIP to be used for providing mental health treatment to Maximum Custody prisoners. Pilot at 1. The Pilot outlines the existing Maximum Custody review process apparently used in the PIPs, which makes clear that the ICC does not review the appropriateness of a patient's Maximum Custody status for the first two weeks the patient is in the licensed psychiatric hospital. *Id.* After that, the ICC does not reconsider a patient's placement on Maximum Custody status until their Pre-MERD and MERD reviews, or unless a patient's IDTT has referred the patient to the ICC after determining the patient complied with certain treatment goals. *Id.* The decision to suspend a patient's Maximum Custody status is left to the sole discretion of the ICC chair, i.e., the Warden. *Id.* Finally, Defendants' Pilot document does not identify any methodologies by which they would propose to evaluate the efficacy of the Pilot, including identification of any outcome measures, comparisons to other programs, or discussing what a successful pilot might look like.

Plaintiffs initially note that no policy or directive governing the use of Maximum Custody status in the PIPs, including outlining the specific procedures and requirements discussed in the Pilot document, has ever been provided to Plaintiffs or discussed in the workgroups. Does one exist? Plaintiffs are not aware of any requirement in Title 15 or the DOM that Defendants must confine patients to cages before giving them mental health treatment. Per Title 15, patients classified as Maximum Custody merely "shall be under the direct supervision and control of custody staff." 15 CCR § 3377.1(a)(1)(C). What is Defendants' authority for requiring all patients on Maximum Custody to be caged during mental health treatment? Do medical patients on Maximum Custody status, or any other category of patients, receive treatment in cages?

Similarly, Plaintiffs are concerned that the vague rules governing Defendants' placement and retention of class members on Maximum Custody status imposes an unconstitutional custodial barrier to needed mental health treatment. The fact that the Warden alone has the discretion to suspend or maintain Maximum Custody status for hospitalized patients in need of the system's most intensive mental health treatment is deeply problematic. *See Estelle v. Gamble*, 429 U.S. 97 at 104-05 (1976) (custodial interference with prescribed medical treatment constitutes deliberate indifference). It is not apparent why Defendants' Maximum Custody practices could not or should not be modified in order to permit these extremely sick patients to receive constitutionally adequate mental health care in a licensed inpatient setting like the PIP. Defendants should develop alternative custodial security measures that do not interfere with treatment rather than incorporating the existing Maximum Custody designation and restrictions wholesale in the psychiatric hospital setting reserved for the most acutely ill class members. CHCF's PIP is already the highest custody inpatient program Defendants offer, which Defendants intentionally built inside prison walls based on the SVPP model in order to ensure CDCR could control security with electric fences to eliminate the risk to public safety of escape, in contrast to the DSH programs. This high-custody hospital setting should require little, if any, use of restraints for treatment and programming, much less the use of cages.

Why are Defendants unable to conduct the initial ICC in a shorter period of time than ten business days, i.e., two weeks, for this relatively small group of prisoners? Under what circumstances can the ICC waive Maximum Custody status, and what proportion of patients are eligible for such consideration? Why can't the ICC waive or suspend every prisoner's Maximum Custody status for the duration of their inpatient hospitalization, or at least for those prisoners whose underlying RVRs do not involve violence and/or occurred well before their PIP admission? Why should custodial factors and decision-makers have total and unilateral control over the Maximum Custody determination in this licensed inpatient setting, with the discretion to totally disregard clinical input on the effect this highly restrictive status may be having on a patient's mental health and treatment progress? And why should Maximum Custody status only be reconsidered in the three narrow circumstances identified by Defendants in the Pilot, which could result in class members remaining on Maximum Custody status for their entire inpatient stays?

Plaintiffs have previously requested information about Defendants' use of Maximum Custody status in the PIPs in an effort to fully evaluate this proposal, but have not yet received responsive data that would allow for evaluation, for instance, of how long patients in the PIP remain on Maximum Custody status currently. *See* M. Shinn-Krantz to N. Weber June 18, 2019 Email Request and Related Thread, attached as **Attachment C**. There are no timeframes in Defendants' proposal, beyond the ten-day

timeframe for an initial ICC, for how long a Maximum Custody classification may last. Plaintiffs are concerned that the lack of timeframes will lead many patients to remain on Maximum Custody indefinitely. The Special Master has expressed serious concern about similar indefinite and prolonged custodial interference with patients' access to treatment in prior reports on Defendants' inpatient programs. *See, e.g.*, Special Master Inpatient Report, May 30, 2014, ECF No. 5156, at 25, 28. Plaintiffs reiterate their request for this information in advance of further discussions.

Information Defendants have provided, however, raises concerns because it shows that PIP patients are much more likely to be classified as Maximum Custody than the CDCR population as a whole. Enclosed as **Attachment D** is an Excel chart provided by Defendants on March 5, 2019, showing the point-in-time inpatient census as of that date. At that time, approximately 14% of the 391 patients at CHCF's PIP were Maximum Custody, slightly higher than the roughly 13% of patients across all of the PIPs. Each of these percentages is much higher than the system-wide average of 5% reported in a recent Legislative Analyst's Office report enclosed hereto as **Attachment E**. *See* LAO Report, Improving California's Prison Inmate Classification System, May 2019 at 9, Fig. 8 (reporting 2018 data). Without additional data or explanation from Defendants, it is unclear how long patients at CHCF PIP are classified at Maximum Custody, or how many other patients are classified as Maximum Custody at some point during their inpatient stays.

Plaintiffs look forward to further discussion and information sharing on this topic.

Sincerely,

ROSEN BIEN
GALVAN & GRUNFELD LLP

/s/ Marc J. Shinn-Krantz

By: Marc J. Shinn-Krantz

MSK:MSK
Enclosures
cc: *Coleman* Special Master
Adriano Hrvatin
Tyler Heath
Robert Henkels
Sean Rashkis
Coleman Co-Counsel
Elise Thorn
Damon McClain
Christine Ciccotti
Joanna Mupanduki

Exhibit CCC

From:	Nick Weber
To:	Michael W. Bien; Kyle.Lewis@doj.ca.gov; RSilberfeld@robinskaplan.com; Adriano Hrvatin; Damon McClain; Lucas Hennes; Elise Thorn; Tyler Heath
Cc:	Toche, Diana@CDCR; Bick, Joseph@CDCR; Daye, Eureka@CDCR; Coleman Special Master Team; Coleman Team - RBG Only; Steve Fama; Donald Specter; Barrow, Roscoe@CDCR; Neill, Jennifer@CDCR; Kelso, Clark@CDCR; Armstrong Team - RBG only; Melissa Bentz
Subject:	RE: Coleman: 489-3, Armstrong 581-3 [IWOV-DMS.FID6429]
Date:	Monday, June 22, 2020 4:40:39 PM
Attachments:	2020-0619 Update Immediate Cancellation of All Non Essential Inmate Movement.pdf COVID-19 Mandatory 14-Day Modified Program (2).pdf

Michael,

Please see the attached memorandum regarding the 14-Day Modified Program as well as an email regarding the immediate cancellation of all non-essential inmate movement. We will discuss these during the taskforce tomorrow.

Thanks.

Nick Weber
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From: Michael W. Bien <MBien@rbgg.com>
Sent: Monday, June 22, 2020 10:03 AM
To: Kyle.Lewis@doj.ca.gov; Weber, Nicholas@CDCR <Nicholas.Weber@cdcr.ca.gov>; RSilberfeld@robinskaplan.com; Adriano Hrvatin <Adriano.Hrvatin@doj.ca.gov>; Damon McClain <Damon.McClain@doj.ca.gov>; Lucas Hennes <Lucas.Hennes@doj.ca.gov>; Michael W. Bien <MBien@rbgg.com>; Elise Thorn <Elise.Thorn@doj.ca.gov>; Tyler Heath <Tyler.Heath@doj.ca.gov>
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Subject: Coleman: 489-3, Armstrong 581-3 [IWOV-DMS.FID6429]

The following was posted on CDCR's website on Friday, June 21:
June 21, 2020 update:

- We sincerely regret to inform you that an incarcerated person from Avenal State Prison (ASP) died June 20 at an outside hospital from what appear to be complications related to COVID-19. The exact cause of death has not yet been determined. The individual's next of kin has been notified. This is the 19th death of an incarcerated person within the California Department of Corrections and Rehabilitation (CDCR) related to COVID-19, and the first of an incarcerated person from ASP. No additional information is being provided to protect individual medical privacy. The online Patient Tracker has been updated. ASP currently has 132 incarcerated persons who are actively positive for COVID-19. CDCR takes the health and safety of all those who live and work in our state prisons very seriously and will continue to work diligently to address the COVID-19 pandemic.
- There are 1,875 incarcerated persons with active cases of COVID-19 statewide. To view more detailed case and testing information, see the CDCR and CCHCS Patient Testing Tracker.
- There are currently 342 active CDCR/CCHCS employee COVID-19 cases statewide (627 cumulative; 285 returned to work). See the CDCR/CCHCS COVID-19 Employee Status webpage for a breakdown by location.
- A few weeks ago we invited the community to share Father's Day messages with our population and we received nearly 45 minutes of content. This **video** includes messaging from our partners from the Center for Restorative Justice Works, local Inmate Family Councils and CCI Friends and Family. These messages will be playing on the institution television systems starting this weekend for at least the next week. Videos received after the submission deadline will be added next week.
- Effective Monday, June 22, 2020, all institutions will implement a mandatory 14-day modified program to further prevent the spread of COVID-19 within our facilities. Individuals will have access have access to health care services, yard time, phone calls, canteen, packages and religious programming while allowing for physical programming while allowing for physical distancing and proper

Please provide plaintiffs' counsel and the Special Master with any documents or memorandum imposing a new "mandatory 14-day modified program to further prevent the spread of COVID-19 within our facilities." Please also provide answers to the following questions:

1. Has CDCR/CCHCS imposed new restrictions on movement of incarcerated persons between CDCR prisons or additional requirements

for testing or quarantine related to movement?

2. The sentence highlighted in yellow is incomplete and somewhat incomprehensible. Please explain and/or correct. What programming and activities are allowed? Where are the standards and guidelines written? What instructions have been given to Wardens and Health Care CEO's?
3. How does the new "mandatory modified program" change or modify programming or treatment for Coleman patients?

Thanks.

Michael Bien

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Memorandum

Date: June 19, 2020

To: Associate Directors, Division of Adult Institutions
Wardens

Subject: **COVID-19 MANDATORY 14-DAY MODIFIED PROGRAM (2)**

The California Department of Corrections and Rehabilitation's priority is to protect the health and well-being of our staff and the inmate population, as well as providing a safe environment. The purpose of the memorandum is to announce measures intended to reduce staff and inmate exposure to the Coronavirus (COVID-19).

Effective Monday, June 22, 2020, all institutions will implement a mandatory 14-day modified program. Each institution will be responsible for either creating or amending their current Program Status Report taking all of the following information into consideration:

- The entire institution will be affected, except for Restricted Housing Units, Correctional Treatment Centers, and Psychiatric Inpatient Programs, etc.
- Movement will be via escort - maintain increased physical distancing unless security would dictate otherwise (i.e. Administrative Segregation Unit placement). Movement will be in such a fashion as to not mix inmates from one housing unit with another housing unit
- Feeding – Cell feeding or one housing unit at a time, maintaining physical distancing and disinfecting tables and high touch areas between each use
- Ducats – priority only
- Visiting – none
- Family visiting – none
- Legal visits – urgent/emergency, via telephone or video conference where available. Board of Parole Hearings will continue with attorney contacts as required
- Workers – critical and porters. All workers shall use appropriate PPEs at all times
- Showers – maintain distancing and disinfect between each use per memoranda: *COVID-19 Guidance for Daily Program Regarding Social Distancing for Cell or Alternative/Dorm Style Housing of Eight Person Cohort* dated, May 11, 2020, and *COVID-19 Related Cleaning Protocols for Institutions* dated, April 8, 2020.
- Health care services – limited to essential clinical services including urgent/emergent and by priority ducats. When applicable, such as no inmate movement at all, conduct 7362 rounds in the housing units.
- Medication(s) distribution – Wardens, please work with your Chief Executive Officers and Chief Nurse Executives to establish a process. When applicable, conduct podium pass within the unit. If movement to the yard, canteen, and/or feeding in the dining halls continues, med pass shall be maintained at the pill windows, maintaining physical distancing and not mixing inmates from different housing units.

- Law Library – PLU or paging option while maintaining physical distancing in the library
- Dayroom–maintain reduced occupancy to ensure increased physical distancing
- Recreation - One housing unit/dorm at a time. Do not mix inmates from different units.
- Canteen is permitted - shall be conducted in a manner to ensure physical distancing. If unable to accommodate physical distancing, facilitate delivery method
- Packages are permitted
- Phone calls are permitted - ensure physical distancing and disinfect between each use
- Religious programs shall be cell front, or deliver materials to the housing unit/dorm/cells
- Educational materials to be provided either cell front, or to the dorm
- Request for Health Care Services Forms, CDCR-Form 7362, will be distributed and picked up in the housing units by staff

During this time, Community Resource Managers, Education Department staff, and others designated by the Warden shall facilitate the delivery of increased games, program materials, reading books, or other items to the housing units. Housing unit/dorm officers and supervisors are expected to conduct additional rounds, and spot checks of inmates in an effort to reduce self-harm and/or suicide attempts.

All institutions will be required to provide a copy of their Program Status Report, Part-A, to their respective Associate Director each day for this 14-day period. Institutions are expected to brief staff and inmate advisory committees on this directive as this modified program is currently only slated to be in effect for 14 days, through July 5, 2020.

Thank you for you continued efforts in managing this COVID-19 event. If you have any additional questions, please contact your respective Associate Director.

CONNIE GIPSON
Director
Division of Adult Institutions

cc: Kimberly Seibel
Charles Callahan
Patrice Davis
Justin Penney

State of California
Department of Corrections and Rehabilitation

Memorandum

Date: May 27, 2020

To: Associate Directors, Division of Adult Institutions
Wardens

Subject: **COVID-19 OPERATIONAL GUIDELINES MONITORING AND ACCOUNTABILITY**

The purpose of this memorandum is to provide expectations for monitoring and accountability of operational guidelines for the California Department of Corrections and Rehabilitation (CDCR) Division of Adult Institutions as it relates to our efforts to provide a safe and healthy environment during the statewide emergency caused by COVID-19.

During weekly inspection tours, Captains or area managers shall be required to fill out the attached COVID-19 TOUR CHECKLIST, in order to verify staff are following the COVID-19 protocols. This checklist will be completed to provide verification of compliance with relation to the following memoranda: *COVID-19 Guidance for Daily Program Regarding Social Distancing for Cell or Alternative/Dorm Style Housing of Eight Person Cohort* dated, May 11, 2020, and *COVID-19 Related Cleaning Protocols for Institutions* dated, April 8, 2020. The checklist shall be submitted to the respective Associate Director by noon on Monday for the preceding week. The following are items that will need to be taken into consideration when inspecting an area which include:

- Social distancing
- Wearing of mask (staff and inmates)
- Dorms and tent cohorts separated by six feet apart in all directions
- COVID-19 announcements
- Increased cleaning/disinfecting
- Poster Display
- Hand Sanitizer

Wardens shall ensure that shower schedules are created to ensure cleaning in between each use. For example, showers might be opened from 0800-0900, closed from 0900-0930 for cleaning, opened again at 1000-1100, then closed again at 1100-1130 for cleaning. Inmate porters shall clean showers, toilets and sinks between uses, and this cleaning activity shall be documented on the cleaning logs. Inmate porters must be provided ample cleaning supplies and protective equipment (including gloves and masks). This too must be documented on the cleaning logs.

Additionally, when a cell or bunk is vacated, the assigned inmate porter shall be responsible for disinfecting the space. For restrictive housing units, this task will be performed by staff. The cleaning of vacated bunks will be documented on the cleaning logs. When cleaning, inmates and staff shall wear, at a minimum, gloves and masks.

Captains and area managers shall continue to review the cleaning logs on a weekly basis for the housing units and kitchens, etc. Every Monday by noon, Wardens shall submit the cleaning logs for the prior week to their respective Associate Director by uploading the information to the Mission SharePoint site. Associate Directors shall review the information to ensure compliance.

If you have any questions or concerns, please contact your respective Mission Associate Director.

Original Signed

CONNIE GIPSON
Director
Division of Adult Institutions

Attachments

cc: Kimberly Seibel
Patrice Davis

Memorandum

Date: April 8, 2020

To: Associate Directors, Division of Adult Institutions
Wardens

Subject: **COVID-RELATED CLEANING PROTOCOLS FOR INSTITUTIONS**

The California Department of Corrections and Rehabilitation's priority is to protect the health and well-being of our staff and the offender population as well as providing a safe environment. The purpose of the memorandum is to reduce staff and inmate exposure to the coronavirus (COVID-19) within our institutions by providing guidance on cleaning and disinfection protocols as recommended by the Centers for Disease Control and Prevention (CDC). Due to the current COVID-19 pandemic, and out of an abundance of caution, we are distributing information on best practices for cleaning and disinfecting your work areas.

According to the CDC definitions, retrieved March 3, 2020, from: https://cdc.gov/Coronavirus/2019-ncov/comunity/organizations/cleaning-disinfection:

Cleaning - refers to the removal of dirt and impurities, including germs, from surfaces. Cleaning alone does not kill germs. But by removing the germs, it decreases their number and therefore any risk of spreading infection.

Disinfecting - works by using chemicals, for example EPA-registered disinfectants, to kill germs on surfaces. This process does not necessarily clean dirty surfaces or remove germs. But killing germs remaining on a surface after cleaning further reduces any risk of spreading infection.

Staff are to ensure that assigned porters are thoroughly cleaning communal areas (dayrooms, showers, restrooms, offices, etc.) a minimum of twice per shift during second and third watches with the option to clean more often if needed. The area porters will initial the cleaning schedule template (see attachment) documenting the time it was complete. Staff will sign the sheet verifying that they have reviewed and ensured the additional cleaning was completed. As we increase our cleaning times, we must continue to practice social distancing when possible.

It is recommended staff increase the frequency in which they disinfect the touchpoints (i.e. telephones, tables, door knobs, desk areas, etc.) by using Sani Guard 24/7 in their work area. Once the Sani Guard has been applied to a surface, it should be allowed to set for 10 minutes to maximize its effectiveness.

Attached is essential information on the cleaning solutions used in the institutions, and dilution ratios for mixing Cell Block and Sani Guard 24/7.

If you have any additional questions, please contact your Mission Associate Director.

CONNIE GIPSON
Director
Division of Adult Institutions

PROTOCOL: CLEAN AND DISINFECT for emerging pathogen COVID-19

Best Practices : CLEAN AND DISINFECT for emerging pathogen COVID-19

Option 1 -

CELL BLOCK 64 - Refer to label instructions for Adenovirus type7. Mix 8oz of CELL BLOCK 64 to one gallon of water. Apply to surface, lightly agitate and let disinfectant set on the surface for a minimum of 10 minutes, then wipe clean.

Option 2 -

Clean with Cell Block 64 at the normal dilution ratio of 2 oz per gallon of water (chemical dispensers are set to this ratio). Apply Cell Block 64, agitate and let set on surface for a minimum of 10 minutes and wipe dry. Apply SANI-GUARD 24/7 at 3 oz per 5 gallons of water (refer to Sani Guard 24/7 label instructions for H1N1). Allow disinfectant to remain wet on the surface for a minimum of 10 minutes and wipe off or let air dry.

Option 3-

Disinfect only - **PLEASE NOTE**, surface must be free of debris and clean before applying Sani Guard 24/7.

Refer to product label instructions for H1N1. Dilute 3oz of Sani Guard 24/7 to 5 gallons of water. Apply solution to non porous surfaces and remain wet for a minimum of 10 minutes. Wipe or let air dry.

CELL BLOCK 64 LABEL

Please review the entire bottle label before use.

From the Cell Block 64 Label:

DILUTION (1:64) (660 ppm qual)	2 oz per gallon of water 4 oz per 2 gallons of water	8 oz per 4 gallons of water 10 oz per 5 gallons of water	12 oz per 6 gallons of water

DIRECTIONS FOR USE

It is a violation of Federal law to use this product in a manner inconsistent with its labeling.
This product is not for use on medical device surfaces.
DISINFECTION /CLEANING/DEODORIZING DIRECTIONS: Remove heavy soil deposits from surface, then thoroughly wet surface with a use-solution of 2 ounces of the concentrate per gallon of water. Use 8 oz per gallon of water to kill Adenovirus Type 7. The use-solution can be applied with a cloth, mop, sponge, or coarse spray or by soaking. For sprayer applications, use a coarse spray device. Spray 6-8 inches from the surface, rub with a brush, cloth or sponge. Do not breathe spray. Let solution remain on surface for a minimum of 10 minutes. Rinse or allow to air dry. Rinsing of floors is not necessary unless they are to be waxed or polished.
Food contact surfaces must be thoroughly rinsed with potable water. This product must not be used to clean the following food contact surfaces: utensils, glassware and dishes.

(Continued directions for use.)
CLEANING AND DISINFECTING HARD NONPOROUS SURFACES ON PERSONAL PROTECTIVE EQUIPMENT RESPIRATORS: Preclean equipment if heavily soiled to ensure proper surface contact. Add 2 oz. of this product to one gallon of water. Use 8 oz per gallon of water to kill Adenovirus Type 7. Gently mix for a uniform solution. Apply solution to hard, nonporous surfaces of the respirator with a brush, coarse spray device, sponge, or by immersion. Thoroughly wet all surfaces to be disinfected. Treated surfaces must remain wet for 10 minutes. Remove excess solution from equipment prior to storage. Comply with all OSHA regulations for cleaning respiratory protection equipment (29 CFR §1910.134).

From the Sani-Guard 24-7 Label:

Sani-Guard 24-7 is a hospital Disinfectant, Bactericidal according to the current AOAC Disinfectants Use-Dilution Method, Fungicidal according to the AOAC Fungicidal Test, and Virucidal* according to the virucidal qualification, modified in the presence of 5% organic serum against:

Bacteria
Burkholderia cepacia
Campylobacter jejuni [Campylobacter]
Corynebacterium ammoniagenes
Escherichia coli [E. coli]
Escherichia coli pathogenic strain O157:H7 [pathogenic E. coli]
Klebsiella pneumoniae [Klebsiella]
Listeria monocytogenes [Listeria]
Pseudomonas aeruginosa [Pseudomonas]
Salmonella enterica [Salmonella]
Salmonella typhi [Salmonella]
Shigella dysenteriae [Shigella]
Staphylococcus aureus [Staph]
Staphylococcus aureus - Community Associated Methicillin-Resistant [CA-MRSA] [NRS123] [USA400]
Staphylococcus aureus - Methicillin-Resistant [MRSA]
Yersinia enterocolitica
Viruses
*Adenovirus Type 5
*Adenovirus Type 7
*Hepatitis B Virus [HBV]
*Hepatitis C Virus [HCV]
*Herpes Simplex Virus Type 1 [Herpes]
*Herpes Simplex Virus Type 2 [Herpes]
*Human Coronavirus
*Human Immunodeficiency Virus Type 1 [HIV-1] [AIDS Virus]
*Influenza A2 / Hong Kong Influenza Flu Virus
*Norovirus - Feline Calicivirus
*SARS Associated Human Coronavirus
*Vaccinia Virus [Pox Virus]
Fungi
Aspergillus niger
Trichophyton mentagrophytes

DILUTION:

Disinfection (1:213)	3 oz. per 5 gallons of water [450 ppm active qual]
Sanitizer (1:256)	1/2 oz. per gallon of water [2 1/2 oz. per 5 gallons of water] [400 ppm active qual]
Sanitizer (1:512)	1 1/4 oz. per gallon of water [1 oz. per 4 gallons of water] [1 1/4 oz. per 5 gallons of water] [200 ppm active qual]
Sanitizer (1:640)	1 oz. per gallon of water [1 oz. per 5 gallons of water] [150 ppm active qual]

DIRECTIONS FOR USE

It is a violation of Federal law to use this product in a manner inconsistent with its labeling.
DISINFECTION / VIRUCIDAL*/ FUNGICIDAL / MOLD AND MILDEW CONTROL DIRECTIONS:
Add 3 oz. of Sani-Guard 24-7 per 5 gallons of water (or equivalent dilution) to disinfect hard, nonporous surfaces.
Before use in federally inspected meat and poultry food processing plants and dairies, food products and packaging materials must be removed from the room or carefully protected. When used on surfaces in areas such as locker rooms, dressing rooms, shower and bath areas and exercise facilities, this product is an effective fungicide against Trichophyton mentagrophytes (the athlete's foot fungus). Apply use-solution with a cloth, mop, sponge, sprayer or by immersion, thoroughly wetting surfaces. For sprayer applications, use a coarse spray device. Spray 6 - 8 inches from surface, rub with brush, sponge or cloth. Do not breathe spray.
Note: For spray applications, cover or remove all food products.
Treated surfaces must remain wet for 10 minutes. Wipe dry with a clean cloth, sponge or mop or allow to air dry. Rinse food contact surfaces such as counter tops, tables, picnic tables, exteriors of appliances and or stove tops with potable water prior to reuse. Do not use on glasses, dishes or utensils as a disinfectant. For heavily soiled areas, preclean first.

CALPIA
Quality Products ★ Changed Lives ★ A Safer California

Memorandum

Date: March 25, 2020

To: CALPIA Healthcare Customers

From: California Prison Industry Authority • 560 East Natoma Street • Folsom, California 95630-2200

Subject: **SARS-CoV-2 Supplemental Communication**

CALPIA was notified by Lonza, LLC, manufacturer of components used in the production of Cell Block 64 and Sani-Guard 24-7, of the following:

On March 13, 2020 (updated March 19), EPA published an updated list N (https://www.epa.gov/pesticide-registration/list-n-disinfectants-use-against-sars-cov-2) for disinfectant products with emerging viral pathogen and Human Coronavirus claims for use against SARS-CoV-2, the cause of COVID disease.

"Inclusion on this list does not constitute an endorsement by EPA. There may be additional disinfectants that meet the criteria for use against SARS-CoV-2. EPA will update this list with additional products as needed."

Lonza, LLC offers many registrations that were evaluated and accepted by EPA under the Emerging Viral Pathogen program (EVP) listed in Annex 1, and Human Coronavirus listed in Annex 2.

Key clarification:
Annex 1 listed products can make efficacy claims against SARS-CoV-2 in accordance with EPA's Emerging Viral Program.

Annex 2 listed products can be used against SARS-CoV-2 by people only when Annex 1 products are not available. Lonza has submitted Annex 2 products to the EPA to make efficacy claims against SARS-CoV-2 in accordance with EPA's Emerging Viral program. This communication will be updated when Annex 2 product reviews are completed and accepted by the EPA to make claims.

For any supplemental registration based upon any of these listed EPA registered products, customers may make off-label* communications in the following formats:

Cell Block 64 (HWS-64)
COVID-19 is caused by SARS-CoV-2, a novel coronavirus. Cell Block 64 kills similar viruses and therefore can be used against SARS-CoV-2 when used in accordance with the directions for use against Adenovirus type 7 on hard, non-porous surfaces. Refer to the CDC website at https://www.cdc.gov/coronavirus/2019-ncov/index.html for additional information.

Sani-Guard 24-7 (BARDAC 205M-10)
COVID-19 is caused by SARS-CoV-2, a novel coronavirus. Sani-Guard 24-7 (BARDAC 205M-10) kills similar viruses and therefore can be used against SARS-CoV-2 when used in accordance with the directions for use against Norovirus on hard, non-porous surfaces. Refer to the CDC website at https://www.cdc.gov/coronavirus/2019-ncov/index.html for additional information.

If you have any questions, please contact CALPIA at chemicals@calpia.ca.gov.

*Label: The written, printed, or graphic matter on, or attached to, the pesticide or device or any of its containers or wrappers. (https://www.epa.gov/sites/production/files/2018-04/documents/chap-03-mar-2018_1.pdf)

[redacted]

Specialty Ingredients

Lonza

ANNEX 1

NUGEN® MB⁵A Family	EPA Reg. #	Supporting Viral Claim
NUGEN® MB⁵A-256	6836-361	Norovirus (Norwalk Virus) or Rotavirus
NUGEN® MB⁵A -128	6836-362	Norovirus (Norwalk Virus) or Rotavirus
NUGEN® MB⁵A -64	6836-363	Norovirus (Norwalk Virus) or Rotavirus

NUGEN® MB⁵N Family	EPA Reg. #	Supporting Viral Claim
NUGEN® MB⁵N-256	6836-364	Norovirus (Norwalk Virus)
NUGEN® MB⁵N-128	6836-365	Norovirus (Norwalk Virus)
NUGEN® MB⁵N-64	6836-366	Norovirus (Norwalk Virus)

Lonzagard® RCS™ Family	EPA Reg. #	Supporting Viral Claim
Lonzagard® RCS-256 Plus	6836-349	Enterovirus D68 or Norovirus
Lonzagard® RCS-256	6836-346	Enterovirus D68 or Norovirus
Lonzagard® RCS-128 Plus	6836-348	Enterovirus D68 or Norovirus
Lonzagard® RCS-128	6836-347	Enterovirus D68 or Norovirus

Lonzagard® R-82 Family	EPA Reg. #	Supporting Viral Claim
Lonzagard® R-82	6836-78	Norovirus (Norwalk Virus)
Lonzagard® S-18	6836-77	Norovirus (Norwalk Virus)
Lonzagard® S-21	6836-75	Norovirus (Norwalk Virus)
Lonzagard® DC-103	6836-152	Norovirus (Norwalk Virus)
Lonzagard® R-82F	6836-139	Norovirus (Norwalk Virus)
Lonzagard® S-18F	6836-136	Norovirus (Norwalk Virus)
Lonzagard® S-21F	6836-140	Norovirus (Norwalk Virus)

Lonzagard® HWS Family	EPA Reg. #	Supporting Viral Claim
Lonzagard® HWS-256	47371-129	Adenovirus type 7
Lonzagard® HWS-128	47371-130	Adenovirus type 7
Lonzagard® HWS-64	47371-131	Adenovirus type 7
Lonzagard® HWS-32	47371-192	Adenovirus type 7

Lonzagard® Bardac® 205M Family	EPA Reg. #	Supporting Viral Claim
Bardac® 205M 1.3%	6836-277	Norovirus (Norwalk Virus)
Bardac® 205M 2.6%	6836-302	Norovirus (Norwalk Virus)
Bardac® 205M 5.2%	6836-303	Norovirus (Norwalk Virus)
Bardac® 205M 7.5%	6836-070	Norovirus (Norwalk Virus)
Bardac® 205M 10%	6836-266	Norovirus (Norwalk Virus)
Bardac® 205M 14.08%	6836-278	Norovirus (Norwalk Virus)
Bardac® 205M 23%	6836-305	Norovirus (Norwalk Virus)
Bardac® 205M RTU	6836-289	Norovirus (Norwalk Virus)

Disinfecting Wipes Family	EPA Reg. #	Supporting Viral Claim
Lonzagard® Disinfectant Wipes	6836-313	Rotavirus
Lonzagard® Disinfectant Wipes Plus 2	6836-340	Norovirus (Norwalk Virus)

NUGEN® EHP Family	EPA Reg. #	Supporting Viral Claim
NUGEN® EHP RTU	6836-385	Norovirus (Norwalk Virus)
NUGEN® EHP Wipe	6836-388	Norovirus (Norwalk Virus)

[redacted]

Specialty Ingredients

Lonza

ANNEX 2

Bardac® 205M Family	EPA Reg. #	Coronavirus Claim
Bardac® 205M 50%	6836-233	Human Coronavirus SARS Associated Coronavirus

Disinfectant wipes Family	EPA Reg. #	Coronavirus Claim
NUGEN® 2M Disinfectant wipes	6836-372	Human Coronavirus SARS Associated Coronavirus
Lonzagard® Disinfectant Wipes Plus	6836-336	Human Coronavirus SARS Associated Coronavirus