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[redacted]

Re: *Armstrong v. Newsom*: Plaintiffs' August 2026 Review of CDCR's Accountability System at the Six Prisons
Our File No. 0581-03

Dear [redacted]:

We write regarding our review of Defendants' system for holding staff accountable for misconduct. The enclosed report is based on our review of investigation and discipline files produced from CSP-Los Angeles County ("LAC"), California Institution for Women ("CIW"), R.J. Donovan Correctional Facility ("RJD"), California Substance Abuse Treatment Facility ("SATF"), CSP-Corcoran ("COR"), and Kern Valley State Prison ("KVSP") (collectively "Six Prisons").

Plaintiffs continue to find that investigations and discipline fail to comply with the *Armstrong* Court Orders, as affirmed in relevant part by the Ninth Circuit, and with the RJD and Five Prisons Remedial Plans. *See* Dkts. 3059, 3060, 3217, 3218, 3393; *Armstrong v. Newsom*, 58 F.4th 1283, 1288 (9th Cir. 2023).

Plaintiffs have again found substantial evidence that CDCR's accountability system is failing to identify and confirm violations and to hold staff accountable for misconduct. We look forward to discussing these cases and the patterns of accountability system problems revealed by these cases. Plaintiffs' counsel remains concerned about the ongoing failure to take appropriate action in response to repeated violations by the same staff members after, even in our limited sample of cases, it is clear there is a serious

problem. We remain hopeful that the parties will be able to implement remedies to the system to address these longstanding systemic failures, and to improve accountability for staff misconduct.

Sincerely,

ROSEN BIEN
GALVAN & GRUNFELD LLP

/s/ [redacted]

By: [redacted]

[redacted]

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I. CASES INVOLVING A SINGLE OFFICER AT SATF THAT EXEMPLIFY SERIOUS AND ONGOING FAILURES OF THE ACCOUNTABILITY SYSTEM

In our last report, we wrote about an officer at SATF for whom CDCR had sustained multiple findings of misconduct, but who nonetheless had received only a single letter of reprimand. *See* Plaintiffs' May 2026 Review of CDCR's Accountability System at the Six Prisons at PDF pp. 4-14 (May 8, 2026). In this report, we write about another officer at SATF in a similar situation.[1]

Between March 2024 and October 2024, Officer [redacted] was involved in at least four staff misconduct incidents in which he was alleged to have used excessive or unnecessary force against an incarcerated person. In at least three incidents during this period, CDCR sustained findings of misconduct against Officer [redacted] and imposed penalties. But when Officer [redacted] appealed these three cases to the State Personnel Board ("SPB"), CDCR agreed to resolve them simultaneously and reduce the penalties in all three cases to Letters of Reprimand. In other words, CDCR did not impose progressive discipline despite finding that an officer repeatedly committed similar, serious misconduct.

As explained in detail below, these cases again illustrate that, even when the accountability system results in sustained allegations, Defendants fail to impose appropriate discipline. This failure is especially troubling when the violations involve multiple, serious improper uses of force committed by a single officer. The full extent of the harm caused by this officer to the incarcerated population is not known because Plaintiffs' counsel only receive a limited production of cases. Defendants' undermine the entire accountability system by failing to appropriately hold staff accountable for sustained allegations and by failing to progressively discipline officers who repeatedly violate CDCR rules.

(a) [redacted], Sustained (Reduced to Letter of Reprimand)

The first incident is described in the Notice of Adverse Action issued to Officer [redacted] for Incident [redacted] (detailed below).

According to the NOAA, "[o]n or about March 27, 2024," Officer [redacted] was working as a Floor Officer in [redacted] at SATF when he observed [redacted] talking to another incarcerated person through a cell door. *See* NOAA at 13. Officer [redacted] "approach[ed] [Mr.] [redacted] and advised him he had

[1] In addition to these incidents, Officer [redacted] was also involved in SATF-[redacted] which we wrote about in our May 2026 report. *See* Plaintiffs' May 2026 Review of CDCR's Accountability System at the Six Prisons at PDF pp. 18-20.

no reason to be out and to return to his cell . . . . [Mr. [redacted] was holding a broom making sweeping motions and began to walk away from" Officer [redacted] Officer [redacted] then announced loudly, "I am going to escort you to your, hey college, I am going to escort you to your cell, don't make any sudden movements." As he did so, Officer [redacted] reached for Mr. [redacted] arm. Mr. [redacted] pulled away saying, "No, no," and continued to walk away from Officer [redacted] At that point, Officer [redacted] jumped on Mr. [redacted] back, wrapped both his arms around Mr. [redacted] torso, and tackled Mr. [redacted] to the ground, landing on top of him. *Id.*.

The NOAA explained that the force Officer [redacted] used was "not necessary or reasonable to subdue an attacker, overcome resistance, effect custody, or gain compliance with a lawful order." *See* NOAA at 13. Mr. [redacted] was walking away from Officer [redacted] and therefore did not pose "an imminent threat warranting the use of immediate force." *Id.* at 14. Instead of tackling Mr. [redacted] Officer [redacted] should have used "other options," such as "additional dialogue, notifying a supervisor, or implementing a controlled use of force." *Id.* at 13-14.

(b) SATF-[redacted], Sustained (Reduced to Letter of Reprimand)

The second incident occurred on May 16, 2024. [redacted] was standing in the day room of [redacted]. In an interview, Mr. [redacted] explained that he had asked Officer [redacted] for a shower, but Officer [redacted] refused. *See* Investigation Report at 3. That refusal prompted Mr. [redacted] to ask to speak with sergeant. But Officer [redacted] also refused this request and ordered Mr. [redacted] to return to his cell. *See* BWC 1 at 15:12:54. An unidentified incarcerated person standing nearby asked Officer [redacted] why he was not allowing Mr. [redacted] to speak to a sergeant. Officer [redacted] responded, "Because this is my building and I'm running it right now. You don't need to talk to the sergeant for that." *Id.* at 15:13:00 to 15:13:03.

After another interaction with the unidentified incarcerated person standing nearby, Officer [redacted] turned to Mr. [redacted] and said "I'm allowing you a chance right now to walk to your cell." Mr. [redacted] responded, "I am asking you patiently and kindly may I talk to the sergeant?" Officer [redacted] replied, "No." *Id.* at 15:13:20 to 15:13:28. "For what reason?" asked Mr. [redacted] "For what reason? You don't need to because I'm giving you the answers you need." *Id.* at 15:13:28 at 15:13:32. At this point both the unidentified incarcerated person and Mr. [redacted] object, and Mr. [redacted] replies saying, "And I feel the answers that you are giving me are not justifying what's going on." *Id.* at 15:13:32 to 15:13:39.

Officer [redacted] then directs his attention to the incarcerated person standing nearby, telling him to step back and not to move. Turning to Mr. [redacted] Officer [redacted] says, "I'm going to escort you to your cell, do you understand that?" *Id.* at 15:13:45 to 15:13:47. Officer [redacted] then reaches to grab Mr. [redacted] left bicep with his right hand

and pulls on Mr. [redacted] arm. With his hands crossed in front of his body, Mr. [redacted] shrugs his left shoulder up to retract his left arm away from Officer [redacted] *Id.* at 15:13:50 to 15:13:51; *see also* BWC 2 at 15:13:50 to 15:13:51. Officer [redacted] continues to pull on Mr. [redacted] arm. When Mr. [redacted] does not move, Officer [redacted] immediately wraps his arms around Mr. [redacted] torso and hip tosses him to the ground. *See* BWC 2 (linked above) at 15:13:51 to 15:13:53. Other than slightly pulling away from Officer [redacted] grasp, at no time during this incident, including after he had been tossed to the ground, did Mr. [redacted] resist Officer [redacted]

The Hiring Authority considered the first and second incidents together and found that, in both, Officer [redacted] had used unnecessary force (L1). The Hiring Authority did not find that the force Officer [redacted] used in either incident was excessive. *See* 402/403. The baseline penalty for unnecessary force is Level 2—a 5% salary reduction for a period of 1-2 qualifying pay periods. But the Hiring Authority elected to impose a Level 3 penalty and reduced Officer [redacted] salary by 5% for a period of 9 qualifying pay periods. Though the Hiring Authority's rationale for escalating the penalty against Officer [redacted] is unclear, we suspect that it did so because it found that the mitigating factors were outweighed by aggravating factors, including that Officer [redacted] had committed "repeated acts of misconduct resulting in prior sustained adverse action," and that he did not accept responsibility for his misconduct. *Id.* at 3; *see also* 15 C.C.R. section 3392.5.

(c) Third Incident

We have little information about the third incident involving Officer [redacted] during this period. We are aware of it only because it was consolidated with Officer [redacted] appeal to the SBP in the first two incidents, described above, and the fourth incident, described below. The effective date of the NOAA related to this incident was June 30, 2025, and the Hiring Authority imposed a Level 3 penalty, reducing Officer [redacted] salary by 5% for 6 qualifying pay periods. *See* Stipulation at 3.

Please produce the investigation file for this incident. In the alternative, please provide a summary of the incident and the misconduct findings the Hiring Authority sustained.

(d) SATF-[redacted], Sustained (Reduced to Letter of Reprimand)

In the fourth incident, the Hiring Authority again sustained an allegation of unnecessary force against Officer [redacted]

Prior to the force, [redacted] —a class member with mobility and vision disabilities—had reported chest pains. The incident begins with Officer [redacted] approaching Mr. [redacted] and explaining that he

is going to put Mr. [redacted] in waist restraints, presumably to facilitate Mr. [redacted] transport to medical. *See* BWC 1 at 19:26:10 to 19:26:11. What unfolds next is a force incident against a person with disabilities that is so clear on video it should have resulted in immediate action against the officer. Mr. [redacted] who is seated in wheelchair and wearing dark sunglasses, asks, "Who is that?" *Id.* at 19:26:11. After Officer [redacted] identifies himself, Mr. [redacted] says, "I want to talk to a Sergeant," and appears to object to being put in waist restraints.[2] *Id.* at 19:26:11 to 19:26:15. Officer [redacted] responds, saying something like "Ok we gotta get you in waist restraints." Mr. [redacted] then begins to turn his wheelchair away from Officer [redacted] *Id.* at 19:26:15 to 19:26:24.

At the same time, Officer [redacted] approaches Mr. [redacted] and says, "We're going to take you to the clinic. We gotta put chains on." *Id.* at 19:26:24 to 19:26:25. Mr. [redacted] does not respond but wheels himself backward, away from Officers [redacted] and [redacted] and under the stairs to the upper tier. Officer [redacted] says in a louder force, "Hey. You're going to put chains on. Hey, stop moving your hand." *Id.* at 19:26:26 to 19:26:31. Mr. [redacted] hands are on the wheels of his wheelchair and he is using them to move away from Officer [redacted] Officer [redacted] again says, "We need to put waist restraints on you." Mr. [redacted] who is now beneath the tier stairs, again says, "I want to talk to a sergeant." *Id.* at 19:26:32 to 19:26:34.

As Mr. [redacted] spins his wheelchair to point it away from Officer [redacted] and roll forward, Officer [redacted] asks, "What are you doing?" *Id.* at 19:26:35. Mr. [redacted] continues to roll forward in his chair, away from Officer [redacted] and out from underneath the stairs as Officer [redacted] shouts, "Hey [redacted] You need to stop." *Id.* at 19:26:36 to 19:26:43. At this point, two more officers, including Officer [redacted], approach Mr. [redacted] *Id.* at 19:26:43. While standing in front of Mr. [redacted] and facing him, one or both of these officers tell Mr. [redacted] that they need to put him in waist restraints. *Id.* Mr. [redacted] takes out his tapping cane, extends it, and then holds it with two hands between his legs, with the upper portion of the cane leaning against his left shoulder. *Id.* at 19:26:43 to 19:26:47.

There are now four officers surrounding Mr. [redacted] at least two of whom are telling Mr. [redacted] in loud voices that they are going to put him in "chains" or waist restraints. Mr. [redacted] begins to object, and says to Officer [redacted] "Get away from me." *Id.* at 19:26:48. Mr. [redacted] then asks whether another officer would "tell [Officer [redacted] to get away from me?" *Id.* at 19:26:50 to 19:26:53. Officer [redacted] does not "get away" from Mr. [redacted] Instead, he reaches with both of his hands to grab Mr. [redacted] right arm.

[2] From the BWC produced, it appears that a Sergeant was present in the unit when Mr. [redacted] made this request.



Id. at 19:26:52.

When Mr. [redacted] tries to move his right arm away from Officer [redacted] Officer [redacted] rears back, pulling Mr. [redacted] arm with his left hand, and then strikes Mr. [redacted] right shoulder with his right elbow. *Id*. at 19:26:53.

After Officer [redacted] strikes him, Mr. [redacted] leans forward and away from Officer [redacted] in his wheelchair. Officer [redacted] than wraps his right arm around Mr. [redacted] neck, and pulls him out of the wheelchair and on to the ground. The wheelchair topples over, Mr. [redacted] face slams into the floor, and Officers [redacted] and [redacted] land on top of Mr. [redacted] *Id*. at 19:26:53 to 19:26:57. *See also* BWC 2 at 19:26:53.



See AVSS at 19:26:50.



See AVSS at 19:26:52.

After tackling Mr. [redacted] out of his wheelchair, Officers [redacted] and [redacted] handcuff Mr. [redacted] behind his back using regular restraints; Mr. [redacted] is silent and not moving as they do so. *See* BWC 1 at 19:26:58 to 19:27:24. When the officers sit him up a few seconds later, Mr. [redacted] says something to the effect of, "I still have chest pains," and then, a few moments later, "I can't be in these handcuffs. I gotta be in waist restraints." *Id.* at 19:27:46 to 19:28:06. Officer [redacted] responds:

> Right now, that's the only thing that you are going to be in because you cannot comply with direct orders. We tried--I tried to place you in regular waist restraints, now you made it into an emergency. That's all that we have available. We're going to help you up and you're going to sit on this chair and we're going to take you to medical to the holding cell. And you'll be evaluated for a 7219, all right?

Id. at 19:28:06 to 19:28:23.

As Officer [redacted] finishes this sentence, another voice, presumably an incarcerated person, can be heard shouting, "Stop lying!" *Id.* at 19:28:20. Video and Officer [redacted] Staff Narrative of the incident (*see* Exhibits at 56)—and Officer [redacted] own words—confirm that Officer [redacted] was lying: waist restraints were readily available.

The Hiring Authority found that the force Officer [redacted] used was unnecessary (L1) and imposed a Level 3 penalty, reducing Officer [redacted] pay by 5% for 6 qualifying pay periods. *See* 402/403.

(e) Fifth Incident - [redacted]

Plaintiffs have not done an extensive search but became aware of one complaint, the fifth incident involving Officer [redacted] during this period, from a civil rights complaint filed in the United States District Court for the Eastern District of California in December 2025. [redacted], the plaintiff in this case, alleges that on October 10, 2024, Officer [redacted] was escorting him out of [redacted] in handcuffs when Officer [redacted] joined the escort. *See* FAC at 5. Mr. [redacted] First Amended Complaint (FAC) alleges that "[i]t is well known that Defendant [redacted] enjoys assaulting inmates especially while they are in restraints." *Id.* . So, when Officer [redacted] joined the escort, Mr. [redacted] "turned his head to the right," saw Sgt. [redacted], and said, "I don't want [redacted] to escort me. I don't feel safe!" *Id.*

At this point, Officer [redacted] picked Mr. [redacted] "up off the ground and slamed [sic] him on his face." *Id.* Then Officer "[redacted] punched Plaintiff in the right side of the face." *Id.* at 6. As Mr. [redacted] hit the ground, Officer [redacted] "tripped and landed on [Mr. [redacted] back and head." *Id.* . A third officer then intervened and "pushed

[Mr. [redacted] face into the hot asphalt giving him a severe road rash on the side of his face." *Id*. Officers [redacted] and [redacted] joined this third officer in "grinding [Mr. [redacted] face into the asphalt." *Id*.

Notably, Mr. [redacted] also alleges that Officer [redacted] "has an extensive history of assaults on Inmates who are in restraints," and has "openly admitted to [Mr. [redacted] and other Inmates that he is a proud member of the 'Green Wall' Gang." *Id*. at 7.

(f) Consolidated Appeal to the SBP

In November 2025, the parties agreed to a stipulation that resolved Officer [redacted] appeals of the first four incidents described above.[3] In effect, the stipulation reduced a penalty that, in the aggregate, amounted to a 5% reduction in pay for 21 qualifying periods, to a 5% reduction in pay for just 6 months, and three letters of reprimand. *See* Stipulation at 2-4.

(g) Conclusion

These incidents evince a pattern: Officer [redacted] resorts to unjustified, immediate, and dangerous force against class members with disabilities who present no imminent threat. We recognize that CDCR can no longer discipline him for these incidents, **but we ask that you reassign Officer [redacted] to a post in which he cannot interact with and harm class members.**

The manner in which these incidents were ultimately resolved also illustrates problems with CDCR's accountability system—problems we have raised repeatedly over the last several years. For example, as we have pointed out before, CDCR undermines its own progressive discipline system by stipulating to lesser penalties when clear evidence establishes that misconduct occurred. These cases also demonstrate how the failure to recognize a problematic pattern of behavior and the slow pace of investigations can combine to allow a single officer to repeatedly harm class members without receiving any interventions such as interim training or guidance that might prevent future, continued misconduct.

Plaintiffs' counsel would like to know:

1. What, if any, information in Defendants' accountability system should have led the Hiring Authority or other CDCR management to detect a pattern of allegations of serious use of force incidents involving Officer [redacted]?

[3] The first two incidents were consolidated together in SBP case number [redacted]. The third incident's SBP case number is [redacted]. And the fourth incident's SBP case number [redacted].

2. What, if any, action could have been taken by the Hiring Authority had Defendants' accountability system led to the Hiring Authority or other CDCR management detecting a pattern of allegations of serious use of force incidents involving the same officer?

3. What, if any, information in Defendants' accountability system should have led investigators to connect these allegations for the benefit of Hiring Authority decision-making?

4. What, if any, action could have been taken by investigators in these cases to connect these allegations for the benefit of Hiring Authority decision-making?

5. How many complaints alleging unnecessary or excessive force have been filed against Officer [redacted] since March 2024?

6. Are there any other pending use of force allegations against Officer [redacted] currently under investigation by CDCR? If so, how many? What steps will be taken to ensure that investigators and the Hiring Authority are aware of the problematic pattern of sustained and non-sustained cases involving this single officer?

7. How are staff trained to respond to incarcerated people who ask to speak with a Sergeant? Under what circumstances are those requests honored? Under what circumstances are they denied?

8. Plaintiffs' counsel request that, given conduct revealed on footage where this officer has acted in complete disregard of people's disabilities and has rushed to use dangerous force when there is no imminent risk of harm, this officer be immediately re-assigned to a position in which he does not come into direct contact with incarcerated people with disabilities or serious mental health issues.

Please report on what action is taken in response to this request.

II. CARU IMPROPERLY IMPOSES CORRECTIVE ACTION FOR SUSTAINED ALLEGATIONS OF IMPROPER FORCE

In multiple cases produced this quarter, the Centralized Allegation Resolution Unit ("CARU") properly identified and sustained use-of-force violations but imposed only corrective action, which is inconsistent with CDCR's disciplinary matrix. Unnecessary Force Without Injury (L1) has a baseline penalty of Level 2 (1**2**3), but the CARU did not impose adverse action in any of the cases below. *See* 15 C.C.R. § 3392.5. In one case, the CARU explained that it imposed a lower-than-baseline penalty because the employee does not have a history of discipline, but that justification is inconsistent with regulations.

See 15 C.C.R. § 3392.5(c)(4) ("The Employee Disciplinary Matrix is based on the assumption that there is a single act of misconduct at issue and **this is the employee's first adverse action**.") (emphasis added). In another case, the CARU listed no aggravating or mitigating factors, yet imposed a lower-than-baseline penalty, again in violation of regulations. *See* 15 C.C.R. § 3392.5(c)(5) ("The hiring authority shall impose the base penalty unless aggravating or mitigating factors… are identified"). In a third case, it is unclear why the CARU imposed less than the baseline penalty; the mitigating factors listed on each of the 402/403s did not justify the CARU's downward departure from the matrix[4]:

- **COR-[redacted], Sustained (Letter of Instruction)**: On April 1, 2025, Officer [redacted] used unnecessary force on [redacted]. The video footage shows Officer [redacted] removing Mr. [redacted] from his cell in [redacted], an EOP unit, after Mr. [redacted] was reportedly experiencing chest pains. Mr. [redacted] is handcuffed behind his back and calmly walking in the direction of the escort. While walking forward, he begins looking over his right shoulder (Officer [redacted] is on Mr. [redacted] left side), and Officer [redacted] tells him to look forward. Mr. [redacted] complies and also tells Officer [redacted] to "quit grabbing me." In response, and immediately, Officer [redacted] places his leg in front of Mr. [redacted] and throws him to the ground head-first. *See* BWC at 17:20:40 to 17:21:00. The CARU appropriately sustained allegations of failure to observe and perform within the scope of training (D26, **1**2345) and unnecessary use of force without injury (L1, 1**2**3). *See* 402/403 at 4. In so doing, the CARU found that "there did not appear to be an imminent threat when [Officer [redacted]] utilized force against IP [redacted]." *See* Closure Documents at 6. The CARU found three mitigating factors and three aggravating factors. *Id. at* 4. But the CARU concluded that, because of "factors" (which were not described in the 402/403) and because Officer [redacted] did not have any prior sustained allegations of adverse action, "a mitigation downward to an LOI was the appropriate penalty." *Id.* The CARU only imposed corrective action. *Id. at* 3.

- **COR-[redacted], Sustained (Letter of Instruction and Training)**: On February 13, 2025, Officer [redacted] used unnecessary force on [redacted]. Officer [redacted] and another officer were waiting for Mr. [redacted] to be medically evaluated by a nurse in the dayroom of the EOP Restrictive Housing Unit, Building [redacted]. Mr. [redacted] was handcuffed behind his back and sitting in a chair, and Officer [redacted] was standing behind him over his left shoulder. The video shows Mr. [redacted] being verbally disrespectful to Officer [redacted] and Officer [redacted] tells him several times

[4] These cases reveal the failure of staff to react appropriately during interactions with people with mental illness in multiple situations that led to dangerous, harmful, and confirmed unnecessary uses of force.

to face forward but otherwise makes no attempt to de-escalate the situation. Around 15 seconds after sitting in the chair, Mr. [redacted] calls Officer [redacted] a "bitch," at which point Officer [redacted] immediately grabs Mr. [redacted] by the neck or chest and throws him backwards to the ground. *See* AVSS. The CARU appropriately sustained allegations of failure to observe and perform within the scope of training (D26, **1**2345) and unnecessary use of force without injury (L1, 1**2**3). *See* 402/403 at 4. The CARU concluded that, "[w]hile IP [redacted] continued to make belligerent statements, his body language remained compliant and it did not appear that he resisted physically or attempted to stand." *See* Closure Documents at 24. According to the CARU, Officer [redacted] decision to use force was not justified by policy because "[t]here was not an imminent threat present or articulated which would warrant the immediate use of force you utilized when you pulled him to the ground." *Id.* The 403 lists a number of mitigating and aggravating circumstances, none of which appear more significant than any other. *Id.* at 4. However the CARU imposed only corrective action. *Id at 2*. Staff should have been prepared to react differently to Mr. [redacted] given that his behavior was foreseeable in the EOP RHU. His actions align with his active mental health problems including but not limited to antisocial personality disorder, bipolar I disorder, and intermittent explosive disorder. *See* 7/2/2026 MH Master Treatment Plan.

- **SATF-[redacted], Sustained (Letter of Instruction and Training)**: On October 30, 2024, Sergeant [redacted] used unnecessary force when he punched or pushed (it is unclear from the video) [redacted] in the back while Mr. [redacted] was in a holding cage. The investigation was initiated because Associate Warden Carrie Critchlow authored a memorandum to the warden indicating that, while reviewing this incident package, she observed that Sergeant [redacted] "appears to punch/strike incarcerated person [redacted] in the back." *See* IR at 3. A.W. Critchlow highlighted discrepancies between Sergeant [redacted] written incident report and the video footage, suggesting that his report is not accurate and may have been dishonestly written. *Id.* She referred the case for administrative investigation. *Id.* At the start of the incident, Mr. [redacted] is in a holding cage in the program office, apparently because he was refusing to accept his housing assignment. *Id.* at 4. A sergeant approaches the holding cage and is immediately verbally aggressive with Mr. [redacted] dismissing his concerns with his housing compatibility and telling him that he "is the problem." *See* BWC 1 at 11:07:20-40. After the sergeant escalates the situation, Mr. [redacted] spits on her, which is most clearly seen on the body-worn camera of Sergeant [redacted] who was standing just behind the incident. *See* BWC 2 at 11:07:46.[5] The sergeant who

[5] Mr. [redacted] explained to the investigator that his actions were the result of his mental illness: "It's my mental health. I was paranoid." *See* IR at 13. Instead of requesting that clinical staff speak with Mr. [redacted] the sergeant antagonized him and downplayed his

was spit on immediately steps away, and Sergeant [redacted] approaches the holding cage, pulls out his OC spray, points it at Mr. [redacted] and says, "Turn your ass around! Turn around!" *See* BWC 2 (linked above) at 11:07:51. Sergeant [redacted] then deactivates his body-worn camera so that he can conduct a strip search on Mr. [redacted] before escorting him to a restrictive housing unit. Moments after deactivating his camera, Sergeant [redacted] appears to look down the hallway then punch (or push) Mr. [redacted] through the tray slot of the holding cage. *See* AVSS 1 at 11:08:06; AVSS 2 at 11:08:06. Sergeant [redacted] explained to the investigator that he used force because Mr. [redacted] "pulled away" "[a]s he began to remove his jacket and hand it to me." *See* IR at 20. The investigator appropriately highlights the inconsistency between the sergeant's testimony and the video footage: "[redacted] did not appear to remove any clothing until after [redacted] punched/pushed [redacted]." *Id.* at 11. For reasons that are unclear, the CARU did not sustain an allegation of dishonesty but did appropriately sustain an allegation of unnecessary force. *See* 402/403 at 8. The CARU listed no mitigating or aggravating factors on the 403, even though the CARU could have found that the misconduct was intentional and willful, that Sergeant [redacted] was a supervisor and should be held to a higher standard, that the inherent nature of the act was inappropriate, or that Sergeant [redacted] was evasive, dishonest, or intentionally misleading during the investigation, among others. *See* 15 C.C.R. § 3392.5(c)(11) (listing potential aggravating factors). The CARU imposed only corrective action and listed no justification for departing from the disciplinary matrix, in violation of CDCR policy. *See* 402/403 at 10-11.

According to CDCR's own regulations, officers found to have engaged in excessive or unnecessary use of force should receive adverse action unless consideration of the aggravating and mitigating factors warrants a downward departure in penalty. In the cases discussed above, the CARU failed to justify any mitigation of the penalties. In fact, in the second and third cases, any departure from the baseline should have increased the penalty, as the officers' improper uses of force were intentional and retaliatory (for being verbally abused in the second case and for spitting on a sergeant in the third case). These accountability failures send a consistent message to officers that improper uses of force are not serious forms of misconduct.

These cases represent a growing pattern that we have observed, where the CARU is increasingly likely to identify and sustain misconduct but fails to impose the appropriate level of discipline. *See, e.g.*, Pls.' May 2026 Review of CDCR's

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mental health needs: "There's no problem. You have no problem. You are the problem. I'm tired of moving you and I'm tired of you going mental health. Stop and listen. Stop and listen. I'm not moving you anywhere. You are properly endorsed." *Id.* at 11 (emphasis added). The CARU did not identify any policy violations related to the sergeant's escalatory behavior.

Accountability System at PDF p. 25 (COR-[redacted] sustained an allegation of unnecessary force but imposed only corrective action); Pls.' Feb. 2026 Review of CDCR's Accountability System February 2026 at PDF pp. 29 to 33 (RJD-[redacted] sustained an allegation of failing to intervene to stop misconduct and endangerment, a baseline Level 5 penalty, but imposed only Level 1). The CARU's reasoning for departing from the baseline penalty is either unclear from the documentation or inconsistent with regulations. The CARU's failure to impose correct discipline is often compounded before the State Personnel Board ("SPB"), where CDCR often inexplicably stipulates to even lower penalty. *See, e.g.*, Pls.' May 2026 Review of CDCR's Accountability System (linked above) at 2 to 3 (SATF-[redacted] & SATF-[redacted], CDCR stipulated to corrective action after sustaining allegations of excessive force in one case and unnecessary force in another case); Pls.' Aug. 2025 Review of CDCR's Accountability System at PDF pp. 21 to 22 (SATF-[redacted], CDCR stipulated to no penalty after a hiring authority imposed a Level 5 penalty for an officer punching a class member in the face). If CDCR is serious about reducing improper uses of force in its prisons, it must start imposing appropriate adverse action for use-of-force policy violations.

III. FAILURE TO ACCOMMODATE DISABILITIES RESULTING IN THE USE OF FORCE

Plaintiffs' counsel continue to identify multiple cases each quarter in which CDCR's accountability system fails to hold staff accountable for the failure to accommodate class members with disabilities, including serious mental illness, resulting in the inappropriate, unnecessary, dehumanizing, and sometimes excessive use of force against people with disabilities. The first two cases illustrate how, despite the clear need, staff fail to provide basic *Armstrong* disability accommodations to class members, ultimately resulting in uses of force that – with disability accommodations – could have likely been avoided. In both cases, the investigator and all subsequent reviewers failed to identify the connection between the need for a disability accommodation and the inappropriate use of force, and failed to reference any disability-related, policies and policy failures on the part of staff in the investigation report. The third case illustrates an egregious failure to accommodate a class member in mental health crisis during escort to a crisis bed. And the fourth case illustrates how the use of force can unnecessarily result in the expansion of the *Armstrong* and *Coleman* class.

Ultimately, these cases represent ongoing examples of how the accountability system continues to fail to hold staff accountable for clear, disability-related staff misconduct in violation of years of court orders.

1. KVSP-[redacted] Not Sustained

In this case, officers failed to accommodate [redacted]), when they refused to provide accessible

transportation. Instead, they attempted to lift the class member out of his wheelchair and force him up steps and into an inaccessible van. Their actions resulted in an avoidable and unnecessary use of force that violated Mr. [redacted] ADA rights. Despite clear video evidence of the incident, the CARU did not sustain any allegations about either the ADA violation or the unnecessary use of force. Moreover, the investigation was incomplete, as it failed to mention that the class member is [redacted] and has a no-stairs restriction, which made the use of a transport van with a large step inappropriate for him.

On April 22, 2025, at approximately 11:00 am, officers initiated an appropriate and court-ordered controlled use of force to extract Mr. [redacted] from his cell and transport him to a mandatory court appearance. Staff removed Mr. [redacted] from the cell, placed him in restraints, and put him in his wheelchair. *See* Exhibits at 25.

Mr. [redacted] asserts that, after he was extracted from his cell, he made clear to staff that, because he is unable to climb stairs, he could not be transported in a van without a wheelchair lift. He states that staff informed him that no wheelchair accessible van was available and that therefore they would instead force him into an inaccessible van. *See* [redacted] Interview at 2:37 to 3:15.

Available video of the incident begins after this conversation when staff begin to record him being forced against his will into the inaccessible van. As the video shows, the van that staff were attempting to force Mr. [redacted] to board requires a person to climb three steps. Mr. [redacted] is sitting in his wheelchair outside of R&R in waist restraints. A lieutenant announces that officers are continuing the controlled use of force from earlier in the day because Mr. [redacted] is refusing to board the transportation van, failing to acknowledge that the refusal related to his asserted right to ADA accommodations. Mr. [redacted] states, "I am an ADA inmate and I am refusing to be touched." He then says, "There's my wheelchair." Viewed in context, these statements reflect his effort to reiterate to staff and make clear on video that he is refusing to board the van because it is inaccessible. *See* BWC at 12:42:22 to 12:42:45.

Officers then push Mr. [redacted] wheelchair to the entrance of the van. Two officers grab Mr. [redacted] under his arms and lift him from the chair. Mr. [redacted] goes limp. Two other officers approach to assist. As the officers attempt to force Mr. [redacted] into the van, he begins to resist. A significant use of force ensues, during which Mr. [redacted] head hits the sliding door of the van, officers forcefully push him into the van, and Mr. [redacted] allegedly bites one of the officers. Ultimately, the officers are able to close the door with Mr. [redacted] in the van. *See* BWC (linked above) at 12:42:40 to 12:44:44.

Four days later, Mr. [redacted] filed a 602 about the incident. He wrote: "While at R&R awaiting transport, I refused to climb the trans van steps to load up. [The officers] took it upon themselves to physically grab me and load me up the trans van. While doing so, they beat me by socking me in the face and slamming my head into the van floor." *See* 602.

Following an AIU investigation, the CARU did not sustain any allegations of unnecessary or excessive force.[6] *See* 402/403. The CARU did not consider any allegations that officers violated the ADA.

The CARU's decision not to hold any staff accountable was a serious error. First, the CARU should have considered and sustained allegations that officers violated CDCR's ADA policies. At the time of the incident, Mr. [redacted] was [redacted] and had a documented "no stairs" chrono. *See* April 2025 DPP Roster. As shown in the video, the van that officers wanted Mr. [redacted] to enter had three steps. Moreover, Mr. [redacted] informed officers that he was not agreeing to board the van because it was not accessible. Any attempt to require him to board the van violated policy because it was not consistent with Mr. [redacted] documented accommodation needs. Nevertheless, the CARU failed to even consider this obvious ADA violation.

Second, the CARU should have sustained the unnecessary use-of-force allegations. The officers caused this unnecessary and dehumanizing force incident by failing to accommodate a class member with confirmed disabilities and stair limitations. The start of the video in this case shows that Mr. [redacted] had made the officers aware of his valid reason for not entering the inaccessible vehicle. With a wheelchair accessible vehicle, the use of force could have been avoided entirely. Instead, the officers ignored Mr. [redacted] ADA rights and escalated the situation, resulting in the use of force in which both Mr. [redacted] and at least one of the officers sustained injuries.

With respect to the failure to accommodate Mr. [redacted] disability, the investigation report is incomplete. See IR. Though the investigation report does mention that Mr. [redacted] was in a wheelchair when this incident occurred, it does not (1) identify that Mr. [redacted] is designated as [redacted] (2) list any of his limitations or required accommodations, including the no-stairs limitation, or (3) mention that accessing the van required climbing three steps. In addition, the report's exhibits do not include any documentation of Mr. [redacted] disability or accommodations. *Id.* at 6. Finally, the investigation report fails to mention the remedial plan requirement that "[t]he special needs of inmates with disabilities shall be considered in transporting them", nor the requirement that "[a]ccessible vehicles shall be used to transport inmates/parolees in wheelchairs and those whose disability, i.e., mobility, necessitates specialized transportation." *See Armstrong* Remedial Plan, Section IV.I.9. These shortcomings in the report do not excuse the CARU's failings; the ADA violation in this case is documented on video and clear. Nevertheless, the investigator's incomplete report set the

[6] At First and Second Levels of Review, the IERC did not identify any issues with the use of force. *See* Exhibits at 67 to 72. For reasons unclear, the Second Level Review occurred on May 13, 2025, more than two weeks after the filing of the staff complaint. The IERC then suspended its review while the AIU investigated.

CARU up for failure by not including all relevant information regarding the officers' failure to accommodate Mr. [redacted] disability.

This case, in which the AIU and the CARU both failed to recognize quintessential violations of CDCR's disability policies, suggests that Defendants still have a long way to go before they come into compliance with the Court's staff misconduct orders.

2. RJD-[redacted], Not Sustained

In this case, officers' failure to reasonably accommodate [redacted]) led to an unnecessary use of force.

Ms. [redacted] uses a walker and a cane and has a special cuffing restriction. According to the investigation report, officers were escorting Ms. [redacted] out of the housing unit after she was seen throwing property around the day room and was deemed a risk. *See* IR at 3. Video footage shows that, at the time the officers initiate her escort, Ms. [redacted] quickly complies with officers' orders to cuff up, and Officer [redacted] uses two sets of handcuffs to cuff Ms. [redacted] in front of her body. *See* BWC 1 at 14:02:00 to 14:02:10. The officer and Ms. [redacted] both confirm that prior to being cuffed, Ms. [redacted] requested that her special cuffing chrono be honored, but Officer [redacted] denied her this request "until the waist restraints arrived". *See* Exhibits at 40, 74. As the escort begins, Ms. [redacted] is seen holding her cane in her left hand, and the right side of her walker with her right hand. Due to the short length of the cuffs, she is unable to reach both sides of her walker. *See* BWC 1 (linked above) at 14:02:10 to 14:02:17. As such, she stops momentarily; she states as she lost her balance. *See* BWC 1 (linked above) at 14:02:18; IR at 5. Officer [redacted] grabs onto Ms. [redacted] right arm with both hands and says: "Stop, don't even start. Just go. Stop." Meanwhile, Officer [redacted] tells Ms. [redacted] "Don't resist." Ms. [redacted] responds, "I'm not homie, I'm not resist…" Before she can finish her sentence, Officer [redacted] drives her backwards and throws her and her walker to the ground. *See* BWC 2 at 14:02:09 to 14:02:22. Ms. [redacted] sustained injuries to her shoulder and hip. *See* Exhibits at 57.

CDCR opened an investigation into the use of force when, during review of the incident, Ms. [redacted] alleged excessive and unnecessary force against staff. The Incident Commander then suspended and referred the case for further review. *See* Exhibits at 3. During the first level of IERC review, Ms. [redacted] explained that "[she has] a hard time walking by [herself] without [her] walker," and that her "hands would [not] go across [the walker] like they do with the waist chains." She further explained that she "lost her balance [and] they took it as resisting." *See* Exhibits at 5.

As justification for why Officer [redacted] did not retrieve waist restraints prior to escorting Ms. [redacted] out of the unit, he said that he feared that other incarcerated people might attack Ms. [redacted] and he did not believe that he had time to retrieve waist restraints. *See* IR at 6. Instead he opted to accommodate her by applying two sets of handcuffs until

the waist restraints could be obtained. *See* Exhibits at 40. Despite his awareness of a need for an accommodation to safely escort Ms. [redacted] and the obvious difficulty of using a walker when unable to extend one's hands to the width of the walker handles, Officer [redacted] quickly resorted to immediate force, taking her to the ground when she paused, later stating that he "did not believe [redacted] lost her balance." *See* IR at 6.

The Hiring Authority incorrectly failed to sustain any allegation of misconduct. *See* 402/403 at 2.

Force could have been avoided had Officer [redacted] accommodated Ms. [redacted] disability. Rather than forcing Ms. [redacted] to attempt to walk without full use of her walker, Officer [redacted] could have taken multiple different actions to respond to the situation – including his perceived threat to her safety. The officer could have initiated an alarm, prior to the use of force, to secure the unit. He could have then retrieved waist restraints or a wheelchair to conduct the escort. Or, because there were two escort officers present, they could have sat her down while radioing for another officer to retrieve waist restraints, a wheelchair, or some other accommodation. Instead, despite acknowledging her apparent need for a cuffing accommodation in order to use her walker, Officer [redacted] proceeded with the escort anyway, even after it was apparent that she was not able to use her walker, in violation of CDCR policy that requires officers to accommodate class member's disability when applying handcuffs. *See* DOM 51020.6(g) (mechanical restraints "shall be applied" to people with disabilities to "ensure effective application while reasonably accommodating the [incarcerated person's] disability"). This failure to accommodate ultimately resulted in an unnecessary use of force when, after she paused during escort, immediate force was used to take her down. Ms. [redacted] neither presented an imminent threat during the escort nor threatened Officer [redacted] during the interaction. Ms. [redacted] "resistance" was only because Officer [redacted] failed to provide her a disability accommodation. As such, both shoving Ms. [redacted] into the wall and throwing her to the ground was unnecessary and dangerous. The Hiring Authority should have sustained an allegation of staff misconduct against Officer [redacted] for failing to perform within the scope of his duties and training when he improperly denied Ms. [redacted] a reasonable disability accommodation. The Hiring Authority should have also sustained unnecessary force without injury (L1, 123).

This case involves two extremely common force scenarios for *Armstrong* class members observed by Plaintiffs' counsel during case reviews; use of immediate force when someone with a mobility disability pauses or hesitates during escort, and use of immediate force when a class member is deemed to be "resisting" when asserting their right to cuffing accommodations during an incident. Recently, Defendants have said that no front cuffing accommodation exists, and that policy does not provide for front cuffing. If true, this directly violates the *Armstrong* Remedial Plan ("ARP") requirement that "inmates who have a disability that prevents application of restraint equipment in the ordinarily prescribed manner shall be afforded reasonable accommodation… mechanical

restraints shall be applied to ensure effective application while reasonably accommodating the inmates' disability." *See* ARP § IV.I.7. Plaintiffs' counsel wish to continue to discuss the requirement that staff must provide cuffing accommodations to people who, as in this case, are unable to safely walk without accommodation. Plaintiffs also seek to continue to discuss how, as in this case, it is essential for staff to consider disabilities during escort, and especially whether the escort is paused as a result of the disability, before resorting to dangerous and unnecessary immediate force.

3. COR-[redacted], Not Sustained

This case involves an officer two-hand shoving a suicidal class member to the ground for no apparent reason while the class member was handcuffed behind his back, in ankle restraints, and struggling to walk. The investigation was initiated after the associate warden over Corcoran's restrictive housing units authored a memorandum to the warden describing the force as unnecessary and excessive, indicating that the officer's incident report was inconsistent with the video footage, and stating what appears to be happening is that the class member is having trouble walking. *See* Exhibits at 4. Despite the associate warden's concern about the officer's improper use of force and inaccurate reporting, the allegations were not sustained. In fact, the only discipline issued in this case was to the class member who was thrown to the ground, for "resisting staff," which is not evident in the video. *Id.* at 50.

On December 20, 2024, officers are escorting [redacted] from his housing unit to the [redacted] because Mr. [redacted] reported that he was suicidal. *See* Investigation Report at 1, 4. The fixed-camera footage shows Mr. [redacted] being escorted around the track with an officer on either side of him and a sergeant behind him. *See* AVSS at 17:37:00. Mr. [redacted] is handcuffed behind his back, secured in ankle restraints, and appears to be struggling to walk. At 17:37:15, Officer [redacted] stops the escort and says something to Mr. [redacted] who appears to listen to the order before the escort begins again. Mr. [redacted] takes a few steps forward, and seconds later, Officer [redacted] puts both of his hands on Mr. [redacted] right shoulder and shoves him to the ground, with Mr. [redacted] momentarily becoming airborne. *See* AVSS (linked above) at 17:37:22.

The body-worn camera footage does not make the impetus for Officer [redacted] decision to use force any clearer. As Mr. [redacted] is walking around the track, Sergeant [redacted] who is trailing the escort, starts making friendly small-talk with Mr. [redacted] Mr. [redacted] answers each of the sergeant's questions in a calm manner. At 17:37:25, however, Officer [redacted] stops the escort and says, "Stop pulling, alright. Stop pulling. I'm going to tell you one more time: stop pulling." Again, it is not clear on the video that Mr. [redacted] is pulling at all though, as noted by the associate warden, he is shackled and is struggling to walk. But after taking a couple more steps, Officer [redacted] says, "Stop", then immediately initiates a use-of-force. Mr. [redacted]

does not appear to do anything in the moments before the force that would justify Officer [redacted] decision to use immediate force. *See* BWC at 17:37:00 to 17:37:32.

Mr. [redacted] received an RVR for this incident, and neither the RVR narrative nor any of the officers' incident report narratives are consistent with the video footage. The narrative of the RVR, issued for "Resisting Staff," tracks with Officer [redacted] incident report and states that Mr. [redacted] "began to start aggressive behaviors and demeanor as he stopped the escort multiple times, began tensing his right forearm and pulling his forearm in a downward motion towards the center of his body and was stating 'don't touch me.'" *See* Exhibits at 43, 58. Those alleged actions are not evident on the video; Mr. [redacted] did not stop the escort, nor did he say "don't touch me," in any of the video files produced in the investigation file. The investigation report notes this fact—"It should be noted during my review I did not observe or hear [redacted] say the words 'don't touch me' or 'get off me'"—but caveats that finding by explaining that "the BWC footage of the subjects started mid escort when the escort was half way across the facility yard." See IR at 5.[7] Sergeant [redacted] wrote in his incident report that he observed Mr. [redacted] "suddenly stop the escort and turn his head to Officer [redacted] while pulling forward with his right arm," causing Officer [redacted] to react with immediate force. *See* Exhibits at 38. But Officer [redacted]—not Mr. [redacted]—stopped the escort, and the video footage from Sergeant [redacted] body-worn camera shows Mr. [redacted] head facing downward at the time force was used.

The associate warden responsible for the restrictive housing units at the prison, Associate Warden Chappell, identified the force as both unnecessary and excessive and called into question the accuracy of Officer [redacted] incident report. In a memo to the warden, A.W. Chappell wrote:

> In viewing the footage provided, it appears as if IP [redacted] is struggling to walk as he is cuffed behind his back and has leg restraints on. Officer [redacted] indicates in his report that IP [redacted] during the escort began "to start aggressive behaviors and demeanor as he stopped the escort multiple times." Officer [redacted] indicates the necessity of his force was for his safety as well as his partners safety due to IP [redacted] "violent behavior." This appears to be contrary to what the AVSS and BWC footage shows. At no time does IP [redacted] appear to be violent. When reviewing the footage for this IRT, it appears IP [redacted] is struggling to walk with the leg

[7] The longest video footage produced in this file—one of the escort officer's BWCs—includes one minute and 42 seconds of footage before Officer [redacted] used force. *See* BWC 2. At no point during that nearly two minutes did Mr. [redacted] say, "Don't touch me."

> restraints. The amount of force that officer [redacted] uses appears to be unnecessary and excessive.

See Exhibits at 4.

The investigator in this case did not thoroughly identify the discrepancies between the officers' incident reports and the video footage, other than noting the inconsistency about whether Mr. [redacted] stated "don't touch me." The investigator, who was not assigned until eight months after the incident was initially flagged by the AW, was unable to interview Officer [redacted] because he was out on a medical leave and "not responding to [the investigator's] attempts to contact him." *See* IR at 10, Exhibits at 4. Ultimately, the investigator concluded the investigation without interviewing the main subject because of "the impending statute of limitations for this investigation." *Id*. The CARU did not sustain allegations of dishonesty against any of involved officers for their inaccurate incident reports. *See* 402/403.

As A.W. Chappell pointed out in the memo to the warden, the use-of-force in this case violates policy. At the time Officer [redacted] used immediate force, Mr. [redacted] is not presenting an imminent threat; he is secured in handcuffs and ankle restraints, shuffling around an otherwise empty track, and being escorted by three officers. Moreover, the amount of force was extremely disproportionate to the threat presented in that shoving a person who is handcuffed and restrained around the ankles with full force onto the ground is excessive and very dangerous. The CARU had sufficient video footage to sustain allegations of unnecessary and excessive use of force against Officer [redacted] Its reasoning for failing to do so is both unclear and contrary to CDCR policy.

We request that CDCR void the RVR issued to Mr. [redacted] that resulted from this incident.

4. SATF-[redacted], Not Sustained

In this incident, an officer used immediate and unnecessary force against a person who was calmly and passively standing against her cell door in an empty dayroom. The officer's use of immediate force escalated the situation, triggering additional force by ten more officers. This case came to the AIU after being referred for investigation during the First Level Review as part of the Institutional Executive Review Committee ("IERC") process. *See* Exhibits at 3-4. Despite clear evidence that officers used unnecessary and excessive force, the CARU failed to sustain the allegation of staff misconduct.

AVSS and BWC footage from the incident shows officers responding to a Code 1 (disruptive incarcerated person) in building [redacted]. The fixed-camera footage shows [redacted] leaned back against her cell door, with every other cell door closed and no other incarcerated person in view. *See* AVSS at 19:33:15; BWC at 19:33:00 to 19:33:15. According to Ms. [redacted] medical records, one of her close

family members died around the time of the incident. A mental health clinician noted that Ms. [redacted] has been "feeling unsupported by custody staff that would ask her for help with the housing unit but would not give her time on the phone with her family to process the loss." *See* Inpatient Progress Note. The video footage of the incident shows nearly a dozen officers arrive as Ms. [redacted] remains standing by her cell door with her arms crossed in front of her in an empty dayroom. She does not present an immediate threat to staff. Officer [redacted] approaches Ms. [redacted] and immediately escalates the situation by grabbing her right arm to cuff her. *See* AVSS (linked above) at 19:33:39. When she resists handcuffs, multiple officers grab her and throw to the ground for passively resisting cuffing. In all, it appears eleven officers used force to grab, throw, and restrain Ms. [redacted] without any attempt to use de-escalation techniques or controlled force, as she did not pose an imminent threat.

Ms. [redacted] was not in the Mental Health Delivery System at the time of the incident. The day after this incident, Ms. [redacted] was admitted to a mental health crisis bed ("MHCB") after endorsing suicidal ideation with a plan and intent to hang herself. *See* Inpatient Progress Note (linked above). After her eight-day stay in the MHCB, Ms. [redacted] was discharged to the EOP level of care, where she remains today. *See* 8-14-24 IDTT.

The body-worn camera footage makes clear that no staff member attempts to de-escalate the situation, in violation of CDCR policy. *See* 15 C.C.R § 3268(b)(1) (officers must attempt to use verbal persuasion to prevent the need for force); DOM § 51020.5(a) (same). As Officer [redacted] approaches Ms. [redacted] he says, "Turn around." He takes a few more steps and says again, "turn around," while twirling his finger. He then immediately grabs Ms. [redacted] resulting in a violent and likely avoidable use-of-force. *See* BWC at 19:33:35. Neither Officer [redacted] nor any of the other ten officers on the scene stop to ask Ms. [redacted] why she is refusing to return to her cell, what would make her go back to her cell peacefully, or even explain to her that she needs to submit to handcuffs. After entering the building, assessing the situation, and determining that only one incarcerated person was passively noncompliant, the officer had ample time to de-escalate the situation to avoid force. Instead, Officer [redacted] created the necessity to use force and violated CDCR's de-escalation requirements. *See* 15 C.C.R. § 3268(b)(2) (officers should only use force if "verbal commands and de-escalation techniques do not work, or are not feasible in light of the situation").

According to the Request for Administrative Review, a captain at SATF wrote: "The force used by Officer [redacted] appears to be unnecessary and/or excessive and controlled use of force should have been initiated." *See* Exhibits at 4. Yet, the CARU found no violation of policy without any explanation and clear video evidence to the contrary. *See* 402/403.

IV. MISUSE OF THE SPECIAL-CONDITIONS CLOSURE PROCESS

CDCR regulations permit the Department to close certain staff-misconduct investigations without completing the full range of ordinary investigative steps. Under 15 C.C.R. § 3486.2(b)(4), an investigator may recommend closure based on a "special condition" when either: (1) video and audio recordings provide conclusive evidence that the alleged misconduct did not occur; or (2) no additional investigative steps can be pursued because the claimant provided insufficiently specific information and refused to cooperate with efforts to obtain additional information. If the special condition does not apply, or if additional investigation is warranted, the case must be returned for further investigation.

Plaintiffs' counsel has supported—and continues to support—CDCR's use of this process. Properly applied, the "special conditions" closure process allows CDCR to focus investigative resources on cases that require further factual development. When objective evidence conclusively proves that alleged misconduct did not occur, requiring investigators to conduct unnecessary interviews or review cumulative evidence wastes resources that could be directed to cases that need them.

Our review of special conditions cases shows that Defendants are using the process to end investigations when the evidence, particularly video evidence, is not conclusive. Two cases in this production illustrate CDCR's misuse of the "special conditions" closure process. In the first case, the evidence confirmed the misconduct occurred, but the Hiring Authority did not sustain the allegation; in the second case, the video evidence was inconclusive as to whether the misconduct occurred, but CDCR still closed the case without conducting any other investigation:

- **SATF-[redacted], Not Sustained:** This case involves CDCR using the "special conditions" closure process to not sustain an allegation, even though the video footage actually proves the misconduct occurred. [redacted] alleged that Officer [redacted] violated body-worn-camera requirements by failing to deactivate his camera during an unclothed body search on September 6, 2025. The video confirms Mr. [redacted] allegation. At approximately 09:23:18 a.m., during a search in the dayroom of his housing unit before release to yard, Mr. [redacted] turned around in front of Officer [redacted] squatted, and coughed without lowering his boxers. At 9:23:24 a.m., Officer [redacted] told him, "Aye, you got to drop the boxers homie." Mr. [redacted] then lowered his boxers, squatted, and coughed. Officer [redacted] did not reach toward his BWC to turn it off until approximately 9:23:32 a.m., after Mr. [redacted] had lowered his boxers and completed the search procedure. *See* BWC; AVSS 1; AVSS 2; IR at 2.

  The video also appears to show a separate violation that CDCR did not identify or investigate. Officer [redacted] conducted the unclothed body search in the housing-

unit dayroom while other incarcerated people were present. The footage shows approximately three incarcerated people in the dayroom as Officer [redacted] released people from their cells for yard. As Mr. [redacted] approached the exit, Officer [redacted] directed him to lower his boxers, squat, and cough, and Mr. [redacted] complied in the open dayroom. See BWC; AVSS 1; AVSS 2. CDCR regulations provide that, "[w]henever possible, unclothed body inspections of incarcerated persons shall be conducted outside the view of others." 15 C.C.R. § 3287(b). Nothing in the Investigation Report addresses why the search was conducted in view of other incarcerated people or identifies this apparent violation for further investigation.

During the investigation, Officer [redacted] acknowledged that his BWC remained on during the unclothed search and agreed with Mr. [redacted] allegation that he failed to deactivate it. See IR at 3. He explained that he was distracted by other incarcerated people and that Mr. [redacted] lowered his boxers before he could turn off the camera. *Id*. He denied recording the search intentionally or for sexual gratification. *Id*.

Despite the video and Officer [redacted] admission, CDCR closed the investigation using the special-conditions process and did not sustain the allegation. The 402/403 reasoned that [redacted] knew the policy, had properly deactivated his camera during two earlier searches, and began reaching for his camera "[a]s soon as the UBS [unclothed-body search] started," although there was "a delay in that process." *See* 402/403 at 3. But the video shows Officer [redacted] directing Mr. [redacted] to lower his boxers and Mr. [redacted] complying before Officer [redacted] turned off his camera. Officer [redacted] explanation may be relevant to whether the violation was inadvertent and what corrective or adverse action to take, but it does not establish that the alleged conduct did not occur. Indeed, the video and [redacted] own statement establish that the misconduct occurred. The same footage also appears to show an additional violation of CDCR's requirement that unclothed body searches be conducted outside the view of others whenever possible, yet the Investigation Report does not address that conduct at all. CDCR should not have used the special-condition process for to not sustain the allegations in this case. *See* 15 C.C.R. § 3486.2(b)(4)(A)(1).

- **SATF-[redacted], Not Sustained:** CDCR closed this case using the "special conditions" process even though the video footage does not prove that the misconduct did not occur. [redacted] alleged that Correctional Supervising Cook [redacted] slammed a dining-hall serving window shut on or immediately in front of his face and called him an "entitled" n-word while Mr. [redacted] was attempting to obtain a diabetic snack. *See* IR at 1. The available recordings capture portions of the incident, but do not conclusively establish

whether the alleged misconduct occurred. The kitchen-side fixed-camera footage shows Supervisor [redacted] attempting to close the serving window, the window swinging back open twice, and Supervisor [redacted] succeeding in closing it on his third attempt. *See* AVSS 1 at 17:46:40 to 17:46:55. The recording does not establish the amount of force [redacted] used or what prompted him to close the window. The other surveillance angle does not clearly show the relevant interaction. *See* AVSS 2 at 17:46:43 to 17:46:52. An officer standing nearby, Officer [redacted] is wearing a BWC, but that footage does not provide a clear view or clear audio of the disputed interaction. *See* BWC 1 at 17:46:50 to 17:47:00. Another nearby officer's BWC footage begins after it occurred. *See* BWC 2 at 17:46:45 to 17:47:00.

Nevertheless, the investigator concluded that the recordings conclusively disproved Mr. [redacted] allegation. The investigator found that Supervisor [redacted] did not forcefully slam the window, was not laughing, and was not seen speaking to Mr. [redacted] and concluded that the incarcerated kitchen worker, rather than Supervisor [redacted] appeared to be laughing. *See* IR at 3–4. Based on that conclusion, CDCR did not interview Mr. [redacted] Supervisor [redacted] or other potential witnesses, even though several incarcerated people were present during the incident, including an incarcerated kitchen worker who was standing next to Supervisor [redacted] at the serving window. CDCR closed the investigation under § 3486.2(b)(4)(A)(1). *Id.* at 4–5.

CDCR's use of the "special conditions" closure process was inappropriate in this case. The video does not conclusively disprove the alleged misconduct conduct occurred because the conduct, including whether Supervisor [redacted] made the alleged racial comment is not clearly captured. The OIG, who was attached to this case, likewise disagreed that the investigation was sufficient, noting that staff witnesses had not been interviewed and that additional video evidence should have been included. *See* 402/403. The Hiring Authority nevertheless found the investigation sufficient, did not sustain the allegation, and took no action. *Id.*

V. FAILURE TO ADEQUATELY INVESTIGATE STAFF MISCONDUCT ALLEGATIONS RELATED TO A DEATH IN CUSTODY

1. RJD-[redacted] & RJD-[redacted] Not Sustained

[redacted], died by suicide on January 6, 2025 in an EOP housing unit at RJD. *See* IR at 3.

Following his death, two clinical staff interns filed reports disclosing the names of three incarcerated witnesses who were living in his unit at the time and who independently reported to staff that they heard someone who was suicidal and crying out for help before Mr. [redacted] was found. *See* Exhibits at 4, 8. One witness reported

that the cries for help went silent and then, sometime later, they heard keys rustling and staff attempting to resuscitate someone. *Id.* at 8. The investigation report mentions that the floor officer had been in his office watching YouTube videos in the hours before Mr. [redacted] was discovered unresponsive in his cell. *See* IR at 4. This evidence is not addressed further beyond stating that it was referred to OIA for a separate investigation into whether he was violating policy by watching videos on a state computer. *Id.* Despite the discovery that floor staff may have been less than alert on the night of Mr. [redacted] death, the investigator fails to gather additional relevant evidence necessary to determine whether staff failed to perform within the scope of their duties in order to prevent a death in custody in a mental health housing unit. Instead the investigator concludes the report by stating that, "*no subject(s) were identified for this investigation"* and, based on a *"lack of evidence to support the allegations, all investigative efforts were exhausted." Id.* at 9.

The three incarcerated witnesses each reported the same general allegation that they heard someone crying for help and saying they were suicidal before Mr. [redacted] was discovered unresponsive in his cell at 3 am on January 6th. *See* IR at 3-6. According to the investigation report, the witnesses could not provide many details and could not say the exact time they heard the cries, but they believed it was third watch. *Id.* at 4-6. When asked how long it took in between the calls for help and when the alarm sounded one stated, "it seemed to be a longer time than he would have expected for someone who is calling for help from their cell." *Id*. at 6. Another stated he heard the yelling and approximately two hours later, staff entered the [redacted] in building [redacted] and took [redacted] out of the cell". *Id.* at 5-6. Taken together, the allegations place the alleged failure to respond to suicidality and cries for help somewhere between third watch on January 5th and first watch on January 6th, when he was discovered.

First, the investigator fails to retain and review all relevant footage during this time period. The investigator pulls only three videos. The is fixed camera AVSS footage for the dayroom but only video during third watch on January 5th, and not first watch on January 6th was retained. Also, it is unclear whether fixed cameras in this unit have audio, some units at RJD do have audio. This camera does not and is therefore not helpful in this case. The other two videos were BWC video for only one of multiple staff members who were in the unit at the time, the floor officer. *See* IR at 9.

The investigator fails to accurately report on the relevance of critical evidence discovered during his review of BWC footage. Specifically, during his review of first watch BWC footage, the investigation report states, "I reviewed BWC footage, dated January 6, 2025, titled [redacted] 131800 **23:00:00-03:31:00 (Exhibit 8)**." *See* IR at 4. The following is a synopsis of what is depicted within the BWC footage:

> Correctional Officer [redacted] is observed conducting his institutional counts. During the course of his shift, leading up to the incident of Incarcerated Person [redacted] suicide, no verbal call for

> assistance, help or advisement of suicidal ideations were captured during BWC review.

Id.

This statement mischaracterizes the Officer [redacted] actions and omits reference to a large chunk of missing footage. In reality, the BWC reveals that Officer [redacted] is in his office, at points with the door closed, and at points with a loud fan going, watching videos on the computer for most of his watch. *See* BWC. For example, only a few minutes after the clip begins, music can be heard playing in the background and, at around 23:02:18 a loud audible humming, possibly a fan, can also be heard. *Id.* at 23:02:18. He remains in the office with the door closed for approximately 20 minutes before walking on to the floor. *Id.* At around 23:32:14 he is back in the office watching videos again. By 23:36:15 he removes his BWC and places it on his desk while videos can be heard playing in the background. *Id.* at 23:36:15. The camera remains on the desk, an additional violation of BWC policy that is not referenced in the report, with the lights out in the office and the door opened only a crack while videos can be heard playing in the background until around 12:10:30. *See* 15 C.C.R. Section 3270.3. At 00:17:31 a female officer enters the unit and, after saying something to the officers at which point one responds, "No way! What the fuck!" she instructs them to deactivate their cameras, also in potential violation of BWC policy. *See* BWC (linked above) at 00:17:31. When Officer [redacted] camera is reactivated, around 00:24:33, he is back in the office with the lights off and videos playing. Over the next few hours he is on the phone, at one point for nearly thirty minutes until his call is interrupted when count was ordered. *Id.* at 00:32:37 – 01:01:15. Following count, Officer [redacted] is back in the office with the lights off, his camera removed, and he is watching loud videos with the additional loud sound of the apparent fan in the background. *Id.* at 01:09:47. This continues until the BWC footage clip ends, inexplicably at 01:29:52. The next clip does not pick back up until 2:57:44 am, just before Mr. [redacted] is found. None of this context, which is directly relevant to whether Officer [redacted] may have been unable to hear whether anyone cried out for help in the mental health housing unit, was mentioned in the investigation report.[8] Nor was there any explanation for why an hour and a half of the floor officer's BWC footage is missing.

[8] The footage revealed additional concerns where at around 11:22:0 Officer [redacted] steps in to relieve a custody officer who is conducting an apparent one-on-one observation of a different suicidal class member at cell 145. During the period he is supposed to be watching the class member he can be seen checking his apple watch, turning his body/camera away from the door, flipping through a notebook, and, at one point leaves the door to talk to the other staff member, failing to maintain direct observation of the cell. *See* BWC (linked above) at 23:22:01 to 23:23:11; 23:24:32 to 23:24:52; 23:26:09 to 23:26:54.

The investigator does include an additional note, that appears to be an aside, stating that the officer was observed watching YouTube videos and was observed not wearing his personal alarm. *See* IR at 4. These observations were apparently not deemed relevant to this investigation as they were instead referred to OIA to be addressed in a separate case, [redacted]. However, the issue of whether the floor officer was in his office watching YouTube videos and therefore may not have heard the cries for help coming from Mr. [redacted] are central to the allegation in this case.

Also central to this case is an explanation for why an hour and a half of footage is missing, just prior to Mr. [redacted] being discovered.

The investigator fails to interview Officer [redacted] who should have been identified as the subject of this investigation. Other staff members who were apparently present were interviewed including the correctional officer who was stationed as suicide watch for a different class member 19 cells away. *See* IR at 7. He stated that he did not hear cries for help that night, but was unsure about whether he would have heard anything based on where he was positioned. *Id*. The control booth officer was also interviewed and stated that he did not hear cries for help that night, and had he heard anything he would have notified the floor officer on duty. *Id.* at 8-9. There is no explanation for why BWC was not retained or reviewed for these staff members.

Although the investigator concluded that the statements from the three incarcerated witnesses, who independently reported hearing cries for help were "inconsistent", there was no effort to identify and interview others who were living in the unit at the time and who may have additional information.

Finally, the investigation report concluded with a note stating, "*During the course of the investigation, coupled with inconsistent incarcerated person witness interviews and completed staff witness interviews, no subject(s) were identified for this investigation. Based upon video evidence, witness interviews, and lack of evidence to support the allegations, all investigative efforts were exhausted.*" *See* IR at 9 (emphasis added).

This is a surprisingly poor investigation in to serious allegations surrounding the death of a person in custody.

VI. FAILURE TO HOLD STAFF ACCOUNTABLE DUE TO THE FAILURE TO RETAIN VIDEO FOOTAGE

1. KVSP-[redacted], Not Sustained

In this case, *Armstrong* class member [redacted], alleged that officers failed to protect him as four other incarcerated people violently attacked him on the yard at KVSP. AVSS footage appears to confirm that, as alleged by Mr. [redacted] there was a delay in officers

taking visible action to attempt to stop the attack that, given the incident involved multiple people attacking him, could have resulted in life threatening injuries or death. Investigative failures make it difficult to fully confirm whether staff misconduct occurred in this case. Regardless, the evidence that is uncovered suggests that, at the very least, a questionable response to a serious attack occurred and additional training should have been provided but was not.

The investigator accurately reported the events of March 4, 2025, as captured by AVSS, beginning at approximately 11:01:24 hours when three incarcerated people began to hit, kick and jump on Mr. [redacted] who had been seated outside the incontinence laundry exchange. *See* Incident Report at 2; 602. Officer [redacted] who was approximately 40 feet away, was the closest officer to the incident. He did not begin to make a radio call until approximately 7 seconds after it started; at that same time, yard Officer [redacted] who was responding from approximately 150 yards away, was the first to make the radio call. *See* [redacted] Interview at 4:27 to 4:47. In the meantime, the three assailants, soon joined by a fourth, continued their assault, including picking up a walker and using it to strike Mr. [redacted] "During this time [redacted] was observed pacing back and forth approximately forty (40) feet from the incident. At approximately 11:01.43 hours, [redacted] reached for his duty belt and unholstered what appeared to be a grenade. [redacted] was observed fiddling with the object; however, never used it." See IR at 2-3. The attack continued for over 20 seconds, until approximately 11:01:47, when the assailants stopped and assumed a prone position as two other responding officers ran towards the incident with their MK9's unholstered and aimed. *See* AVSS at 11:01:25 to 11:02:00.

Extreme delays compromised the investigation in this case. The KVSP OOG received Mr. [redacted] 602 on March 13, 2025, less than 10 days after the March 4, 2025 incident, and the investigator was assigned shortly thereafter on April 1, 2025; however, the investigator waited until January 21, 2026, more than 10 months after the incident, to request video. *See* 602; Email dated January 21 re Footage Request. As a result, only limited AVSS footage of the incident was available, presumably what had already been preserved related to the attack itself. BWC footage was not available making it difficult to corroborate multiple statements made by the subject officer regarding what action (or lack thereof) he took. For example, during his investigation interview, Officer [redacted] stated that he did in fact give multiple orders to the assailants to stop the attack. *See* [redacted] Interview at 8:28 to 8:35. In answer to why he did not close the distance to within 20 feet of the attack in order to utilize his MK9, Officer [redacted] stated he "was waiting for responding staff so we could proceed together for [his] safety" reporting that other incarcerated people, not visible in the limited AVSS footage, were behind him. *Id.* at 9:55 to 10:20. Additional footage from other angles was essential to evaluate the risk of action vs. the risk of non-action in order to determine what action should have been taken. He further stated he pulled out his grenade, but did not have time to fully prep it before the attack ended. *Id.* at 10:42 to 10:53. The video evidence shows that Officer

[redacted] did not utilize force available to him to stop the violent, potentially life-threatening, attack on a disabled incarcerated person for more than 20 seconds.

Officer [redacted] the primary subject of the investigation, was not even identified until the first responding officer was interviewed on February 6, 2026, 11 months after the 602 was received. *See* IR at 3. No interview of the class member, Mr. [redacted] was conducted. Although he did not identify COs by name in his 602, an interview may have revealed the subject officer more quickly. Instead, the investigator wrote no interview was conducted because AVSS captured the entire incident. *Id.* at 4.

The investigation also fails to address the additional allegation that staff further compromised his safety by making him sign a compatibility chrono under "duress" that resulted in him being placed back in the same housing unit as the assailants who just attacked him. *See* 602. Immediately following the incident, Mr. [redacted] was documented in extreme pain, as evidenced by bruised ribs. *See* TTA RN Summary, March 4, 2025. Mr. [redacted] alleged that he refused subsequent medical attention, including an x-ray of his ribs, because he feared the assailants were waiting to attack him again if he sought medical treatment. *Id*. On March 14, 2025, Mr. [redacted] was seen by nursing staff, where he presented with similar pain levels. *See* 7362, Nursing Face-to-Face. The investigator should have gathered additional evidence about whether staff violated policy by returning everyone to the same housing section following the attack and whether Mr. [redacted] did sign the compatibility chrono under "duress."

Class members with serious disabilities in prison are especially vulnerable and must rely on staff to take action to protect them, if attacked. The investigation failures prevent us from having a clear picture of exactly what unfolded on the yard that day and following the incident when everyone was returned to the same housing unit. But, the limited video that was produced suggests that something more should have been done in response to the complaint filed in this case, even if simply to provide additional training to the subject officer.

VII. FAILURE TO HOLD STAFF ACCOUNTABLE DUE TO THE FAILURE TO COMPLY WITH THE STATUTE OF LIMITATIONS

Plaintiffs' counsel continue to encounter cases each quarter where discipline cannot be imposed because the statute of limitations has expired. As Defendants have acknowledged, the significant backlog of open, pending investigations means that many cases are reaching or are past the statute of limitations to impose discipline. The OIG confirmed this issue in their recent report. *See* May 2026 OIG Report at 33. According to the OIG, the AIU closed 5,379 cases in 2025 and finished the year with 13,393 open investigations. *Id*. "Of the 5,379 investigations the [AIU] closed in 2025, the deadline to impose discipline had expired before the investigations concluded in 265 investigations, or 5 percent." *Id*. However, "[o]f 13,393 investigations that were open at the end of the year, the deadline to impose discipline had already expired in 1,774 investigations, or 15

percent." *Id*. As Defendants have warned, the issue of cases being lost to the statute of limitations is worsening.

In the May report, Plaintiffs reported on multiple cases in which CDCR elevated a case for AIU review based on potential misconduct requiring adverse action, but then failed to complete those investigations within the statute of limitations. *See* May 2026 Report at 30 to 36. As the Court Expert noted in his most recent report on Defendants' accountability system, "it is especially unfortunate if adverse action is precluded in a case where CDCR staff has already found evidence of misconduct." Dkt. 3785 at 2. The problem continues. For example, in LAC-[redacted], a class member's allegation that officers deprived him access to a restroom while he was locked in a holding cage was initially routed for an institution-level review. *See* IR at 1. After that review and report was completed, the case was elevated for AIU investigation in January 2025, with 10 months to go before the statute of limitations expired. *Id.* However, the AIU investigation was not completed for another year, in January 2026, even though the local inquiry had already ascertained many of the relevant facts. *Id.* at 8. As a result, despite a sustained finding of misconduct, the CARU was only able to issue corrective action in the form of training to both officers. *See* [redacted] 402; [redacted] 402. CDCR must prioritize cases with likely adverse action for completion within the statute of limitations. Plaintiffs will follow up with Defendants to seek any documents or guidance that CDCR issues about AIU's prioritization of cases for completion within the statute of limitations

VIII. CONCLUSION

Plaintiffs will continue to work with Defendants and the Court Expert to attempt to bring Defendants into compliance with the Court's Orders and the Remedial Plans.