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10 UNITED STATES DISTRICT COURT  
11 NORTHERN DISTRICT OF CALIFORNIA  
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13 JOHN ARMSTRONG, et al.,

14 Plaintiffs,

15 v.

16 GAVIN NEWSOM, et al.,

17 Defendants.  
18

Case No. CV 94-2307 CW

**COURT EXPERT'S QUARTERLY  
REPORT ON INVESTIGATIONS AND  
DISCIPLINE**

19 Pursuant to the Court's orders for remedial measures at RJD, LAC, COR, SATF, CIW,  
20 and KVSP, the Court Expert provides the following report on implementation of CDCR's new  
21 investigations and discipline system.

22 **Changes to Centralized Screening and AIU**

23 Over the past several months, Plaintiffs have raised concerns that the Centralized  
24 Screening Team (CST) is not functioning as the Court's remedial plans contemplate. As the  
25 Court is aware, the remedial plan requires that CST review all complaints filed by or on behalf of  
26 an incarcerated person to determine whether they allege staff misconduct and, if so, whether the  
27 staff misconduct is of a form listed on the Allegation Decision Index (ADI). CST routes  
28 allegations of ADI staff misconduct to the Office of Internal Affairs Allegation Inquiry Unit

1 (AIU) for investigation and allegations of non-ADI staff misconduct to Locally Designated  
2 Investigators (LDIs) for inquiry. “Routine” complaints, meaning those that do not allege staff  
3 misconduct, are sent to local Offices of Grievances. *See* Dkt 3336-1 (Five Prison Remedial  
4 Plan), 4-5. Importantly, CST is not an investigative body, and its staff are not trained to conduct  
5 investigations or inquiries. Under the court-ordered remedial plan, the role of CST is not to  
6 evaluate the merits of a complaint but only to determine whether it alleges staff misconduct and,  
7 if so, whether it alleges a type of misconduct on the ADI.

8         As the Court Expert has reported since the inception of the new investigations and  
9 discipline process, the volume of cases flowing to CST has consistently exceeded CDCR’s initial  
10 estimates. *See* June 2022 Report (Dkt. 3420), 2. This has raised concerns not just about CST’s  
11 ability to screen complaints but about the effect on the workload of AIU investigators and LDIs,  
12 who, as a result of the larger-than-expected number of cases, may struggle to conduct  
13 comprehensive and unbiased investigations within the remedial plan’s timelines. Recognizing  
14 this problem, CDCR has explored various options for reducing the number of cases that CST  
15 sends to AIU. For example, CDCR worked with mental health staff to implement policies for  
16 identifying the most frequent filers of staff misconduct complaints and routing their complaints  
17 to the institutions for initial review. Dec. 2023 Report (Dkt. 3555). In 2022, CDCR also proposed  
18 implementing a “causal connection” screen pursuant to which CST would assess whether a  
19 complaint sufficiently alleged that a staff member’s actions were connected to a protected status  
20 or activity before referring the matter to AIU. Sept. 2022 report (Dkt. 3433). After Plaintiffs  
21 raised concerns with both the reliability of this proposed screen and the notion that it would  
22 result in CST reviewing the merits of complaints (concerns the Court Expert shared), CDCR  
23 implemented it only at non-*Armstrong* prisons, *see* Dec. 2022 Report (Dkt. 3449), and  
24 subsequently discontinued the practice. *See* Dec. 2023 Report (Dkt. 3555). However, based on  
25 their review of screening decisions in randomly-selected cases, Plaintiffs continued to suspect  
26 that CST was reviewing the merits of complaints before making a routing decision. *See* Sept.  
27 2023 Report (Dkt. 3513); Dec. 2023 Report (Dkt. 3555).

1 Plaintiffs’ concerns were well founded. At a meeting to discuss CST in January 2024,  
2 Plaintiffs and the Court Expert learned that CST was designating at least some complaints as  
3 routine based on CST’s assessment of the merits, rather than based on the nature of the  
4 allegations as they appeared on the face of the complaint. Further, CST was using the  
5 “clarification interview” process—which allows CST staff to interview a complainant when  
6 necessary to better understand what his or her complaint alleges—to conduct cursory  
7 investigations and, it appears, designating as “routine” complaints that, based on the clarifying  
8 interview, did not appear to raise meritorious claims of staff misconduct.

9 The Court Expert shares CDCR’s concerns about AIU and LDI caseload and has  
10 repeatedly expressed to the parties that adjustments to the screening and routing procedures may  
11 be appropriate. However, the current investigations and discipline process is the product of  
12 extensive and collaborative negotiations and is governed by Court order; it is not appropriate for  
13 CDCR to change the screening process without at least giving notice to—and ideally consulting  
14 with—Plaintiffs and the Court Expert. On this occasion and others, however, CDCR has chosen  
15 to make unilateral changes to the system without notice.

16 Most egregiously, the Court Expert and Plaintiffs learned through a January 2024 report  
17 by the Office of the Inspector General that, in August 2020, CDCR “violated its regulations by  
18 redirecting backlogged allegations of staff misconduct to be processed as routine grievances.”  
19 OIG Special Review No. SR-23-01 (Jan. 29, 2024), 1.<sup>1</sup> Briefly stated, the OIG found that CDCR  
20 had amassed a backlog of complaints that screening teams had determined alleged staff  
21 misconduct.<sup>2</sup> CDCR cleared this backlog by redesignating 595 cases as routine—in other words,  
22 as cases that did not allege staff misconduct—and redirecting them to the local institutions for  
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24 <sup>1</sup> <https://www.oig.ca.gov/wp-content/uploads/2024/01/OIG-Special-Review-No-SR-23-01.pdf>

25 <sup>2</sup> The backlog consisted of cases from the legacy process, under which prison staff reviewed  
26 grievances in the first instance to determine if there was a reasonable belief that misconduct  
27 occurred; if so, the grievance was sent to the Allegation Inquiry Management Section (AIMS)  
28 for investigation. This process was replaced with the current system under which CST makes the  
initial screening decision and AIU (rather than AIMS) conducts investigations. The redirected  
cases predated implementation of the new system.

1 review. The OIG analyzed a random sample of 71 complaints that had been redirected and  
 2 concluded that all 71 of them “contained at least one allegation of staff misconduct” that should  
 3 have been investigated by OIA. *Id.* at 4. When redirecting the backlogged cases, CDCR had  
 4 instructed local institutions to elevate the grievances—sending them back to OIA for  
 5 investigation—if they found the complaints alleged staff misconduct. However, only one of the  
 6 71 cases found by OIG to allege staff misconduct was in fact sent back to OIA for investigation.  
 7 *Id.* at 5.

8 In response to a draft of the OIG report—but before Plaintiffs or the Court Expert knew  
 9 the redirection had taken place—CDCR represented in a letter to OIG that it “undertook a review  
 10 of the grievances within the backlog” and redirected only “grievances [that] the newly activated  
 11 Centralized Screening Team had incorrectly screened as including allegations of potential staff  
 12 misconduct[.]” Report, 8-9 (CDCR’s letter to the OIG). The Inspector General’s final report  
 13 disputed this assertion, finding that nothing in CDCR’s written directive “indicates that the  
 14 department ... had performed a review of those grievances and determined that they had been  
 15 incorrectly screened or misclassified” and noting that “[t]he department did not mention that it  
 16 had performed such a review during any of the conversations we have had ... [n]or did the  
 17 department provide us with any records of having conducted such a review.” *Id.* at 10-11.

18 The Court Expert has profound concerns about CDCR’s actions. First, the redirection  
 19 resulted in closure of hundreds of claims that had been (correctly, according to the OIG’s review)  
 20 determined to raise allegations of staff misconduct that merited investigation; instead, those  
 21 complaints were treated as routine grievances, not allegations of staff misconduct, and reviewed  
 22 by local institutions in processes that the OIG found inadequate in many instances. *Id.* at 6.<sup>3</sup>  
 23 These substantive issues are significant. But just as significant to the Court Expert is the  
 24 Department’s lack of transparency. Even though the parties and the Court Expert had been  
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26 <sup>3</sup> For example, the OIG found that many cases were reviewed by staff not trained as  
 27 investigators, that staff did not always review all the allegations in the complaint, that staff did not always  
 28 review relevant documentation, and that some allegations were investigated by staff that ranked  
 lower than the staff alleged to have committed the misconduct. *See* OIG Report 4-7.

1 engaged in ongoing discussions about CST screening processes and AIU workload, CDCR did  
2 not disclose to Plaintiffs or the Court Expert its decision to redesignate as routine nearly 600  
3 complaints that had been found to allege staff misconduct; much less did it discuss the proposal  
4 in advance. Nor was CDCR forthcoming when the issue came to light through the OIG report.  
5 The Court Expert asked in writing about the review process described in CDCR’s letter to the  
6 OIG, and the Department reiterated that it redirected cases to local institutions only after a  
7 secondary review showed the allegations in the complaints did not rise to the level of staff  
8 misconduct. In a subsequent meeting, however, CDCR revealed that this review was much more  
9 limited and served only to ensure that no allegations concerning use of force or PREA violations  
10 were redirected.<sup>4</sup>

11 This is not the only instance where CDCR took unilateral action to address issues that  
12 were the subject of collaborative efforts. As discussed above, CDCR unilaterally changed the  
13 function of the CST to conduct some merits-based screening of complaints. And as reported last  
14 year, CDCR unilaterally and without notice changed the language of regulations implementing  
15 the Court-ordered reforms that the parties had negotiated. *See* Sept. 2022 Report (Dkt. 3433), 5  
16 (noting that “CDCR published proposed changes to the emergency regulations without giving  
17 Plaintiffs prior opportunity to review them, despite the fact that the changes related to matters  
18 that had been the subject of extensive negotiation” and expressing the expectation that CDCR  
19 would give prior notice should it “anticipate future changes to regulations related to  
20 investigations and discipline”).

21 The parties and the Court Expert have had frank discussions about this lack of  
22 transparency, and CDCR has acknowledged errors in this regard.<sup>5</sup> CDCR must do better. The

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23 <sup>4</sup> The OIG report similarly notes that the redirected cases did not include “those alleging  
24 improper use of force, violations of the Prison Rape Elimination Act, allegations made by  
25 incarcerated people no longer in custody or under parole supervision, and outstanding AIMS  
26 cases whose status the department was still researching as of the date of this publication.” OIG  
Report, 1 n.1.

27 <sup>5</sup> In these discussions, CDCR disclosed that it had conducted a similar redesignation of cases at  
28 RJD and LAC. The Department explained that LDIs asked CST to revisit its screening decisions  
on approximately 1200 cases that LDIs believed had been improperly routed; CST concluded

1 new investigation and discipline process is not perfect and will require refinement. In particular,  
2 changes in both staffing levels and procedures may well be necessary to ensure investigators  
3 have the resources to conduct competent and thorough investigations. But there is a Court-  
4 ordered remedial plan in place. If CDCR believes material changes to the investigation and  
5 disciplines system are necessary, it must proactively discuss those changes with Plaintiffs and  
6 with the Court Expert before implementation. The Court Expert should not have to press for  
7 information or, worse, to wait for the OIG to reveal actions CDCR has already taken. And it  
8 should go without saying that CDCR must be forthright in its responses when asked about  
9 modifications it has implemented or is contemplating.

10 Since the parties' meetings on CST and case redirection, CDCR has issued a set of  
11 proposals with broad changes to the investigations process. These include redefining "staff  
12 misconduct" and modifying the ADI (which would decrease the number of cases that reach  
13 AIU), eliminating certain staffing positions and increasing others (to direct more resources  
14 towards AIU investigation of serious allegations), revamping the software used to track cases,  
15 and creating streamlined processes for allegations that do not require full-blown investigations.  
16 The Court Expert welcomes these suggestions not because he necessarily agrees with all of them  
17 but because they signal acknowledgement that it will require collaboration and transparency to  
18 develop a system that can reliably find and discipline staff misconduct.

### 19 **Case volume and investigation and discipline timelines**

20 CST continues to receive high numbers of cases and to route only a small percentage of  
21 them to AIU. In his last report the Court Expert noted that case totals overall were increasing  
22 while the percentage of cases routed to AIU dropped, a possible indication that CST was  
23 categorizing at least some staff misconduct allegations as routine. As the table below shows, case  
24 volume has dropped slightly while the percentage of cases sent to AIU has increased slightly.

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28 that it had indeed misclassified 230 of those complaints. The Court Expert cannot opine on  
whether CST was right to reclassify these complaints.

Time period	Cases/month (average)	Cases routed to OIA (average)
December 2022 - February 2023	3600	11%
March - May 2023	3770	10%
June - August 2023	4910	8%
September - November 2023	5760	4%
December 2023 - January 2024 <sup>6</sup>	5570	5%

AIU investigations must be completed within 120 or 180 days, depending on whether they are assigned to custody supervisors (sergeants and lieutenants) or to special agents. CDCR continues to fail to meet those deadlines in some cases, although the trend continues to improve. CDCR data shows that for cases received during the five months from December 2022 through April 2023, AIU closed an average of 67% of investigations on time; for cases received during the five months from May through September 2023, the average on-time closure rate increased to 78%. While the remedial plan allows cases to stay open past the 120- or 180-day mark for “extenuating circumstances” (Dkt. 336-1, 6), the Court Expert has not received information from CDCR on the reasons for the delays in these cases. That more than one-fifth of cases received through September 2023 were not closed on time may well be an indication of insufficient staffing at AIU.

Overall, the rate at which discipline has been imposed in closed cases does not appear to have improved since the Court Expert’s last report. At that time, data indicated that 43% of cases closed through October 2023 were pending discipline; the figure remains roughly constant. The Court Expert also reviewed data on cases that are at least one year old. As of October 2023, hiring authorities had yet to act on 16% of the cases AIU had received as of October 2022. The data as of January 2024 is nearly the same: 17% of cases that AIU received as of January 2023 remain pending. The Court Expert and the parties will continue to discuss the timeliness of Hiring Authority decision-making.

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<sup>6</sup> Only two months of data are available here, compared to three for previous periods.

