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PRIVILEGED AND CONFIDENTIAL

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VIA ELECTRONIC MAIL ONLY

[redacted]

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Re: *Armstrong v. Newsom*: Plaintiffs' February 2024 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, which is the ninth such report Plaintiffs have produced, 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").[1] As detailed below and in the accompanying Table A[2] (which is a separate Excel file), Plaintiffs found that Defendants continue to fail to comply with the *Armstrong* Court Orders, as affirmed in relevant part by the Ninth

[1] For RJD and SATF, the production included documents for cases closed between June 1-August 31, 2023. For KVSP and COR, the production included documents for cases closed between July 2-October 1, 2023. For LAC and CIW, the production included documents for cases closed between May 2-August 1, 2023.

[2] This report contains links to external documents and to internal sections within the report. External links are underlined; internal links are not underlined.

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).

I. DEFENDANTS CONTINUE TO FAIL TO CONDUCT COMPLETE AND UNBIASED INVESTIGATIONS AND TO IMPOSE APPROPRIATE AND CONSISTENT DISCIPLINE

More than three years after the RJD Order, Defendants have now fully implemented the court-ordered changes to their accountability system. Defendants handled nearly all of the cases that Plaintiffs reviewed for this report under the "new" system. These cases show, however, that Defendants' system still is not working to hold staff accountable when they violate policy and harm class members.[3]

The cases in this report reveal the same serious accountability failures that Plaintiffs have reported on for multiple quarters. Investigators in the Allegation Investigation Unit ("AIU") within the Office of Internal Affairs ("OIA") and Locally-Designated Investigators ("LDIs") at the institutions routinely fail to discover "what happened." They often do not gather all relevant evidence, including available video evidence critical for determining whether misconduct occurred. Investigators also frequently mischaracterize or omit relevant evidence from inquiry and investigation reports, especially when evidence supports the conclusion that staff violated policy. Supervisors, who are responsible for signing off on the reports, do not confirm the accuracy of evidence cited by the investigators. Consequently, investigation reports relied on by Hiring Authorities are incomplete and misleading, making it challenging or impossible for Hiring Authorities to determine whether misconduct occurred. Given the

[3] Throughout the report, Plaintiffs use the phrase "class member" to refer both to *Armstrong* class members (regardless of whether they have a DPP code) and *Coleman* class members at the EOP level of care or higher. The district court held that evidence regarding how Defendants treat and respond to staff complaints from EOP *Coleman* class members is "relevant ... to the extent that [it] is probative of the conditions that disabled inmates experience in CDCR's prisons." Five Prisons Order, Dkt. 3217, at 15; *see also id.* at 56-58. The Ninth Circuit affirmed this conclusion, holding that "[t]he district court was justified in viewing the non-class-member evidence as highly probative of the conditions faced by class members." *Armstrong v. Newsom*, 58 F.4th 1283, 1296 (9th Cir. 2023).

burden of proof in these cases, these investigative failures always favor staff and make accountability less likely.

Even when investigators provide Hiring Authorities with evidence that serious misconduct occurred, Hiring Authorities continue to fail to sustain allegations that staff violated policy. And, in the rare cases where Hiring Authorities do sustain allegations, they often fail to impose appropriate discipline, including by failing to identify applicable categories of the Employee Disciplinary Matrix and by misapplying the Matrix's mitigating and aggravating factors. As with the investigation problems, these decision-making failures always favor staff, and result in inadequate or no accountability. After all, there is no apparent consequence to CDCR for failing to discover or confirm staff misconduct. Plaintiffs remain seriously concerned that Hiring Authorities lack the time necessary to closely review the evidence and to make sound decisions in the hundreds of cases that come across their desks. And Defendants are doing very little, if anything, to monitor Hiring Authorities' decision making.

Plaintiffs have chosen to highlight in this report cases reflecting three areas of concern: (1) use-of-force cases; (2) cases where staff did not respond appropriately to medical or mental health emergencies; and (3) other cases that reflect serious problems with Defendants' culture.

In multiple use-of-force cases, Defendants failed to hold staff accountable when the evidence established that staff violated policies by using force too quickly, by escalating encounters, and by using immediate force when no imminent threat was present. *See* **Section I.A**. These cases include **LAC-**[redacted], in which an officer who has repeatedly violated the use-of-force policy without consequences again improperly used immediate force, this time against a class member requesting a cuffing accommodation for his mobility disability; **LAC-**[redacted], in which an officer refused to help a class member expressing safety concerns and then conducted a retaliatory cell search, which escalated into an improper immediate use of force; **KVSP-**[redacted], in which officers flipped a man backward out of his wheelchair to confiscate a pair of sunglasses; and **LAC-**[redacted], in which an officer used force against a class member in a hospital bed recovering from a seizure who reported he was unable to walk.

Defendants also failed to hold staff sufficiently accountable in a number of cases where evidence showed that staff ignored or responded inappropriately to class members' reports of suicidality and medical emergencies. *See* **Section I.B**. In **COR-**[redacted] **&**

COR-[redacted], the Hiring Authority only imposed a Letter of Reprimand (the lowest level of adverse action, which has no impact on salary or rank) against an officer who provided an actively suicidal class member with guidance for how to commit suicide. In **RJD-**[redacted], the Hiring Authority imposed only corrective action against a control booth officer who refused to follow another officer's request to open the class member's cell to provide him with access to his heart medication. And in **LAC-**[redacted], **KVSP-**[redacted], **COR-**[redacted], **COR-**[redacted], **RJD-**[redacted]**/RJD-**[redacted], and **RJD-**[redacted], Hiring Authorities failed to hold staff accountable or imposed inadequate discipline against staff who callously ignored or delayed in responding to reports of suicidal class members and class members experiencing medical emergencies. In each of these cases, staff demonstrated their disdain and lack of concern for the people they have sworn to protect and keep safe.[4]

Other cases reflect staff's general disregard toward incarcerated people and illustrate Defendants' failure to address such disrespect through the accountability process. *See* **Section I.C**. In **COR-**[redacted], no custody or medical staff were held responsible for leaving a person face down on the ground of a holding cell for more than five hours without helping him back into his wheelchair. In **CIW-**[redacted], the investigator failed to take steps to figure out what happened after two incarcerated people corroborated a complaint that a captain engaged in sexual misconduct. In **SATF-**[redacted], the Hiring Authority failed to hold a sergeant accountable for disrespect toward a person in a wheelchair during an interview about a disability-related staff complaint. In **RJD-**[redacted], an AIU Special Agent conducted an incomplete investigation after a class member was nearly stabbed to death by another incarcerated person only days after the class member had reported to staff that the incarcerated person had a weapon. In **KVSP-**[redacted], the Hiring Authority did not sustain any allegations against a sergeant who, in front of many other staff members, challenged a class member to engage in violence. And in **RJD-**[redacted], the Hiring Authorities did not impose any discipline on officers who endangered a class member by calling them names and publicly blaming them for recalling the dayroom.

[4] Plaintiffs have reported previously on similar misconduct, where officers failed to respond appropriately to class members expressing suicidality. *See* Plaintiffs' September 2, 2022 Report at 8-10; Email from [redacted], Jan. 12, 2024).

II. DEFENDANTS ARE FAILING TO ADDRESS CDCR'S PROBLEMATIC CULTURE

Many of the cases in this report reveal a culture within CDCR in which staff are routinely disrespectful and demonstrate lack of care towards incarcerated people. We further highlight two such cases here that demonstrate the significant work that CDCR must do to improve interactions between staff and incarcerated people. Such changes are necessary to ensure an environment where class members can rely on staff for disability assistance in compliance with the Court's orders and the Remedial Plans.

SATF-[redacted] illustrates the ongoing challenge and risk faced by class members attempting to access the staff complaint process to report disability discrimination. BWC video shows a sergeant reacting in an openly hostile manner towards a class member, denying him further access to the staff complaint process, after he attempted to report disability related misconduct. The sergeant's behavior does not pose the same risk of physical harm as in some other cases. But the misconduct that occurred—staff obstructing access to the court-ordered accountability system—has a profound chilling effect and undermines the entire system. It speaks volumes that this sergeant was comfortable acting in this manner in front of supervisees and other incarcerated people, with a camera on and at a prison currently under heightened *Armstrong* scrutiny.

The second case demonstrates how the failures of the accountability system contribute to CDCR's broken correctional culture and by failing to prevent officers from engaging in future misconduct. In **LAC-**[redacted], Officer [redacted] at LAC used improper immediate force but the Hiring Authority did not sustain any allegations. Plaintiffs have previously written about five other use-of-force violations by Officer [redacted] that the Hiring Authority failed to address. If Defendants' accountability system had identified and addressed Officer [redacted]' prior acts of misconduct, this additional violation could have been prevented. Instead, the repeated failures to hold Officer [redacted] accountable have sent a clear message to him and everyone working with him that CDCR condones his behavior, that he has done nothing wrong, and that future conduct that endangers, intimidates, and discriminates against people with disabilities is acceptable.

CDCR has made much of its effort to implement the "California Model," which CDCR describes as "a human-centered culture of healing, positive staff-inmate

communication, and improved living and working conditions." *See, e.g.*, The California Model, Frequently Asked Questions, What Is the California Model? (last visited Feb. 8, 2024). The cases described in this Report show that CDCR has significant work to do in reaching those goals. In fact, the behavior of staff in these cases runs directly contrary to the California Model. CDCR cannot implement the California Model unless it takes complaints against staff seriously, conducts investigations for the purpose of discovering what happened, and sustains misconduct and imposes appropriate discipline when it discovers problematic behavior.

III. DEFENDANTS ARE NOT COMPLYING WITH PROCEDURAL PROVISIONS OF THE REMEDIAL PLANS

Beyond the substantive problems with investigations and discipline, a number of procedural issues continue to hamper the system. First, there are more than 1,700 completed AIU investigations sitting on the Hiring Authorities' desks awaiting disposition. *See* **Section I.F**. These delays are unacceptable and show that the Hiring Authorities cannot keep up with the workload under the new system.

Second, AIU investigators continue to fail to complete investigations by the deadlines set forth in the Remedial Plans—120 days for investigations conducted by sergeants or lieutenants and 180 days for investigations conducted by Special Agents. For July, August, and September 2023, the three most-recent months for which we have complete data, AIU investigators did not meet the deadlines in 25% of cases. *See* **Section I.E**.

Third, the CST continues to fail to route allegations consistent with the requirements in the Remedial Plan. Plaintiffs reviewed 97 "routine" grievances produced by Defendants. Twenty-three percent of the grievances contained allegations of staff misconduct and thus should not have been classified as routine. In addition, the CST continues to make errors when deciding whether to route staff complaints to the AIU or to LDIs. *See* **Section II**.

The OIG recently published a number of troubling reports that confirm the problems Plaintiffs have identified. The OIG found that (1) Defendants improperly reclassified nearly 600 staff complaints as routine grievances because Defendants lacked the resources to investigate them; (2) the CST made substantial errors processing and routing complaints; and (3) the inquiries conducted by LDIs were of very poor quality.

IV. REMEDIAL CHANGES ARE NECESSARY TO ENSURE COMPLIANCE

Defendants remain substantially out of compliance with the Court's orders and the Remedial Plans. Moreover, Defendants do not appear to be making meaningful changes to correct obvious and long-standing problems. The cases reported on in this and multiple prior reports make clear that the revised system, as it currently operates, still fails to hold staff accountable for disability-related misconduct. Accordingly, unless Defendants quickly commit to making substantial changes, Plaintiffs will have no choice but to return to court to enforce the orders and Remedial Plans to protect the rights of class members.

In Plaintiffs' last report, Plaintiffs listed a number of needed changes. *See* November 2023 Report at 7-8.[5] Defendants have not yet responded to any of these proposals. Plaintiffs incorporate those proposals here and await Defendants' response.

In addition, Defendants must retain all video for a minimum of six months. Far too often, video relevant to investigations is unavailable for review because investigators delay too long in requesting the video. Increasing the standard retention time would, in almost all cases, eliminate this problem.

Defendants must also begin producing files for all investigations conducted by California Correctional Health Care Services ("CCHCS") in which the complainant or victim was an *Armstrong* class member or (for the Five Prisons) a *Coleman* class member at the EOP level of care or higher. Per the Remedial Plans, Defendants must produce all such investigations. *See* Five Prisons Remedial Plan at 14; RJD Remedial Plan at 14.

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[5] Throughout this report, all citations to page numbers of documents refer to the page of the PDF, not to any internal pagination in the document.

We look forward to receiving Defendants' response to this Report by no later than March 15, 2024.

Sincerely,

ROSEN BIEN
GALVAN & GRUNFELD LLP

/s/ [redacted]

By: [redacted]
Senior Counsel

[redacted]
cc: [redacted]

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I. DEFENDANTS CONDUCTED BIASED AND INCOMPLETE INVESTIGATIONS AND IMPOSED INAPPROPRIATE AND INCONSISTENT DISCIPLINE

The Remedial Plans and Court's orders require that Defendants' investigators conduct "comprehensive and unbiased investigations and ensure all relevant evidence is gathered and reviewed" and that Hiring Authorities impose appropriate and consistent discipline. RJD Remedial Plan, § II.B; Five Prisons Remedial Plan, § II.B; *see also* Dkt. 3060, ¶ 5.c; Dkt. 3218, ¶ 5.c.

To evaluate Defendants' compliance, Plaintiffs reviewed all of the cases produced by Defendants. Plaintiffs then selected a subset of those cases for closer review.[6] The complete findings from Plaintiffs' review are contained in Table A. Note that the findings for each prison appear in separate tabs of the Excel file.

As mentioned in the Introduction, Plaintiffs have organized the cases in this report into three categories: (1) cases involving improper uses of force; (2) cases where staff did not respond appropriately to medical or mental health emergencies; and (3) other cases that reflect serious problems with CDCR's culture. The cases within these categories include the same types of accountability problems on which Plaintiffs have previously reported, including incomplete and biased investigations, failures to sustain allegations supported by the evidence, and failures to impose adequate discipline.

A. Failures to Hold Officers Accountable for Improper Uses of Force

1. LAC-[redacted] – AIU, Not Sustained

In this case, Officer [redacted] and Officer [redacted] improperly used immediate force to remove a class member with mobility disabilities from his cell. The officers then escalated the situation by refusing the class member's repeated requests for the use of waist restraints, rather than handcuffs behind his back, so that the class member could use his cane while walking with restraints. The investigator wrote a biased, incomplete

[6] Plaintiffs selected the cases using a variety of criteria, including, but not limited to, whether: CDCR referred the case to the OIA for investigation or direct adverse action; the AIU investigated the case; the AIMS conducted an inquiry; the case involved an allegation related to use of force or disability; the Hiring Authority sustained an allegation; and the case included video evidence. These criteria are intended to identify cases with the most serious and credible allegations of misconduct, which we then review to determine whether Defendants are holding staff accountable when the evidence shows misconduct occurred. Although Defendants have mischaracterized this approach as "cherry-picking" in the past, it is necessary to focus on cases with serious and credible allegations of misconduct to evaluate whether the accountability system is working.

report and the Hiring Authority failed to hold officers accountable for an improper immediate use of force.

As discussed in more detail below, Plaintiffs have now reported on six separate uses of force by Officer [redacted] that violated CDCR's use-of-force policy. The Hiring Authority has not issued him so much as corrective action for any of the improper uses of force. Moreover, none of the cases even acknowledge the existence of the other cases. Defendants' repeated failures to discipline Officer [redacted], despite video showing clear policy violations, demonstrate that Defendants' accountability system is not working.

Class member and staff misconduct declarant [redacted] has a mobility disability and uses a cane. Video footage shows Officer [redacted] and Officer [redacted] at Mr. [redacted]'s cell, with a pink "ADA" sign visible next to the cell. When the cell door opens, Officer [redacted] orders Mr. [redacted] to leave the cell, while Mr. [redacted] stands in the cell with his arms crossed and his mobility disability vest in his hand. Without waiting for Mr. [redacted] to comply, Officer [redacted] grabs Mr. [redacted] by the right wrist and pulls him out of the cell. Mr. [redacted] protests, "I'm ADA, I'm ADA, I'm ADA," as Officer [redacted] pulls Mr. [redacted] by his arm. *See* BWC at 11:52:10. The officers turn Mr. [redacted] to face the cell door and cuff him behind his back. Mr. [redacted] says, "What are you doing? You can't cuff me behind my back." Officer [redacted] responds, "It's just for a second" and tells Mr. [redacted] that the officers will get waist restraints. *Id.* at 11:52:30. Mr. [redacted] states, "You can't cuff me behind my back," and Officer [redacted] replies, "I know that." *Id.* at 11:52:45. Officer [redacted] indicates that they will just have Mr. [redacted] cuffed behind his back while they escort him across the yard. *Id.* at 11:53:10. The officers and Mr. [redacted] argue for another minute, with Mr. [redacted] becoming increasingly agitated, until other officers arrive with and apply waist restraints. *Id.* at 11:53:44.

The immediate use of force against Mr. [redacted]—pulling him from the cell—was an improper immediate use of force. Officers can only use immediate force if the incarcerated person presents an imminent threat to safety and security. *See* DOM § 51020.4. Furthermore, officers cannot use force to obtain compliance with a lawful order, such as Officer [redacted]'s order to leave the cell, unless the person also presents an imminent threat. *Id.* Here, Mr. [redacted] did not present an imminent threat and so Officer [redacted] could not use immediate force. Officer [redacted] wrote that he immediately grabbed Mr. [redacted] because he did "not know[] Quarles [sic] intentions" because the officers had earlier searched Mr. [redacted]'s cell and allegedly found a weapon. *See* Incident Report at 27. Officer [redacted]'s justification, if accepted, would mean that officers could broadly justify the immediate use of force against almost any incarcerated person whom had previously been found to have a weapon. If the

officers truly believed Mr. [redacted] still presented a threat to safety and security, they should have applied waist restraints prior to opening the door.[7]

Officer [redacted] claimed that he continued to use force because Mr. [redacted] began to "actively physically resist" after being grabbed. *See* Incident Report at 27. The video shows Mr. [redacted] bracing himself against the wall with his left hand after Officer [redacted] grabs his right arm. *See* BWC at 11:52:05. It appears that Mr. [redacted] needed to brace himself against his cell wall when Officer [redacted] suddenly grabbed his right arm, given that Mr. [redacted] has a mobility disability and uses a cane to ambulate. Mr. [redacted] was at that time repeatedly stating that he is "ADA." Even if Mr. [redacted] did resist—and there is no clear indication he did—the improper immediate use of force was initiated when Officer [redacted] grabbed Mr. [redacted] after opening the cell, and not moments later during any purported resistance. As is frequently the case, the fact that the officers grabbed the class member and initiated an improper immediate use of force escalated the situation.

Further, the footage clearly shows that after officers removed Mr. [redacted] from his cell, they failed to accommodate his disability despite multiple requests that the officers apply waist restraints so he could walk with his cane. Even though the video shows a clear use-of-force violation and failure to accommodate Mr. [redacted]'s disability, the Hiring Authority did not sustain any allegation against Officer [redacted].

The incomplete and biased investigation report likely made it more difficult for the Hiring Authority to properly impose discipline. For example, the investigator claimed that Mr. [redacted], based on SOMS, "did not have any special handcuffing requirements." *See* Investigation Report at 3. This claim ignores that both Officer [redacted] and Officer [redacted] repeatedly indicated on video that they knew Mr. [redacted] required waist restraints but nevertheless continued to cuff him behind his back. *See* BWC at 11:52:35; 11:52:45; 11:52:49. Moreover, any class member who uses a cane, like Mr. [redacted], should be cuffed in waist restraints so that they can use their assistive device while restrained. The investigator and incident reports also all claimed, without qualification, that Mr. [redacted] had jammed the cell door prior to this incident occurring. *See* Investigation Report at 3. Not only is that fact irrelevant, but it also overlooks that Officer [redacted] repeatedly states on video that the officers may have broken the door. *See* BWC (linked above) at 11:51:34; 11:51:39; 11:51:45. The inclusion of the negative information about Mr. [redacted] and omission of the information that contradicted the officers' accounts biases any reader against Mr. [redacted]. Finally, the investigator uncritically accepted Officer [redacted]'s characterization of Mr. [redacted] placing his hand on the cell wall as "resisting," *see* Investigation Report at 3, when a reasonable

[7] Officer [redacted] and Officer [redacted] had placed Mr. [redacted] back in the cell after the earlier search, despite an order from Lieutenant [redacted] to take Mr. [redacted] to the Facility D gymnasium. *See* Incident Report at 27.

explanation is that Mr. [redacted] was bracing himself due to his mobility disability. The investigator instead used language designed to cast Mr. [redacted] as the instigator of a situation that was actually made more dangerous by the officers' actions.

The 2023 Q3 production for LAC also included another case, LAC-[redacted], in which Officer [redacted] resorted to using force far too quickly. In this case, Officer [redacted] is shown on video slamming an EOP class member to the ground when the person braced his feet to attempt to stop walking during an escort. Officer [redacted]'s use of force may have complied with policy. *See* BWC at 8:05:45. But Officer [redacted] had a host of other options available to him that he did not employ. In particular, he could have stopped the escort to determine why the individual was not continuing to walk. Alternatively, since there were approximately ten officers in close proximity accompanying the escort, Officer [redacted] could have worked with those officers to control the class member in a less violent and dangerous manner.

Plaintiffs have previously reported on five other cases in which Officer [redacted] used unnecessary or excessive force, escalated a situation resulting in force, or failed to accommodate a person's disabilities. In LAC-[redacted], Officer [redacted] unnecessarily threw a mentally ill and unresponsive class member off of the top bunk of his cell onto the concrete floor. *See* Feb. 2023 Report at 8-9. In LAC-[redacted], Officer [redacted] and a sergeant used excessive force against a class member with serious mental illness when they slammed him headfirst into the ground during an escort. *Id.* at 27. In LAC-[redacted], Officer [redacted] engaged in two use-of-force violations. First, Officer [redacted] initiated an improper immediate use of force against a class member who was refusing to exit a holding cage. Second, Officer [redacted] then unnecessarily and punitively pepper-sprayed the class member, who was locked in his cell, after the class member allegedly spit on officers. *See* May 2023 Report at 10-12. And in LAC-[redacted], Officer [redacted] and another officer initiated an improper immediate use of force against a class member who was "holding" the tray slot of his cell door, resulting in officers pepper-spraying the class member. *Id.* at 12-13.

The Hiring Authority did not impose corrective or adverse action against Officer [redacted] in any of these cases, which occurred between December 2021 and October 2022, and all of which are captured on video. In none of these cases has anyone at CDCR raised any apparent concern about Officer [redacted]'s quickness to resort to force against disabled class members, including mentally-ill class members, or his failure to deescalate, as required by policy. Not only have these violations not been sustained but there is no apparent recognition that Officer [redacted] could benefit from additional training nor any indication that staff are aware this is a repeated problem. These cases represent a colossal failure of the system and the department to address the "the root cause" of violations, which is the failure of CDCR to identify problematic behavior and to take action in response. *See* Dkt. 3217 at 69. Officer [redacted], who the state paid

$231,897.12 in wages and benefits in 2022,[8] should not be working around incarcerated people with disabilities.

Moreover, all of Officer [redacted]'s improper uses of force occurred in the presence of other officers. CDCR's failure to hold him accountable encourages these officers to engage in similar violations by communicating that they can violate CDCR's use-of-force policies without facing any consequences.

2. LAC-[redacted] – AIU, Not Sustained

In this case, [redacted] refused to return to his cell because he was "having a [sic] incompatibility situation," notifying staff that he needed to move out of his cell to prevent a conflict. *See* 602 at 4. In response, Officer [redacted] conducted an improper cell search to punish Mr. [redacted] for refusing to return to his cell. When Mr. [redacted] still peacefully refused to return to his cell, Officer [redacted] escalated the situation, resulting in an improper immediate use of force. Then, during the investigation, Officer [redacted] likely lied about his justification for conducting the search. Notwithstanding this evidence, the Hiring Authority did not sustain any allegations. Moreover, the investigation report was incomplete and biased, omitting and mischaracterizing essential evidence.

As shown on video, Officer [redacted] approaches Mr. [redacted] in the dayroom and says "I'm letting you know right now, that B.S. you're trying to play [with the bed move], if you keep on doing it I'm going to move you nowhere." *See* BWC 1 at 18:46:38. Officer [redacted] then asks Mr. [redacted] if he is refusing to return to his cell. Mr. [redacted] indicates he is. Officer [redacted] then immediately walks to Mr. [redacted]'s cell on the upper tier and begins to search it.

Upon arriving to the cell, Officer [redacted] says to Mr. [redacted]'s cellmate, "nothing against you." *See* BWC 1 (linked above) at 18:47:28; 18:47:33. Officer [redacted] then proceeds to search the cell while Officer [redacted] stands outside the cell. A third officer approaches and the officers have the following conversation:

Officer: What do you guys have going on here?

Officer [redacted]: The guy at the first table doesn't want to take it in.

Officer: What's his deal?

Officer [redacted]: He doesn't want to take it in.

[8] A search of Transparent California for "[redacted]" produces only one result for a Correctional Officer who worked for California in 2022 and indicates that officer received $231,897.12 in wages and benefits.

Officer: He doesn't want to take it in? He's refusing housing?

Officer [redacted]: He just doesn't want to come to his assigned housing. He lives in here. Why, I don't know.

Officer: Oh, so you're just doing a good old fashioned cell search.

Officer [redacted]: Yeah.

Officer: Oh ok.

Officer [redacted]: It's random.

See BWC 1 (linked above) at 18:49:53; BWC 2 at 18:49:53.

After Officer [redacted] finishes the search, he orders everyone in the housing unit to return to their cells. Mr. [redacted] does not return to his cell and continues sitting peacefully at a table in the dayroom. Officer [redacted] and Officer [redacted] then have a short conversation at the podium, which shows they were already contemplating using force against Mr. [redacted]:

Officer [redacted]: So what, what are you going to do now?

Officer [redacted]: You ready to belts on? You better fucking .... Don't spray because you might spray me.

Officer [redacted]: I'm not gonna spray.

Officer [redacted]: I'm gonna handcuff him right now.

.....

Officer [redacted]: What's his issue? Why doesn't he want to take it in?

Officer [redacted]: Because he wants me to do a bed move right now.

Officer [redacted]: OK. He wants a move?

Officer [redacted]: Yeah, he wants to move to 2 block.

See BWC 1 (linked above) at 18:52:40.

Officer [redacted] then makes a phone call from the podium to the control booth. He says, "Keep 222 [Mr. [redacted]'s cell] open. Yeah, I'm going to handcuff this man and put him in there. Just get ready in case shit hits the ground…. I'm gonna handcuff him.... Once shit hits the ground, [redacted] is gonna help me." The control booth officer asks if he should call for additional officers. Officer [redacted] declines, saying he'll just handle it with the "regular protocol." *See* BWC 1 (linked above) at 18:53:25; BWC 3 at 18:53:30.

Officer [redacted] and Officer [redacted] then walk over to Mr. [redacted], who is still sitting alone at a dayroom table. The dayroom is mostly empty by this time. Officer [redacted] again tells Mr. [redacted] that he needs to return to his cell. Mr. [redacted] remains seated. Officer [redacted] tells him that he is going to handcuff him. Mr. [redacted] does not move to submit to handcuffs. Officer [redacted] then pulls Mr. [redacted]'s left arm. Mr. [redacted] tenses his arm, making it impossible for Officer [redacted] to apply the handcuffs. Officer [redacted] lets go. A moment later, he grabs Mr. [redacted]'s left arm again and pulls with greater force to move it behind Mr. [redacted]'s back. Officer [redacted] then tackles Mr. [redacted] to the ground, face first, and falls with his weight on top of him. Officer [redacted] and Officer [redacted] gain control of Mr. [redacted]'s arms and handcuff him. *See* BWC 1 (linked above) at 18:54:20; AVSS at 18:54:20.

The video shows that Officer [redacted] conducted a punitive and retaliatory cell search and improperly used improper immediate force against Mr. [redacted].

With respect to the search, CDCR policy prohibits officers from using cell searches "as a punitive measure []or to harass an inmate." *See* 15 C.C.R. § 3287(a)(2). Officer [redacted]'s own statements establish that he searched Mr. [redacted]'s cell to retaliate against and harass Mr. [redacted] because Mr. [redacted] refused to return to his assigned housing and was frustrating Officer [redacted] by insisting that he receive a cell move immediately. Mr. [redacted]'s behavior may well have violated CDCR's rules. But the appropriate response to those rule violations was to issue him an RVR, not to conduct a retaliatory cell search.

Officer [redacted] also violated CDCR's policy regarding immediate use of force. Policy provides that staff may only initiate an immediate use of force if the incarcerated person presents an imminent threat to safety and security. *See* DOM § 51020.4. Controlled force must be used in all other circumstances. *Id.* Moreover, policy specifies that "if it is necessary to use force solely to gain compliance with a lawful order, controlled force shall be used." *Id.* Lastly, CDCR policy states that "the unresisted application of authorized restraint equipment is not a use of force," which means that the resisted application of handcuffs is a use of force. *See* DOM § 51020.5. Here, since Mr. [redacted] made clear that he was not going to submit to handcuffs, as soon as Officer [redacted] touched him, it constituted a use of force.

Though Mr. [redacted] was refusing to comply with a lawful order to return to his cell, he did not present an imminent threat. He was sitting peacefully and alone at a table in a mostly unoccupied dayroom. There was no justification to use immediate force against him. If force was necessary to move him back into his assigned cell, then the only option was to use controlled force, which has multiple safeguards in place to attempt to avoid force and injury to staff and incarcerated people. All of the force Officer

[redacted] used against Mr. [redacted], from grabbing of his arm to throwing him on the ground, therefore violated policy.

Moreover, the use of force violated policy because Officer [redacted] escalated the situation and did not take steps, as required by policy, to deescalate. *See* DOM § 51020.5 ("Employees shall attempt to use verbal commands and verbal deescalation, followed by a reasonable amount of time for compliance before resorting to use of force."). To begin with, Officer [redacted] conducted the retaliatory search, which escalated tension between him and Mr. [redacted]. Then, the conversation at the podium between Officer [redacted] and Officer [redacted] shows that they approached the situation hoping to use force, rather than trying to avoid it. In addition, as shown on video, Officer [redacted] did nothing to try to deescalate the situation—such as attempting to discuss the situation with Mr. [redacted], calling a supervisor, warning him about a potential RVR, bringing additional officers to the scene, or consulting with mental health—and escalated the situation by quickly threatening Mr. [redacted] ("This is the last time.").

Despite these clear policy violations shown on video, the Hiring Authority did not sustain any allegations.

The responsibility for holding staff accountable falls on the Hiring Authority, who must determine whether an investigation is complete and unbiased and then make decisions based on the evidence. *See* Five Prisons Remedial Plan at 7-8. Here, however, the investigator did the Hiring Authority no favors. The investigation was so incomplete and biased that it likely made it difficult for the Hiring Authority to evaluate the evidence.

First, the investigator omitted from the report important statements made by officers. The investigation report contains none of the dialogue among the officers at Mr. [redacted]'s cell that confirms the search was punitive and conducted in retaliation for Mr. [redacted]'s refusal to return to his cell. The investigator's summary of the cell search is that "no property was observed to be damage(sic) or destroyed." *See* Investigation Report at 3. Similarly, the report did not include any of the dialogue between Officer [redacted] and Officer [redacted] at the podium before the use of force, which show that the use of force was premeditated and therefore further violated policy.

Second, the investigator's description of the use of force was inaccurate, biased, and incomplete:

> [redacted] orders [redacted] to return to his cell to which [redacted] responds "shut the hell up." [redacted] tells [redacted] he is going to place him ([redacted]) in handcuffs.

> [redacted] grabs [redacted] [sic] left wrist, when [redacted] begins to resist by not allowing [redacted] to place him in handcuffs. [redacted] is taken to the ground and placed in handcuffs.

See Investigation Report at 3. This description ignores that Mr. [redacted] had made clear that he intended to resist the application of handcuffs, meaning that Officer [redacted]'s actions escalated the encounter and constituted a use of force as soon as he touched Mr. [redacted]. The investigator omits any discussion that would have made clear that no imminent threat existed to justify the force (*e.g.*, that Mr. [redacted] was sitting quietly at the table or that the dayroom was mostly empty). The investigator states that Officer [redacted] "grab[bed] [redacted] [sic] left wrist," when he actually grabbed his wrist and then yanked Mr. [redacted]'s arm behind his back with significant force. The investigator also omitted any information to place the use of force in context, such as information regarding Mr. [redacted]'s reason for refusing to return to his cell, the punitive and retaliatory cell search, the officers' conversation at the podium contemplating the force, and Officer [redacted]'s phone call to the control booth.[9] Lastly, the investigator relied heavily on the IERC's conclusion that the force was proper, despite the IERC reaching an incorrect conclusion.

Third, the investigator included numerous statements from Mr. [redacted] that are irrelevant to his allegation, but that paint Mr. [redacted] in a bad light. *See* Investigation Report at 3 (noting that Mr. [redacted] said to Officer [redacted] "[F]uck you" and "Shut the hell up"). The inclusion of these statements, which are not material to whether the cell search was retaliatory or the force was proper, reflects bias against Mr. [redacted].

This case is also problematic because Officer [redacted] was likely dishonest during the AIU investigation, but neither the Hiring Authority nor the investigator pursued this issue. Officer [redacted] claimed in the interview with the investigator that the reason he searched the cell was "to ensure no contraband or unusual activity was occurring." *See* Investigation Report at 4. Based on the video, which shows Officer [redacted] stating that he was searching the cell because Mr. [redacted] was refusing to return to his cell, that justification is false. The investigator should have asked about the inconsistency between Officer [redacted]

[9] The investigator also failed to note that Officer [redacted], in his incident report, did not, as required by policy, identify the deescalation strategies he used and the circumstances leading to the use of force. *See* Incident Report at 58; DOM 51020.17; DOM 51020.17.1.

[redacted]'s statements in the interview and the video, and the Hiring Authority likely should have found that Officer [redacted] was dishonest to the investigator.[10]

Plaintiffs have previously reported on a retaliatory and harassing cell search by officers at LAC that led to a use of force. *See* May 2023 Report at 27-31; November 2023 Report at 11-20. The lack of accountability in these cases suggests that Defendants do not consider retaliation to be a serious form of misconduct. Further, staff behavior here is especially problematic when viewed in the context of what Mr. [redacted] was asking for—the right to be housed safely and to prevent any harm from an impending altercation with another incarcerated person. These cases reflect a broken correctional culture, in which Defendants permit officers to disregard the legitimate safety and disability concerns raised by class members and to react aggressively and punitively when people assert their rights and attempt to obtain help.

3. KVSP-[redacted] – AIU, Not Sustained

In this case, a sergeant and an officer used dangerous, unnecessary, and excessive force against *Armstrong* class member [redacted]. Staff put him in a chokehold and then flipped him over backward in his wheelchair, all because he had a pair of sunglasses in his pocket in an area of the prison where he was purportedly not supposed to. Despite the clear use-of-force violations, the Hiring Authority did not sustain any allegations. The investigation report was also biased and incomplete.

Mr. [redacted] reported that Officer [redacted] had said he would take Mr. [redacted]'s sunglasses because he was not permitted to possess them in the program area. *See* 602 at 9-10. BWC shows Mr. [redacted] sitting in his wheelchair in the program hallway. Officer [redacted] reaches aggressively into Mr. [redacted]'s shirt pocket to attempt to take Mr. [redacted]'s sunglasses. *See* BWC 1; BWC 2; AVSS. Mr. [redacted] jerks backward. Sergeant [redacted] then says, "Put him in cuffs. He's done. He's gonna have to be locked up." Officer [redacted] reaches out to grab Mr. [redacted]'s arm to apply restraints. Mr. [redacted] pulls away. Sergeant [redacted] then wraps his arm around Mr. [redacted]'s neck and pulls him over backwards in his wheelchair, slamming Mr. [redacted] to the ground. After the incident, Mr. [redacted] had a reddened area on his arm and reported back pain. *See* 7219 at 34.

Officer [redacted] and Sergeant [redacted]'s use of force was an egregious violation of CDCR's force policies. Per policy, officers (1) must only use immediate force when an incarcerated person poses an imminent threat to safety and security; (2) must attempt

[10] The AIU investigation report also includes the allegation that Officer [redacted] made misleading statements in an RVR. *See* Investigation Report at 1. However, it does not appear that an RVR was produced to Plaintiffs' counsel.

to avoid force by attempting to deescalate; and (3) must only use a reasonable amount of force to accomplish their lawful objective. *See* DOM § 51020.5; DOM § 51020.4. Officer [redacted] and Sergeant [redacted] violated all three of these policies.

First, the possession of sunglasses does not, from any reasonable perspective, represent an imminent threat to safety and security. To use immediate force to confiscate sunglasses from a class member,[11] who is sitting peacefully in his wheelchair but is unwilling to give them up voluntarily, is a gross violation of the immediate/controlled use-of-force policies.

Second, Officer [redacted] could have attempted to deescalate the situation by threatening to issue an RVR. As a supervisor, Sergeant [redacted] should have done more to defuse the situation. Instead, Officer [redacted] tried to grab the sunglasses from Mr. [redacted]'s pocket. And then the officers escalated the situation by attempting to restrain Mr. [redacted] (which is a use of force because it was resisted).

Third, the amount of force the officers used was excessive. There was no need to flip Mr. [redacted] backwards from his wheelchair in order to obtain the sunglasses and restrain him.[12]

These violations are all shown on video. Nevertheless, the Hiring Authority did not sustain any allegations. *See* Memo at 1. It is particularly concerning that the Hiring Authority did not hold Sergeant [redacted] accountable here. As a supervisor, he should be modeling compliance with the force policy.

The investigation report was also profoundly incomplete and biased. Most importantly, the investigator failed to accurately describe the video of the incident. The entire description of the video is as follows:

> [The AVSS] depicts, [redacted] being counseled by [redacted] and becomes aggressive when [redacted] removed his sunglasses. [redacted] and [redacted] took Woods to the ground and place him in handcuffs. BWC footage for Sergeant [redacted] depicts, [sic] [redacted] become [sic] aggressive with [redacted] when [redacted] takes his sunglasses.

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[11] Sunglasses are a reasonable accommodation for certain vision disabilities, including photophobia. *See* Pls.' Letter re [redacted], Aug. 25, 2023. Plaintiffs previously have written to Defendants about staff's failure at KVSP to permit people to possess sunglasses in the program area when the glasses are an accommodation. *Id.*

[12] Sergeant [redacted] may also have violated CDCR's policy prohibiting chokeholds when he wrapped his arms around Mr. [redacted]'s neck as he threw him to the ground. *See* DOM § 51020.5.

See Investigation Report at 3. The investigator makes no reference to Officer [redacted]'s aggressive attempt to grab Mr. [redacted]'s sunglasses from inside of Mr. [redacted]'s shirt pocket. In stating only that the officers "took [redacted] to the ground," the investigator fails to describe the excessive and dangerous force used by the officers, including putting Mr. [redacted] in a choke-hold and flipping him backward out of his wheelchair. The investigator does not mention that no imminent threat existed at the time the officers tried to restrain Mr. [redacted], but rather insinuates that Mr. [redacted] presented an imminent threat. And the investigator does not identify that the officers escalated, rather than deescalated the situation, all because Mr. [redacted] possessed a pair of sunglasses.

The investigation and report are biased and incomplete in other respects. The investigator included interview testimony from Sergeant [redacted] that "[redacted] raised his right arm and his hand in a fist to strike [redacted]," but did not question Sergeant [redacted] about the fact or otherwise note that the video shows no such thing. *See* Investigation Report at 6. The investigator included interview testimony from Sergeant [redacted] that Mr. [redacted], after the incident, stated "he was going to stab [redacted] if he did not stop messing with him," when that comment, which paints Mr. [redacted] in a bad light, has no bearing on whether the use of force complied with policy. *See* Investigation Report at 6. Additionally, Mr. [redacted] reported in his interview that Officer [redacted] retaliated against him the next day by removing all his personal property, but the investigator did not investigate this claim. *See* Investigation Report at 4. These problems with the investigation report made it more difficult for the Hiring Authority to reach the right result.

Mr. [redacted] may or may not have violated a technical local operating procedure by having sunglasses in the program area. But there is no conceivable justification for flipping him over out of his wheelchair to attempt to fix that issue.

4. LAC-[redacted] – AIU, Not Sustained

In this case, Officer [redacted] failed to accommodate [redacted] when he reported he could not walk following a seizure. Instead, Officer [redacted] escalated the encounter, resulting in a potentially unnecessary use of force that caused injuries. Nevertheless, the Hiring Authority did not find any misconduct. And the investigation report was incomplete and biased.

Video shows Mr. [redacted] sitting in waist restraints on a hospital bed in the TTA after being evaluated following a seizure. *See* BWC at 22:17:55; First Medical Responder Note, June 20, 2022. Officer [redacted] stands near the bed and repeatedly orders Mr. [redacted] to stand up. Mr. [redacted] says at least five times that he cannot stand. When Officer [redacted] tells Mr. [redacted] to look away, Mr. [redacted] says "I have to use the restroom. I'm not refusing. I can't stand up." When Officer [redacted] asks him why he cannot stand up, Mr. [redacted] yells "because my fucking legs feel like jello." According to his incident report, Officer [redacted] then places his left hand on Mr. [redacted]'s right bicep to assist him to

his feet (this action cannot be seen on camera). *See* Incident Report at 55. The video then shows that Mr. [redacted] either begins to stand up or to sit up straighter. In response, Officer [redacted] reaches his right hand into the view of the camera and shoves Mr. [redacted] backwards onto the gurney. *See* BWC (linked above) at 22:18:40. The 7219 showed that, as a result of the force, Mr. [redacted] had swelling in the back of his head, and possibly scratches on his neck, upper right arm, and torso. *See* 7219 at 62.

Policy requires that officers attempt to deescalate situations to avoid using force. *See* DOM 51020.5. Here, Officer [redacted], by failing to simply accommodate Mr. [redacted], escalated a routine escort by insisting Mr. [redacted] walk when he said he was unable to, resulting in a use of force when none was likely needed. Mr. [redacted] posed no threat as he was sitting on the bed stating his legs could not support him and requesting to use the bathroom. To resolve these issues, Officer [redacted] could have offered Mr. [redacted] a wheelchair for the escort and allowed him to use the bathroom. Instead, by repeatedly and aggressively ordering Mr. [redacted] to stand, then grabbing Mr. [redacted] to lift him to his feet, Officer [redacted] escalated the situation, making force more likely. Given this failure to provide simple accommodations, the Hiring Authority should have, at minimum, sustained an allegation for failure to observe and perform within the scope of training (D26, **1**2345) and possibly also for unnecessary force (L1, 1**2**3 (unnecessary force) or L2, 4**5**6789 (unnecessary force causing injury)).

Additionally, the investigator's report was biased and incomplete. The investigator omitted that Mr. [redacted] reported he could not stand, a fact critical to understanding whether Officer [redacted] complied with policies requiring deescalation and provision of accommodations. The investigator also failed to note that Officer [redacted], in his incident report, did not, as required by policy, identify the deescalation strategies he used and the circumstances leading to the use of force. *See* DOM 51020.17; DOM 51020.17.1.

B. Failures to Hold Staff Accountable for When They Do Not Respond Appropriately to Reports of Suicidality and Medical Emergencies

1. COR-[redacted] & COR-[redacted] – AIU, Sustained (discourteous comments); AIU, Sustained (refused to accommodate shoe request); Adverse – (Letter of Reprimand)

In these cases, Officer [redacted] was disrespectful, discourteous, and antagonistic to [redacted], who was actively suicidal and in an MHCB at the time. Officer [redacted] repeatedly threatened to pepper spray Mr. [redacted], provided instructions to Mr. [redacted] for how to commit suicide, told Mr. [redacted] he was a "baby" and "scared of going to the yard," referred to himself as "a killer," and suggested that Mr. [redacted] "look for [him]" when he is released from prison. Shortly thereafter, Mr. [redacted] engaged in self-harm. Then, when Mr. [redacted] requested shoes for an escort, Officer [redacted] cursed at Mr. [redacted] repeatedly, refused to help him, and

inaccurately asserted that Mr. [redacted] refused the escort. The Hiring Authority did sustain the allegations that Officer [redacted] made inappropriate statements encouraging Mr. [redacted] to commit suicide and cursed at Mr. [redacted] during the interaction regarding shoes, but imposed an inappropriately low, Level 1 penalty. And the Hiring Authority did not sustain any additional allegations related to Officer [redacted]'s other discourteous and dangerous comments, likely because the investigator failed to include details of those comments in the investigation report.

According to the BWC footage, Officer [redacted] approached Mr. [redacted]'s MHCB cell after being informed by medical staff that Mr. [redacted] may have had some glass in his hand. Officer [redacted] opens the door and he and Mr. [redacted] have the following interaction:

> Officer [redacted]: What's going on, bro? You have anything in your hands?
>
> Mr. [redacted]: I just showed [the other officer] my hands, bruh.
>
> Officer [redacted]: Okay, so the moment you start cutting yourself, we have every right to spray you. I'm letting you know right now…
>
> Mr. [redacted]: Y'all ain't going to be here forever.
>
> Officer [redacted]: I know…
>
> Mr. [redacted]: When y'all walk away, that's when it happens.
>
> Officer [redacted]: That's cool. That's cool. You do what you have to do, I do what I have to do. The moment we [see] you though, **you're getting lit up**. [Closes cell door.] I'll be watching you right now. The moment you do it [hurt yourself], **you're getting lit up**.
>
> Mr. [redacted]: [Unable to hear through the cell door.]
>
> Officer [redacted]: Well when I come back, if I see blood, you're getting lit up.
>
> Mr. [redacted]: [Unable to hear through the cell door.]
>
> Officer [redacted]: Look, man, you've been here too long. You been here too long. **I don't know [if] it's because you're scared of going to the yard, or because you're like a baby**... I just don't get it. Are you scared to go to the yard?
>
> Mr. [redacted]: I'm a killer, blood.
>
> Officer [redacted]: **I'm a killer too**.

See BWC at 9:12:09 (emphasis added).

Mr. [redacted] becomes upset and begins speaking aggressively through his cell door. In response, Officer [redacted] continues to antagonize Mr. [redacted], repeatedly

saying, "And that's why you're behind bars." *See* BWC (linked above) at 9:13:13. He also tells Mr. [redacted], "When you get out [of prison], then you look for me." *See* BWC (linked above) at 9:13:40. Finally, after two minutes of threatening, provoking, and demeaning Mr. [redacted], Officer [redacted] says, "I'm trying to help you out, [redacted]." *See* BWC (linked above) at 19:13:59

About 15 minutes later, Officer [redacted] makes additional, discourteous and dangerous remarks. First, he says, "I can be a dick and say this.... If you really want to kill yourself, go EOP, go back to [housing unit] [redacted] where you can get a razor, and then do it [commit suicide] there." *See* BWC at 9:28:47. A few minutes later, Officer [redacted] says, "I'm going to tell you as a man. If you want to kill yourself, you have a choice.... You want to kill yourself, get discharged, go to [redacted], when you get a razor [unintelligible], do it then." *See* BWC at 9:45:49.

Less than hour after Officer [redacted] told Mr. [redacted] how to kill himself, Mr. [redacted] did cut his wrist. *See* Progress Note at 1.

After Mr. [redacted] engages in self-harm, Officer [redacted] goes to Mr. [redacted]'s cell to escort him to an interview with the sergeant. Before leaving his cell, Mr. [redacted] asks for his shoes. *See* BWC at 10:39:50. Officer [redacted] replies, "I'm not going to get the fucking shoes, I'm not going to get the fucking shoes. You going to get up or not?" Mr. [redacted] answers, "I'm not going barefoot over there." Officer [redacted] replies, "Okay, fuck you then. I'm not going to go get them, fuck I'm tired here." Officer [redacted] then tells the sergeant that Mr. [redacted] refused the interview.

For reasons unclear, CDCR conducted two investigations, led by two different investigators, into Officer [redacted], one for the shoe interaction and one for the remaining conduct. The Hiring Authority sustained one charge of discourtesy (D1, **1**23456) against Officer [redacted] in each case, based on the statements regarding using a razor to commit suicide and for cursing at Mr. [redacted] during the shoe incident. The Hiring Authority imposed a single Level 1 penalty (Letter of Reprimand) for both cases. *See* 402/403 1; 402/403 2; NOAA at 9.

The Hiring Authority should have issued a more severe penalty. Officer [redacted] was stationed to work in a crisis unit around people with significant disabilities who are actively suicidal. He should have been held to an especially high standard for protecting the lives of this vulnerable population. The seriousness of Officer [redacted]'s comments, the fact that Mr. [redacted] did engage in self-harm, and Officer [redacted]'s failure to show Mr. [redacted] basic human decency warranted aggravating the penalty above the baseline. Moreover, the Hiring Authority failed to identify multiple aggravating factors that applied, including that the misconduct was intentional and willful, that serious consequences occurred, that the misconduct resulted in injury to a person, and that more than one act of misconduct forms the basis of the disciplinary action. *See* Disciplinary Matrix, 15 C.C.R. § 3392.5(c)(11). The Hiring Authority also should have considered

and possibly sustained a charge of negligent or intentional endangerment (D2, 1**2**3; D3, 45**6**789). Moreover, Letters of Reprimand are a particularly ineffectual form of discipline, as they are the lowest level of adverse action, do not affect an officer's salary or rank, and are removed from personnel files after three years. *See* Cal. Gov't Code § 19589 (removed from file after three years); 15 C.C.R. § 3392.5(a) (no decrease in salary or rank); DOM § 3303.15.1 (letter of reprimand is "lowest level of penalty in the adverse action process").

In addition, the Hiring Authority should have sustained multiple additional charges of discourtesy for Officer [redacted]'s other comments, including threatening to pepper spray Mr. [redacted], calling Mr. [redacted] "scared" and "a baby," saying he was a "killer," and telling Mr. [redacted] to "look for [him]" when he leaves prison. Had the Hiring Authority sustained these other allegations, then the Hiring Authority should have aggravated the penalty because "[m]ore than one act of misconduct forms the basis for the disciplinary action." *See* Disciplinary Matrix, 15 C.C.R. § 3392.5(c)(11)(K).

The Hiring Authority likely did not identify and sustain charges related to the other instances of discourtesy because the investigator mischaracterized Officer [redacted]'s behavior and left out critical details. The report summarized the initial interaction between Officer [redacted] and Mr. [redacted] as follows:

> [redacted] then secured the cell door and maintained his position at the cell door front, initiating a conversation with [redacted]. [redacted] asked [redacted] if the reason he was attempting to harm himself was because he was scared to be released to a facility. [redacted] stated he was trying to help [redacted], and [redacted] responded that he wanted to be re-housed in a state hospital.

See Investigation Report at 3.

The investigation report framed the interaction as if Officer [redacted] was offering support to Mr. [redacted] and earnestly asking whether he had safety concerns. In reality, Officer [redacted] mocked and belittled Mr. [redacted]. Furthermore, though the investigator watched that part of the video, the investigation report did not identify all of Officer [redacted]'s various inappropriate and relevant comments.

These cases also highlight Defendants' troubling practice of splitting related allegations into separate investigations. The AIU should have investigated all of Officer [redacted]'s conduct in a single investigation. Instead, these allegations were reviewed in two investigations conducted by different investigators.

2. LAC-[redacted] – AIU, Sustained – Adverse (L3) (Reduced by SPB for at least one officer)

In this case, the Hiring Authority sustained allegations of negligent endangerment against four officers who delayed nearly twenty minutes in responding to reports of suicidality by [redacted], who had by that time engaged in self-harm. The Hiring Authority should have, however, sustained the more serious charge of intentional endangerment, as BWC footage shows that the officers mocked Mr. [redacted], then intentionally delayed in responding to address his suicidality. Though Mr. [redacted]'s self-harm did not ultimately result in significant injuries, he could have been dead by the time the officers finally reached his cell.

Video shows four officers—Officers [redacted], and [redacted]—sitting in the D3 staff office. An incarcerated person approaches and states, "146 [Mr. [redacted]'s cell] said he's suicidal." BWC 1 at 11:35:40. Officer [redacted] asks "[redacted] is suicidal again?" Officer [redacted] says yes, and Officer [redacted] replies, "Oh, I should have wrote him up yesterday." *Id.* at 11:36:05. Officer [redacted] asks, "How do we know he's suicidal?" Officer [redacted] says, "We don't." Officer [redacted] replies, "Because an inmate told us." *Id.* at 11:36:15. Officer [redacted] says, "Oh, yeah, they don't lie bro." *Id.* at 11:36:17. Officer [redacted] says the report sounds like "hearsay," and Officer [redacted] responds, "They don't lie, those guys don't lie." *Id.* at 11:36:30. The officers then begin talking about different incarcerated people. None of the officers takes any action to address the report that Mr. [redacted] is suicidal.

About fifteen minutes later, another incarcerated person approaches the office to inform Officers [redacted] and [redacted] that Mr. [redacted] had "chopped all on himself." BWC 2 at 11:48:25. Officer [redacted] replies, "Oh God." Officer [redacted] stands up and asks Officer [redacted], "Where did [redacted] go? Because I'm not taking him [redacted] out. One of them needs to take him out." *Id.* at 11:48:55. A few moments later, Officer [redacted] gestures to Officer [redacted] at the podium and asks him to check on Mr. [redacted]. *Id.* at 11:49:35. Officers [redacted] and [redacted] walk slowly and without any sense of urgency over to Mr. [redacted]'s cell, which they reach approximately two minutes after first receiving the report that he had "chopped" himself. BWC 1 at 11:50:13. At the cell, Mr. [redacted] says he sent someone to tell the officers he was suicidal. Officer [redacted], who was present for and discussed with the other officers the original report of suicidality, replies dishonestly, "Oh did he, are you sure?" *Id.* at 11:50:30. Officers [redacted] and [redacted] then escort Mr. [redacted] out of the housing unit for medical attention over 15 minutes after receiving the initial report that Mr. [redacted] was suicidal. *Id.* at 11:51:45.

The Hiring Authority sustained charges against all four officers for negligent endangerment (D2, penalty 1**2**3) and failure to observe and perform within the scope of training, post orders, duty statements, department policy, or operational procedures (D26, penalty **1**2345). *See* 402-403 at 3, 7, 11, 15. The Hiring Authority departed from the

base Level 2 penalty, and imposed on all four officers a Level 3 penalty of a 5% salary reduction for six pay periods. *Id.*[13]

The Hiring Authority erred by not sustaining the more serious charge of intentional endangerment (D3, penalty 45**6**789) against all four officers. LAC operational procedure requires officers to immediately notify health care staff when an incarcerated person expresses suicidal ideation. *See* MHSDS LOP #31 at 36. Here, an incarcerated person clearly informed all four officers that Mr. [redacted] was suicidal and all four officers made statements in the office acknowledging their receipt of the information. Nevertheless, all four officers intentionally decided not to even walk over to check in with Mr. [redacted]. In addition, Officers [redacted] and [redacted] failed to immediately respond to Mr. [redacted]'s cell even after learning that he had "chopped all on himself," further endangering Mr. [redacted]. The evidence therefore shows that, notwithstanding their knowledge of Mr. [redacted]'s suicidality, all four officers willfully failed to act to address the serious and possibly deadly risk of harm.

Even for the lesser charges that the Hiring Authority sustained, the discipline (only one level above the baseline) was inappropriate given the callous disregard for Mr. [redacted]'s wellbeing. The Hiring Authority also included inappropriate mitigating factors for each officer. The Hiring Authority wrongly concluded that each "employee reported the harm caused or independently initiated steps to mitigate the harm caused in a timely manner." *See* 402/403 at 3, 7, 11, 15. Yet the video shows that the officers did nothing to mitigate the harm. And the officers did not self-report their delays in responding; their misconduct was investigated only because Mr. [redacted] filed a 602. The Hiring Authority also listed as a mitigating factor for each officer that "[t]he employee was forthright and truthful during the investigation." *See* 402/403 at 3, 7, 11, 15. As Plaintiffs have previously explained, Defendants should never use this factor to mitigate discipline because officers have a preexisting legal duty to be forthright and truthful during investigations.

The investigation report was biased in ways that may have affected the Hiring Authority's decision-making. Most importantly, the investigator's summary of the video does not include all of the statements by the officers that mock Mr. [redacted] and otherwise reflect their lack of concern for his health and safety. *See* Investigation Report

[13] The file indicates that after an appeal to the State Personnel Board ("SPB"), CDCR agreed to cut Officer [redacted]'s penalty in half. *See* [redacted] SPB Decision Approving Stip. at 3. Officers [redacted] and [redacted] also appealed to the SPB, but the case file contains no information about the outcome or any stipulation to resolve the appeal. The case file does not contain a NOAA for Officer [redacted], even though the Hiring Authority imposed adverse action.

at 3-4.[14] In addition, the investigator included irrelevant statements from the officers intended to paint Mr. [redacted] in a negative light, including Officer [redacted]'s statement that Mr. [redacted] was generally "vociferous and borderline combative." *See* Investigation Report at 6.

3. RJD-[redacted] – AIU, Sustained – Corrective (LOI) (Hiring Authority: Charles Schuyler, Warden at SVSP)[15]

Video evidence confirmed that, for about 30 minutes, Officer [redacted] refused to let [redacted] into his cell to retrieve his nitroglycerin because Mr. [redacted] had been disrespectful to Officer [redacted]. Nitroglycerin is a heart medication taken to address an angina (chest pain) attack that has already started. Generally, people who need nitroglycerin are supposed to carry the medication on their person at all times. Despite this dangerous and retaliatory conduct, the Hiring Authority only imposed corrective action (Letter of Instruction).

Officer [redacted]'s BWC footage shows him refusing to open Mr. [redacted]'s cell door, even though a floor officer requested that he do so. He makes clear he is not opening the door because he perceived that Mr. [redacted] was being disrespectful to him. *See* BWC at 13:58:50 ("When you learn to watch your mouth. Now I'm not opening your door. You need to learn to watch your mouth young man."; also makes crying sounds ("Wah") to himself in response to Mr. [redacted]'s request); 14:02:28 ("You need to start acting like. First off, I don't want that ... You can try again tomorrow, because I am not opening it"; additionally, mumbles to himself, "Stupid dude."); 14:03:30 ("Good luck, [redacted], because you are getting written up for unlawful influence and disrespect"; additional disrespectful comments to [redacted] out of the window of the control booth); Investigation Report at 2 (explaining floor officer requested [redacted] open the door). Mr. [redacted] had to wait about half an hour to retrieve his medication. *See* Investigation Report at 2-3. In his interview with the investigator, Officer [redacted] admitted that "he should have opened it [Mr. [redacted]'s cell door] at the time the floor officer asked him to regardless of what transpired between him and [redacted]." *See* Investigation Report at 5.

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[14] The report does not include the following comments: Officer [redacted]'s mocking statement that the report of Mr. [redacted]'s suicidality was "hearsay"; Officer [redacted]'s mocking comments suggesting that incarcerated people lie; Officer [redacted]'s statements to multiple officers that she did not want to respond to Mr. [redacted]'s cell after learning that he had cut himself; and Officer [redacted]'s dishonest response to Mr. [redacted] suggesting that no one informed the officers that Mr. [redacted] was suicidal.

[15] Throughout the report, Plaintiffs have indicated in headings for cases if the case was decided by a Hiring Authority other than the Hiring Authority in charge of the institution at which the misconduct occurred. Plaintiffs discuss the importance of these cases in **Section I.F**, *infra*.

The Hiring Authority did sustain an allegation against Officer [redacted] for failure to observe and perform within training and policy (D26, **1**2345) and issued corrective action (Letter of Instruction). *See* 402/403 at 2-4. Given Officer [redacted]'s intentional misconduct that put Mr. [redacted]'s health at risk, the Hiring Authority should have sustained an allegation of intentional endangerment (D3, 45**6**789) against Officer [redacted].

4. KVSP-[redacted] – AIU, Not Sustained

In this case, after [redacted] informed staff he was suicidal, staff left him unattended in his cell for all but 23 minutes of the next 1 hour and 43 minutes, until they finally removed him from his cell. The officers' conduct violated CDCR's policy requiring that, once staff become aware of suicidal ideation, staff must place the incarcerated person under "direct observation" until health care staff perform a suicide risk assessment. *See* Mental Health Delivery System Program Guide (2021 Revision) at 178. Despite video evidence and witness testimony confirming this policy violation, the Hiring Authority did not sustain any allegations of misconduct.

As described in the investigation report, AVSS footage shows Officer [redacted] conducting safety checks. At 18:13:35, he approaches Mr. [redacted]'s cell door, stops to speak with him, and then activates an alarm (presumably in response to Mr. [redacted] reporting suicidality). *See* Investigation Report at 3. Officer [redacted] and Mr. [redacted] both reported in their interviews that Officer [redacted] then requested that Mr. [redacted] submit to restraints; Mr. [redacted] refused. *See* Investigation Report at 4, 6. Responding staff arrive to Mr. [redacted]'s cell, then about 25 minutes later Officer [redacted] and other staff walk away from Mr. [redacted]'s cell. Over the next 1 hour and 40 minutes, various staff members, including sometimes Officer [redacted], periodically return to Mr. [redacted]'s cell. Finally, at 19:56:10, Officer [redacted] and another officer approach Mr. [redacted]'s cell, place him in restraints, and escort him out of the housing unit. *See* Investigation Report at 3-4. In total, Mr. [redacted] was not under "direct observation," and was left unattended for 1 hour and 20 minutes of the time period between when he reported his suicidality and when staff removed him from his cell.[16] Psych Tech [redacted] and Sergeant [redacted] (who responded to the scene) admitted in their investigation interviews that custody staff should have remained at [redacted]'s cell door until medical evaluated him. *See* Investigation Report at 6-7; [redacted] Interview at 13:00.

The Hiring Authority should have sustained allegations against Officer [redacted] (and potentially other responding officers who failed to observe Mr. [redacted] and whom the investigator failed to identify) for violating the "direct observation" policy. Instead, the Hiring Authority did nothing to hold any staff accountable.

[16] Plaintiffs reviewed the AVSS to confirm this time period.

5. COR- – AIU, Sustained – Corrective (LOI) (Hiring Authority: Patrick Covello, Warden at MCSP)

In this case, Officers , and ignored reports of suicidality from . The Hiring Authority sustained the allegation against all three officers, but imposed an inappropriate, low penalty (corrective action) for this dangerous misconduct that could have resulted in serious harm to Mr. . Though the investigation uncovered sufficient evidence to support more serious charges, it was also incomplete and biased.

Video shows Officer walking through Building , an EOP building. Mr. , who was in cell , knocked on his door and informed Officer that he was suicidal. Officer says, "Ok, I'm going to let them know," exits the building, and proceeds to the mental health building without notifying anyone of Mr. 's suicidality. *See* BWC 1 at 14:48:29. Moments later, Officers and walk through the unit. Their BWC video captures an incarcerated person repeatedly yelling out that he is suicidal. *See* BWC 2 & BWC 3 at 14:48:43, 14:48:45, 14:48:49, 14:48:51. Officers and exit the housing unit without acknowledging the report of suicidality. Once outside, they have the following conversation:

> Officer : He didn't say he was suicidal. His neighbor didn't say nothing.
>
> Officer : Tell your floor cop. He wasn't saying it, his neighbor was saying it.
>
> Officer : Yeah, his neighbor wasn't saying anything.

See BWC 2 & BWC 3 at 14:49:05.

The officers proceed to the mental health building, where they meet up with Officer . Officer makes a remark that is difficult to understand, but appears to be, " . [Unintelligible] clean my cell. Clean my cell. 143. Clean my cell." *See* BWC 1 at 14:50.

Based on this evidence, the Hiring Authority sustained the allegation that Officers and "ignored [Mr.] when he informed them of having suicidal ideation." *See* Closure Memo. The Hiring Authority, however, imposed only corrective action on the officers (Letters of Instruction). *See* Letters of Instruction at 11, 17-18, 25-26. The facts supported sustaining charges of intentional endangerment (D3, 45**6**789). The statements made by the officers walking to and while in the mental health building show that the officers knew Mr. was suicidal and failed to report it. In addition, Officers and both admitted, after viewing their videos, that they ignored the report of suicidal ideation. *See*

Investigation Report at 7 (Officer [redacted] admitting that he "screwed up"); *id.* at 5-6 (Officer [redacted] providing no explanation for why he did not report Mr. [redacted]'s suicidality). Officer [redacted]'s response was even worse, as he admitted to hearing the report of suicidality, but attempted to avoid responsibility because it may have been Mr. [redacted]'s neighbor who reported it. *See* Investigation Report at 7. Moreover, Officers [redacted] and [redacted]'s dialogue as they walked to the mental health building reflects a callous disregard for Mr. [redacted]'s safety. *See* Investigation Report at 7.

The Hiring Authority also failed to comply with the directive requiring he list all applicable sections of the Disciplinary Matrix and aggravating and mitigating factors. Defendants' June 16, 2023 Response to Plaintiffs' May 2023 Report states that "DAI issued a directive to all HAs that they must properly document all aggravating and mitigating factors that were considered in their decision making process." *See* Response to May 2023 Report at 18. Here, the Hiring Authority did not list the applicable Matrix categories. *See* 402/403 [redacted] at 22-23; 402/403 [redacted] at 14-15; 402/403 [redacted] at 8. Rather than identifying the applicable mitigating and aggravating factors, the Hiring Authority appeared to copy and paste onto the 402/403 the list of all aggravating and mitigating factors on the Matrix, including those that obviously did not apply.

In addition to the problems with discipline in this case, the investigation was incomplete and biased. Most importantly, the investigator either did not notice or chose not to include in the report Officer [redacted]'s mention of Mr. [redacted]'s name when the officers were in the mental health building. This important piece of evidence shows that Officer [redacted] had not forgotten about the report of suicidality and therefore intentionally, rather than negligently, failed to act. The investigator also failed to interview Mr. [redacted], an obvious investigative step needed to place this incident and the officers' lack of response in context. Lastly, the investigator included negative, irrelevant information about [redacted], who submitted a third-party complaint about the officers' failure to help Mr. [redacted]. *See* Investigation Report at 6 (including reports from Officer [redacted] who reported that Mr. [redacted] "would often hold the holding cell hostage while he was in EOP groups and would often want female officers to conduct unclothed body searches of him"). The inclusion of this irrelevant information reflects bias against incarcerated people and in favor of the officers.

6. COR-[redacted] – AIU, Sustained – Corrective (LOI)

In this case, multiple officers ignored [redacted] "man down" calls. Mr. [redacted] reported to staff that he had consumed peanut butter, to which he is severely allergic. *See* Exhibits at 23. Over 25 minutes passed between the first time Mr. [redacted] called "man down" as shown on BWC and when officers finally

notified medical staff. *See* Investigation Report at 6 (9:56:55); BWC 1 at 10:23:30. During that time period, a number of officers heard Mr. [redacted], but failed to act.

The Hiring Authority sustained identical allegations against 11 officers for "ignoring… [redacted]'s…'man down' calls" and issued all 11 officers Letters of Instruction. *See* LOIs at 5, 20, 31, 38, 45, 52, 59, 70, 77, 84, 91. Based on the evidence, this corrective action may have been appropriate for some officers. The Hiring Authority should have, however, sustained allegations of negligent or intentional endangerment (D2, 123; D3, 456789) and imposed a more substantial penalty on Officers [redacted] and [redacted]. Officers [redacted] and [redacted] responded cell-side to Mr. [redacted], who can be heard yelling "man down" multiple times. Mr. [redacted] tells the officers that he is having "chest pains" and has "been asking for help all morning." Officer [redacted] tells Mr. [redacted] he will "let them [medical staff] know right now." *See* BWC 2 at 9:59:26. The officers do not, however, notify anyone about Mr. [redacted]n's emergent medical needs. In their AIU interview, Officers [redacted] and [redacted] both admitted they heard the "man down" claims and failed to notify medical. *See* Investigation Report at 10, 15. This evidence establishes that they intentionally and knowingly endangered Mr. [redacted].

The CCHCS Hiring Authority likely also should have sustained negligent or intentional endangerment charges against PT [redacted]. After officers finally notified PT [redacted] of Mr. [redacted]'s potential emergency, PT [redacted] refused to attend to him, stating he would only respond to reports of chest pains or suicidal ideation. *See* BWC 1 at 10:24:01. According to the investigation report, the AIU sent a memorandum regarding PT [redacted]'s actions to the Chief Executive Officer at COR on March 26, 2023, presumably for the CEO to open an investigation.[17] *See* Investigation Report at 8; Exhibits at 22. As far as Plaintiffs can determine, Defendants have never produced any health care investigation into this incident. **Please produce the health care investigation into this incident.**

7. RJD-[redacted] – AIU, Not Sustained (Hiring Authority: Kevin Hixon, Warden at NKSP)/RJD-[redacted] – AIU, Not Sustained (Hiring Authority: Glen Pratt, Warden at CRC)

These cases stem from the same incident involving [redacted] and Officer [redacted].

In RJD-[redacted], Mr. [redacted] alleged that Officer [redacted] delayed in obtaining medical attention for him after he complained of chest pains because Officer [redacted] believed he was faking it. The investigator confirmed the allegation, noting that "BWC footage revealed [redacted] delayed the immediate medical request of [redacted],

[17] It appears the memorandum was not produced to Plaintiffs.

according to HCDOM 3.7.1. The duration between [redacted] notifying [redacted] about his chest pains and [redacted] notifying medical was 8 minutes. There was no staff observing [redacted] after he complained of chest pains verbally to [redacted]." *See* Investigation Report at 5.

Policy requires that "[i]n all instances (where a patient has notified staff of an emergent medical concern) the employee shall notify health care staff without delay." *See* HCDOM 3.7.1(e)(1)(A). The Hiring Authority should have sustained an allegation of endangerment against Officer [redacted] for failing to comply with this policy.

In RJD-[redacted], Mr. [redacted] alleged that Officer [redacted] issued him a false RVR for malingering and manipulating staff. *See* Investigation Report at 3. Video shows that after discussing a property issue, Mr. [redacted] reported to Officer [redacted] that he had chest pains. *See* BWC at 23:29:15. Officer [redacted] calls a lieutenant, and Officer [redacted] say "he didn't get what he wants so he's going to claim chest pains, I'm going to write him up." *See* BWC at 23:32:12. The lieutenant instructs him to call medical, who direct Officer [redacted] to call an emergency transport vehicle (ETV) for Mr. [redacted] because he has a documented irregular heartbeat. *See* BWC at 23:36:57; 23:37:08. Officer [redacted] still wrote the RVR the next day, after he became aware of Mr. [redacted]'s medical condition and medical staff's decision. *See* RVR at 11; Investigation Report at 2. The Hiring Authority should have sustained the allegation of a false RVR.

8. RJD-[redacted] – AIU, Not Sustained (Hiring Authority: Kevin Hixon, Warden at NKSP)

Video evidence confirmed that, after [redacted] informed Officer [redacted] during safety checks that she had swallowed a razor and was suicidal, Officer [redacted] instructed Officer [redacted] to "keep going [on his rounds]. He [Ms. [redacted]] does this all the time." *See* BWC at 17:09:19; Investigation Report at 2. The video also confirmed that staff left Ms. [redacted] in her cell unsupervised for about 4 and ½ minutes after her report of self-harm and suicidality. *See* Investigation Report at 3.

In his interview with the investigator, Officer [redacted] acknowledged that he should have immediately searched Ms. [redacted], placed her in handcuffs, and removed her from the cell to be evaluated by medical staff. He further admitted that "he initially attempted to follow procedure, but then followed [redacted]'s suggestion" not to assist Ms. [redacted]. *See* Investigation Report at 7. Officer [redacted] also acknowledged that "he should have stopped what he was doing and responded to [redacted]'s cell to assist" and that "he was required to respond according to procedure, although he was aware of [redacted]'s history of manipulating staff." *See* Investigation Report at 4, 5. Policy requires custody staff to contact medical in all cases where there has been a report of suicidality. *See* Mental Health Program Guide at 178. Despite the video evidence and the officers' admissions to failing to follow policy, the Hiring Authority exonerated

Officer [redacted] and did not sustain the allegation against Officer [redacted]. *See* Closure Memo at 1. The Hiring Authority should have sustained an allegation of intentional endangerment against both officers.

C. Other Cases Reflecting Serious Problems with CDCR's Culture

1. COR-[redacted] – AIU, Not Sustained

In this case, custody and medical staff left [redacted] lying face down on the floor in a holding cell in the Treatment and Triage Area ("TTA") for more than five hours without helping him up. Despite staff's inhumane treatment of Mr. [redacted], neither the custody nor medical Hiring Authorities held anyone accountable. From the investigation files, it appears that the Hiring Authorities did not hold staff accountable because (1) custody staff were unwilling to move Mr. [redacted] without the assistance and guidance of medical staff due to a reported fear of injuring him and (2) medical staff believed that Mr. [redacted] was faking his injuries and need for assistance and therefore refused to help. As discussed below, the evidence in this case suggests that Mr. [redacted] was not faking and needed help. But that is almost beside the point. Whether Mr. [redacted] was or was not faking, staff should not have left him lying face down on the floor for five hours.

Mr. [redacted] has a long history of back pain, limb numbness and weakness, and intermittent paralysis as a result of gunshot fragments that remain in his body. *See* Office Visit Note, June 6, 2022,at 1; ED Note Acute Lower Back Pain, June 21, 2022 at 1-2; XR Lumbar Spine – 2 VWS, June 21, 2022; Primary & Secondary Assessment, June 28, 2022. On the date of the incident, Mr. [redacted] was in a wheelchair being pushed by custody staff after returning from an overnight stay at an outside hospital, where he was seen for severe lower back pain and high blood pressure. *See* Outside Records – Hospital, July, 22, 2022, (outside hospital record showing that he rated his back pain as a 10).

At the start of the video footage, Mr. [redacted] is slumped over in the wheelchair, apparently unable to sit up. *See* BWC 1 at 7:42:00 He can be heard occasionally grunting. Two officers push him into a medical examination room. A medical staff member requests that he sit up. Mr. [redacted] loudly replies, "I can't sit up, my back ..." At that point, both officers turn off their BWCs in purported compliance with CDCR's policy requiring deactivation when medical care is provided. *See* BWC (linked above) at 7:44:00.

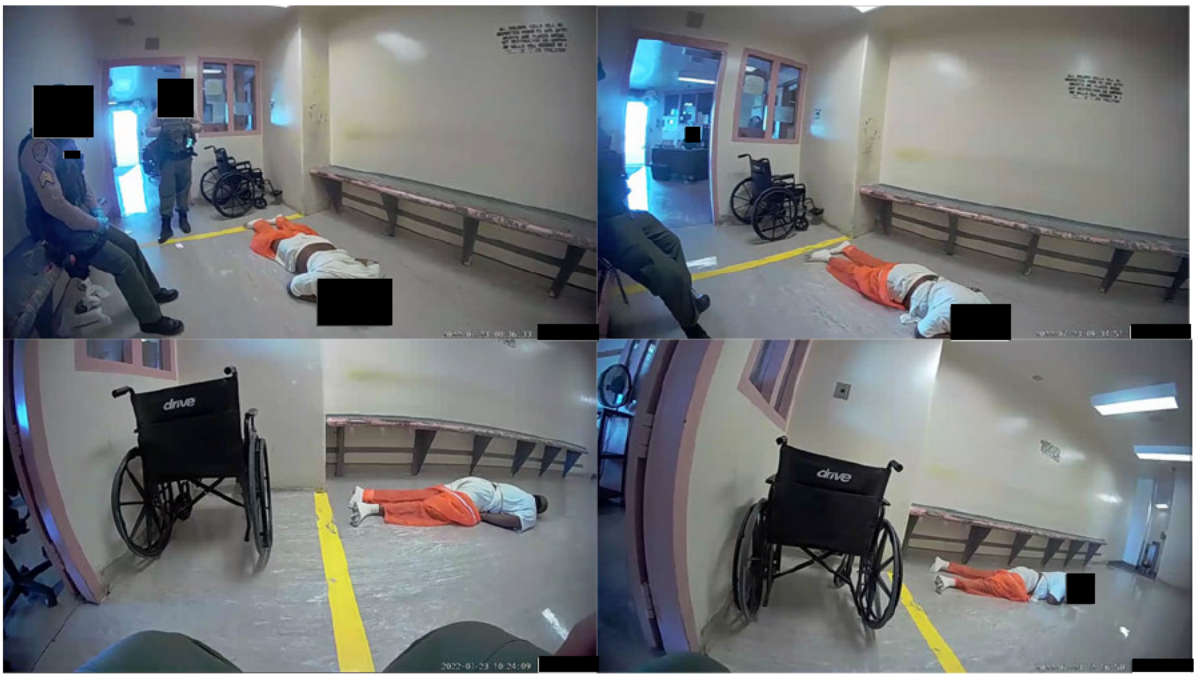
The officers reactivate their BWCs about 14 minutes later. *See* BWC 1 (linked above) at 7:57:34. Mr. [redacted] is lying on the ground of the examination room, face down, with his pants down below his buttocks. After about 10 minutes, four custody officers and the medical staff member lift Mr. [redacted], who is loudly groaning, back into his chair. *See* BWC 1 (linked above) at 8:08:30.

Mr. [redacted] informs staff that he is suicidal. *See* BWC 1 (linked above) at 8:09:43. Medical staff instruct the officers to take Mr. [redacted] to a holding cell in the TTA and watch him until medical staff can place him on a one-to-one watch.

Mr. [redacted] request assistance using the restroom. A medical staff members states, "he [Mr. [redacted]] doesn't need assistance." Mr. [redacted] says "Well someone is going to have to help or I'm shitting on the floor." The medical staff member replies, "when it [defecation] happens, it happens and we'll note it." *See* BWC 1 (linked above) at 8:11:44.

Custody staff push Mr. [redacted] in his wheelchair into a large holding cell in the TTA. Less than a minute later, Mr. [redacted] falls out of his wheelchair to the ground while trying to move to the bathroom. *See* BWC 1 (linked above) at 8:14:15; 8:15:05. The officers are concerned that if they try to move Mr. [redacted], they might cause him further injury, and so wait for medical staff to arrive. The same medical staff member who instructed Mr. [redacted] to defecate on himself arrives and pulls the wheelchair out from under Mr. [redacted] with custody assistance. *See* BWC 1 (linked above) at 8:21:20.

For the next five hours, medical and custody staff leave Mr. [redacted] lying on the ground. The screenshots below show how little his position changes during the time period:



Clockwise from top left: 8:36:33, 9:34:51, 10:24:09, 12:16:50

On two occasions, Mr. [redacted] indicates he needs to use the bathroom. Staff leave Mr. [redacted] on the ground to urinate using a portable urinal. *See* BWC 1 (linked above) at

8:52:56; BWC 2 at 11:25:45. At 12:36:08, medical or mental health staff finally evaluate Mr. [redacted]. *See* BWC 1 (linked above) at 12:36:08; Investigation Report at 3. At 13:45:36, custody staff, without the assistance of medical staff, and without any explanation as to why they waited so long, finally lift Mr. [redacted] back onto his wheelchair without incident. *See* BWC (linked above) at 1:45:36.

The medical and custody Hiring Authorities should have disciplined multiple custody and medical staff for leaving Mr. [redacted] on the floor for over five hours.[18] Even if Mr. [redacted] was faking his need for help, there is no excuse for leaving him on the floor for such a long time.

Making matters worse, the evidence suggests that Mr. [redacted] was not faking. As referenced above, his medical records indicate that he suffered from conditions that might leave him unable to move off the floor without assistance. Though he did not have a DPP code at the time, he is now designated as [redacted] because of weakness in his legs. *See* 1845/7410. Every time that he has to move or that staff try to move him, he reacts as if he is in significant and genuine pain. *See* BWC 1 (linked above) at 8:08:28, 8:21:27, 8:53:00 13:45:40; BWC 2 (linked above) at 11:25:48. And during the time he is on the floor of the holding cell, he barely moves for hours. That medical staff did not believe that Mr. [redacted] had a real condition or needed help—and therefore treated him inhumanely rather than simply providing the assistance he requested—suggests that they see incarcerated people as less than others and do not take seriously their obligation to provide incarcerated people with the same care they would receive in community.

The investigations into this incident were terrible. The AIU investigator did not interview any medical staff or gather any relevant medical records that would have shown Mr. [redacted]'s gunshot injury and previous instances of temporary paralysis. These steps were necessary to determine whether medical staff had a reasonable basis to believe that Mr. [redacted] was faking.

The investigation conducted by CCHCS, which was completed before and attached as an Exhibit to the AIU Investigation Report, was even worse. *See* Exhibit 3: Confidential Inquiry Report, COR SC [redacted].[19] To begin with, the investigator

[18] Staff's conduct implicated multiple categories of the Employee Disciplinary Matrix. *See, e.g.,* Discourtesy (D1, **1**23456); Failure to observe and perform within professional standards, including community standards of care, applicable to a profession (D25, **3**456789); Failure to observe and perform within the scope of training or policy (D26, **1**2345); and Failure to observe and perform within the scope of practice for medical, nursing, psychiatric, psychological, dental, or other health care employees (D27, **3**456789).

[19] It is unclear whether Plaintiffs possess all of the CCHCS investigation files. **Please produce all CCHCS investigations files related to this incident.**

looked only at whether Dr. [redacted] told the officers to let Mr. [redacted] defecate on himself, not at whether medical staff violated policy by leaving Mr. [redacted] on the ground for five hours while accusing him of faking his need for help. Next, the investigator did not review any video footage. Had she done so, she would have confirmed that a medical staff member did, in fact, tell Mr. [redacted] that they would not assist Mr. [redacted] to use the bathroom and that if Mr. [redacted] defecated on himself, "it happens and we'll note it."

The custody and medical staff who left Mr. [redacted] on the ground for more than five hours treated him more like an animal than a person. And yet no one saw a problem and CDCR failed to hold anyone accountable.

2. CIW-[redacted] – AIU, Not Sustained

In this case, the investigator failed to take basic steps to investigate a serious allegation of staff sexual misconduct. [redacted] reported that he observed Captain [redacted] sexually assault multiple incarcerated women, including [redacted], from 2018 to 2022. Specifically, Mr. [redacted] alleged that, on different occasions, Captain [redacted] escorted Ms. [redacted] to his office to fondle her, watched Ms. [redacted] undress through her cell window, and kept the SIM card from Ms. [redacted]'s contraband cell phone because the phone contained nude photos of Ms. [redacted]. *See* Investigation Report at 1. Mr. [redacted] reiterated this information in his interview with the investigator. *Id.* at 2. He also alleged that Captain [redacted] had sexually assaulted other incarcerated women, who he identified by name, in the gym or in his office. *Id.* at 2. He further provided the investigator with the name of an incarcerated person who reported to Mr. [redacted] that she served as a look out for [redacted]. *Id.* When the investigator interviewed Ms. [redacted], she confirmed the allegations. She told the investigator that Captain [redacted] had asked her to take naked photos for him, had asked her to undress in front of him, and had "ask[ed] her what she could do for him for him to help her." *Id.* at 3-4. She also reported to the investigator that Captain [redacted] would ask her what underwear she ordered. *Id.* at 4. She claimed that she did not report Captain [redacted] for fear of retaliation. *Id.* at 4. The investigator then interviewed Captain [redacted], who denied engaging in a sexual relationship with anyone at CIW. *Id.* at 3.

Despite two people providing corroborating evidence about Captain [redacted]'s serious misconduct, the investigator took no additional investigative steps. The investigator should have interviewed the other person who Mr. [redacted] alleged Captain [redacted] sexually assaulted and the person who Mr. [redacted] identified as serving as a lookout for Captain [redacted]; reviewed whether any other incarcerated people filed 602s against Captain [redacted] for sexual misconduct and, if yes, followed up on those leads; and interviewed other staff and incarcerated people, identified from records review, who may have observed Captain [redacted]'s misconduct (e.g., staff and/or incarcerated people from Ms. [redacted]'s housing unit at the time). He did none of those things.

The investigation report was also biased. The investigator included in the report irrelevant, negative information that Captain [redacted] reported about Mr. [redacted]. *See* Investigation Report at 3 (stating that Captain [redacted] reported that Mr. [redacted] "was a problem inmate who was disruptive" and that Mr. [redacted] only moved out of a cell that needed repairs when Captain [redacted] threatened a controlled use of force). Even if this information were relevant, the investigator did nothing to confirm it and simply took Captain [redacted] at his word. The inclusion of this information reflects bias against Mr. [redacted] (the third-party complainant) and in favor of Captain [redacted].

The investigator's failure to perform fundamental investigatory steps and to produce an unbiased investigation report demonstrate a disregard for the incredible seriousness of the allegation. That disregard is particularly troubling in light of the recent criminal charges brought against Officer Gregory Rodriguez, who allegedly sexually assaulted many women while working as a correctional officer at CCWF.[20] Plaintiffs have also written about an additional case in which Defendants conducted a poor investigation into allegations of sexual misconduct. *See* May 2023 Report at 30. (criticizing inadequate investigations into three complaints that a dental hygienist sexually molested four women).

Lastly, this case should have been treated as a criminal investigation, in which investigators are not supposed to interview the subject until it is certain that no criminal referral will occur. Instead, the investigator interviewed Captain [redacted] before interviewing Ms. [redacted]. This behavior by the investigator could have compromised any potential criminal charges had a complete and unbiased investigation uncovered sufficient evidence to support those charges. The case file contains no indication that Defendants even considered approaching the investigation as a potential criminal investigation.

3. SATF-[redacted] – AIU, Sustained – Corrective (Training)

In this case, which Plaintiffs referenced in the introduction to this report, a CDCR supervisor, Sergeant [redacted], was disrespectful and dismissive to and obstructed access to the court-ordered staff complaint process for [redacted],[21] in response to [redacted] filing a claim of disability-related retaliation. The

[20] *See* The California Department of Corrections and Rehabilitation, *CDCR Refers Internal Investigation into Former Correctional Officer to District Attorney for Charges of Sexual Misconduct of Incarcerated Women*, News Releases (Dec. 28, 2022).

[21] [redacted] uses they/them pronouns.

very short (1:36) video clip should be watched, as it captures the essence of the difficulty described by many class members attempting to access the accountability system and the blatant hostility and disrespect they encounter from staff.

[redacted] had filed an 1824 about retaliation and discrimination because of their [redacted] status. *See* 602 at 1 (describing complaint as "retaliation appeals"); BWC at 20:22:20, 20:22:42 (Sergeant [redacted] indicating he was interviewing [redacted] about an 1824 claiming staff were "discriminating because you are [redacted]"). Sergeant [redacted] improperly conducts the staff complaint interview in the public rotunda of the housing unit, in the presence of many other staff and other incarcerated people. When [redacted] protests, asserting their right to be questioned in a confidential location, Sergeant [redacted], in front of two supervisees, denies the request to speak in a confidential setting and says that he will report that [redacted] is refusing the interview. When [redacted] continues to assert his right to a confidential interview regarding the staff complaint, Sergeant [redacted] says to [redacted] "if you want to be a jerk about it, you can leave. Have a good day." [redacted] asks, incredulously, "are you going to talk to me like that?" Sergeant [redacted] says, "yes, I am going to talk to you like that." [redacted] then asks for Sergeant [redacted] to provide them with a 602 form. Sergeant [redacted] refuses, telling [redacted] to "keep walking," and then appears to chase [redacted] away. *See* BWC at 20:22:17.

The Hiring Authority sustained the allegation, but the remedial action taken in this case—a 15-minute "Ethics and Professionalism" training for Sergeant [redacted]—was inadequate. The corrective action failed to address the much larger problems—including the ongoing barriers faced by class members attempting to access the staff complaint process—illustrated by this case. *See* Memo at 16; Training at 45. Lack of training is not the problem here. Sergeant [redacted] has received years of training, including annual court-ordered training on deescalation and interacting with people with disabilities now required of all staff at his prison. *See* Five Prisons Remedial Plan, at 16-17. As a supervisor, he should already know that interviews regarding complaints should be conducted in a confidential setting, that he should not call incarcerated people "jerks," and that he should not refuse to provide a staff complaint form when requested. The Hiring Authority should have taken more seriously this public display of disrespect and obstruction of access to the staff complaint process by a supervisor. Moreover, the Hiring Authority should have removed (either permanently or temporarily) Sergeant [redacted] from conducting investigations into complaints filed by incarcerated people, as his behavior demonstrates he is unsuited for that role.

That this misconduct occurred at SATF, where Sergeant [redacted] and all staff should have heightened awareness of their responsibilities given that SATF is currently under the additional scrutiny of the *Armstrong* Court Expert's investigation, is shocking. The accountability system is supposed to provide Defendants with a tool for ensuring staff comply with policy and treat incarcerated people with dignity and respect. Instead,

in this case, Sergeant [redacted] illustrated conduct described repeatedly by class members throughout the system, which dissuades future complaints by [redacted] and other incarcerated people while failing to prevent future acts of misconduct from occurring.

4. RJD-[redacted] – AIU, Not Sustained (Hiring Authority: Glen Pratt, Warden at CRC)

This case involves the attempted murders of [redacted] and [redacted] on October 7, 2022. Mr. [redacted] and Mr. [redacted] were both stabbed repeatedly by another incarcerated person in the dayroom of Building A3. Plaintiffs' counsel received reports from multiple class members that staff endangered Mr. [redacted] and Mr. [redacted]. Plaintiffs wrote to Defendants on November 18, 2022, requesting that a Special Agent in the AIU investigate the allegations, that Defendants preserve and review all related footage, and that the investigator interview all witnesses. *See* Email from [redacted] to [redacted] re "Attempted Murder of Two Class Members at RJD" (Nov. 18, 2022). While a Special Agent did conduct the investigation, the investigation was incomplete, making it impossible to determine whether officers had contributed to the serious harm suffered by Mr. [redacted] and Mr. [redacted].

Mr. [redacted] alleged that the assailant tried to murder him because officers informed the assailant that Mr. [redacted] had reported that the assailant possessed a weapon.[22] *See* Email from [redacted] to [redacted] re "Attempted Murder of Two Class Members at RJD" (Nov. 18, 2022). As Mr. [redacted] explained during his interview with the investigator, he did not have any direct evidence to support his allegation. *See* Investigation Report at 3. However, the fact that the assailant tried to murder him mere days following the search by staff is strong circumstantial evidence that the assailant found out about Mr. [redacted]'s report to staff. Mr. [redacted]'s allegation is extremely serious. If proven, it should result in termination and possibly criminal prosecution of any involved officers. Given the seriousness of the allegation, CDCR should have conducted a very thorough investigation.

Instead, the investigation was cursory and incomplete. The entire investigation consisted of (1) reviewing BWC footage of the ISU officers' search of the assailant's cell (which did not show them disclosing Mr. [redacted]'s identity); (2) reviewing AVSS of the attack and (3) interviewing Mr. [redacted]. *See* Investigation Report.

The investigator should have turned over many other stones to determine what happened and why Mr. [redacted] was stabbed by the very person whom he'd reported

[22] Plaintiffs also reported that the assailant may have attacked Mr. [redacted] because staff informed the assailant that Mr. [redacted] had a disfavored commitment offense. The investigation into this allegation was generally adequate.

confidentially to staff. In particular, the investigator failed to interview anyone—staff or incarcerated people—other than Mr. [redacted]. The investigator should have interviewed staff to understand the chain of custody of Mr. [redacted]'s report that his assailant possessed a weapon, from Officer [redacted] (to whom Mr. [redacted] provided a note about the weapon) to the ISU officers who searched the assailant's cell. The investigator then should have interviewed all staff who possessed the information to determine whether they shared it with the assailant. The investigator should have also tried to obtain the note that Mr. [redacted] provided to Officer [redacted].

The need for these additional steps is supported by the assailant's statements while officers were searching his cell. An officer affirmatively tells him "[t]he reason we're here is we got a kite saying that you had a weapon in your cell." The assailant responds, "Really, so just any fucking, anybody who gets mad at me can drop a kite saying I got a weapon…. I been over here two years, no weapons, no bullshit at all. And some fucking asshole that gets scared says that I got a weapon and this is what happens." *See* BWC at 10:42:05. While this footage does not depict the ISU officers mentioning Mr. [redacted]'s name, the assailant is clearly angry. The interaction raises serious questions about what occurred in the nine days between the cell search and the attack, and if/how the assailant learned the identity of Mr. [redacted], including potentially through Officer [redacted]. The investigator should have conducted more interviews and reviewed more video footage if needed to determine if that happened.

The investigator also should have interviewed Mr. [redacted], the second victim and Mr. [redacted]'s friend, to determine his understanding of the attack. The investigator should have interviewed [redacted], identified in Plaintiffs' email to Defendants as a witness to the attack who was willing to participate in an investigation. The AVSS footage[23] of the attack depicts the assailant pacing behind Mr. [redacted] and Mr. [redacted] with another incarcerated person, who Plaintiffs believe to be Mr. [redacted], just before the incident. *See* Investigation Report at 3. About 15 seconds into the video, Mr. [redacted] peels away as the assailant approaches Mr. [redacted] and Mr. [redacted] and stabs them. As the last person to speak with the assailant before the attack, the investigator should have asked Mr. [redacted] if the assailant had indicated any motive for the attack. Finally, the investigator should have interviewed other incarcerated witnesses in the building to determine if they knew of the reason for the attack or had heard of staff informing the assailant about Mr. [redacted]'s note.

It is possible that a more thorough investigation into this allegation may have revealed that staff did not inform the assailant that Mr. [redacted]'s note resulted in the cell search or may not have resulted in sufficient evidence to determine whether the allegation was true. It is troubling, however, that CDCR conducted such an incomplete

[23] Plaintiffs have not linked to the footage, which is quite gruesome, because it is described in the investigation report.

investigation into a serious allegation, failing to obtain easily available evidence that may have resolved the claim.

5. KVSP-[redacted] – AIU, Not Sustained

In this case, the Hiring Authority did not sustain any allegations even though video evidence showed that Sergeant [redacted] was disrespectful toward and taunted [redacted]. Mr. [redacted] and Sergeant [redacted] have a verbal dispute in front of many other officers regarding Mr. [redacted]'s disability and whether he was entitled to stand during an alarm as an accommodation. Sergeant [redacted] escalated the situation by taunting Mr. [redacted] with statements like, "I'm waiting for you. I'm waiting for you. What are you going to do? What are you going to do? What are you going to do? Yeah, nothing" and "[a]ll these tough guys man, but you ain't going to do nothing." *See* BWC at 8:05:30. Sergeant [redacted]'s behavior was inappropriate and unprofessional. The Hiring Authority did not sustain any allegations, but should have, at a minimum, sustained charges for discourtesy (D1, **1**23456) and failure to observe and perform within training and policy (D26, **1**2345). When such conduct by a supervisor goes unpunished, it communicates to all staff that the conduct is acceptable.

The failure to sustain allegations may have been at least partly caused by the incomplete and biased investigation report. The investigator omitted from the report all of the problematic statements made by Sergeant [redacted]. Instead, the investigator simply wrote: "[redacted] and [redacted] engaged in the conversation for approximately 30 seconds and [redacted] walked away." *See* Video Quick Close Report at 4. Meanwhile, the investigator included statements by Mr. [redacted]—for example, that he said that Sergeant [redacted] was "talking like a bitch"—that painted Mr. [redacted] in a bad light without including Sergeant [redacted]'s inappropriate responses. *Id.* A Hiring Authority reading the report would have no idea that Sergeant [redacted] had acted unprofessionally.

6. CIW-[redacted] & CIW-[redacted] – Local, Sustained – Corrective (Training); Local, Sustained – Corrective (Verbal Training)

In these cases, Defendants' failed to impose appropriate discipline on Officer [redacted], who the Hiring Authority found was discourteous to class members on two separate occasions. According to information provided by Defendants at the parties' January 11, 2024 meet and confer, Hiring Authorities are expected to aggravate the penalty for a second incident of the same or similar misconduct, even when the first and second incidents occur very close in time. In these cases, the Hiring Authority failed to consider the first sustained finding of discourtesy when determining the discipline for the second sustained finding of discourtesy.

On August 2, 2023, in CIW-[redacted], the Hiring Authority sustained an allegation that Officer [redacted] was discourteous when, on July 8, 2023, Officer [redacted]

told a class member in the Support Care Unit ("SCU"), a unit designated for people at the EOP level of mental health care, that she was going to lock the class member in her cell for the next ten years. *See* Closure Memo at 1. The Hiring Authority imposed corrective action ("training") for this sustained allegation. *See* HA Decision at 9. On August 8, 2023, in CIW-[redacted], the Hiring Authority sustained another allegation that Officer [redacted] was discourteous, finding that, on July 6, 2023, she loudly said, "Ridiculous loser" as she walked by a different class member in the SCU. *See* Closure Memo at 1. The Hiring Authority imposed only corrective action ("training (verbal)") for this sustained allegation. *See* HA Decision at 8. The file for this second sustained finding contains no acknowledgement of the prior sustained finding of discourtesy, even though Chief Deputy Warden Williams made both decisions only six days apart. Furthermore, Chief Deputy Warden Williams did not increase the severity of the response for the second instance of discourtesy, again imposing only training.

For this Defendants' policy to work, Defendants must more clearly convey to Hiring Authorities that they are expected to identify repeated sustained allegations of similar misconduct and aggravate the penalty for the second sustained finding. Defendants must create a system so that Hiring Authorities can easily see all prior sustained allegations of misconduct when deciding on discipline in subsequent cases.

7. RJD-[redacted] – AIU, Not Sustained (Hiring Authority: Glen Pratt, Warden at CRC)

Video evidence confirmed that Officer [redacted] stated to many incarcerated people in the dayroom that [redacted] was responsible for officers recalling the dayroom, thereby endangering Mr. [redacted] and making him a target for retribution. Mr. [redacted] had refused to return to his cell because, as he explained on his 602, Officer [redacted] targeted him because he is black and transgender and has a mobility disability. He also alleged that Officer [redacted] used a racial slur toward him and destroyed sentimental cards made for him by his mother. *See* 602 at 4-5. On the video, Officer [redacted] responded to questions from incarcerated people regarding the reason for closing the dayroom by responding, "[h]e [Mr. [redacted]] doesn't want to lock up…once he locks up, I'll let everybody out again." *See* BWC at 19:48. Officer [redacted] also said, "[h]e [Mr. [redacted]] doesn't want to lock it up. Go talk to him, go talk to [redacted] in 142." *Id* at 19:48:40. In his interview with the investigator, Officer [redacted] admitted "when he closed the Dayroom, he should not have mentioned the reason" and, looking back, "he would not have told other inmates [redacted]'s name; he would have just closed the Dayroom." *See* Investigation Report at 5. The Hiring Authority should have sustained an allegation of endangerment against Officer [redacted].

8. RJD-[redacted] – AIU, Not Sustained (Hiring Authority: Kevin Hixon, Warden at NKSP)

In this case, [redacted] alleged that Officer [redacted] issued him a false and discriminatory RVR for indecent exposure when he was trying to clean himself following an incontinence accident. Officer [redacted]'s BWC footage shows her conducting count. *See* BWC at 21:17:08. When she approaches Mr. [redacted]'s cell, she shines her flashlight through the window and Mr. [redacted] can be heard saying, "I'm here." Officer [redacted] responds, "I can't see you, I have to see you, I can't see you with that curtain covering you." Mr. [redacted] then presumably follows her order and comes out from behind the curtain, though it is not possible to see what happens in the cell. Based on a review of this footage, the investigator concludes, "I did not observe [redacted] engage in the misconduct reported by [redacted]." *See* Investigation Report at 5.

However, the investigator failed to consider whether Mr. [redacted] was stuck between a rock and hard place in complying with the unnecessary order to come out from behind the curtain while cleaning himself, and whether Officer [redacted] should have been more accommodating of his disability and not have issued him an RVR for complying with her order. According to the DOM § 52020.5, "[a] positive/physical count means to count a living, breathing person and physically see that person." Officer [redacted] could see Mr. [redacted]'s face above the curtain, and verified that he was living and breathing when he stated "I'm here." Officer [redacted] was not conducting a standing count that would require Mr. [redacted] to present himself at his cell door.

D. Investigators Routinely Fail to Review Relevant Video Footage of Incidents

Defendants' investigators continue to fail to retain and review relevant video footage.[24] *See* RJD Remedial Plan, § IV; Five Prisons Remedial Plan, § V; *see also* November 2023 Report at 41-43; August 2023 Report at 33-35; May 2023 Report at 41-44; Feb. 2023 Report at 45-49.

For example, in SATF-[redacted], the class member alleged, in part, that officers deactivated their BWCs. This allegation would be simple to prove or disprove if the investigator pulled the officers' BWC footage. Yet the report includes no indication that

[24] Under the Remedial Plans and Defendants' BWC policy, Defendants must retain video footage for all triggering events, including, but not limited to, any allegation of staff misconduct, any PREA allegation, any allegation of misconduct by an incarcerated person, any suspected felonious criminal activity, and any use of force incident. *See, e.g.*, RJD Remedial Plan, § I; Operational Plan No. 28, § VII.B; Five Prisons Remedial Plan, Attachment A ("Operational Plan No. 131"), § VI.B.

the investigator even attempted to request video footage. In addition, in SATF-[redacted], a class member raised allegations about separate incidents on December 11, 2022 (alleging an officer discriminated against him) and December 19, 2022. Although the investigator retained footage for December 19, 2022, the investigator failed to retain footage for December 11, 2022. *See also* COR-[redacted]; KVSP-[redacted]; SATF-[redacted]; SATF-[redacted]; CIW-[redacted].

In other cases, investigators fail to request video within the 90-day retention period, causing the destruction of relevant video footage that is crucial to resolving serious staff misconduct allegations. In **KVSP-**[redacted] (discussed above), a class member alleged that an officer ignored him when he showed him that he had cut his wrist. The class member filed the 602 about 60 days after the incident, well within the 90-day retention period. The AIU, however, delayed nearly three months in assigning the case to investigator, by which time the BWC footage had been destroyed. Similar delays in assigning investigators to cases resulted in important footage being destroyed before it could be retained and reviewed. *See* LAC-[redacted] (claim of excessive force and retaliation claim); LAC-[redacted] (claim of racial discrimination). Plaintiffs have previously reported on this issue. See November 2023 Report at 42; August 2023 Report at 34-35; May 2023 Report at 42-44; Feb. 2023 Report at 46.

Finally, in other cases, CDCR failed to retain and produce video that investigators reviewed and that led to discipline, which prevents Plaintiffs and the Court expert from assessing whether the discipline was appropriate for the misconduct that occurred. The failure to retain video may also prevent the Hiring Authority from imposing adverse action. For example, in LAC-[redacted], [redacted] alleged that officers permitted three other incarcerated people to pack her property and keep some of Ms. [redacted]'s property. A local investigator reviewed BWC and "discovered possible staff misconduct" by Officer [redacted]. *See* Attachments at 5. However, the case file indicates that CDCR failed to retain the video footage that the investigator reviewed. *See* Attachments at 50. The Hiring Authority sustained the allegation against Officer [redacted] for two allegations of failure to observe and perform with the scope of training (D26). *See* 402/403. However, the Hiring Authority departed downward to corrective action in part because video had not been retained. Accordingly, CDCR's failure to retain video may have prevented the Hiring Authority from imposing adverse action when warranted and conceals the misconduct from Plaintiffs' review. *See also* LAC-[redacted] (video again not retained and Hiring Authority ordered corrective action for officer who harassed a class member).

E. AIU Investigations Continue to Be Delayed

AIU staff are continuing to fail to complete investigations by the deadlines set in the Remedial Plans: 120 days for investigations conducted by custody supervisors

(Sergeants and Lieutenants), who conduct nearly all AIU investigations,[25] and 180 days for investigations conducted by Special Agents. **The chart below shows that, for investigations the AIU received in December 2022 September 2023,[26] the AIU closed 29% of the investigations late. For the most recent three months of available data, the AIU closed 25% of investigations late.**

	MONTH RECEIVED	CLOSED-ONTIME	CLOSED-PASTDUE	OPEN	OPEN-PASTDUE	TOTAL	% LATE
2022	**December**	204	108	0	0	312	35%
2023	**January**	298	128	0	0	426	30%
	February	277	133	0	0	410	32%
	March	274	142	0	0	416	34%
	April	212	106	0	0	318	33%
	May	306	99	0	2	407	25%
	June	329	118	2	6	455	27%
	July	279	77	0	5	361	23%
	August	201	59	2	10	272	25%
	September	144	23	2	30	199	27%
	TOTAL	2,524	993	6	53	3,576	29%

F. Hiring Authorities Continue to Demonstrate They Cannot Keep Up With the Flow of Investigations

Hiring Authorities continue to undermine the procedural reforms to Defendants' system by delaying in reviewing and taking action on completed investigations. *See* November 2023 Report at 36-37; August 2023 Report at 12-13. According to data produced by Defendants on February 1, 2024, 45% percent (1,733 of 3,817) of the investigations that the AIU (a) received between December 2022 and January 2024 and (b) has completed are currently waiting for Hiring Authority action.[27] In these cases,

[25] In the last six months for which Plaintiffs have data (August 2023-January 2024), the AIU assigned 1,409 of 1,436 cases (98%) to be investigated by custody supervisors. The CST only assigned 27 of 1,436 cases (2%) to be investigated by Special Agents.

[26] Plaintiffs only present the data for August 2022 to May 2023 because the vast majority of investigations from more recent months (1) are not yet complete and (2) could not possibly be late because they have not yet run up against the deadlines in the Remedial Plan.

[27] Defendants indicated in their response to Plaintiffs' November 2023 Report that the data regarding cases pending with the Hiring Authorities may not be accurate. *See* Defs.' Resp. to Pls.' Nov. 2023 Report at 3. Defendants further indicated they were in the process of updating the Allegation Against Staff Tracking System ("AASTS") to eliminate these errors. *Id.* **Please provide an update regarding (1) whether**

Hiring Authority review is the only thing standing in the way of imposing important corrective or adverse action that can reduce future harm to class members, or exonerating officers who have not violated policy. These backlogs have gotten even worse since Plaintiffs' last report, in which Plaintiffs reported that 43% of completed investigations were pending action by the Hiring Authorities.

The problem is particularly acute at LAC (66% of completed investigations pending with Hiring Authority; 58% in last report), RJD (54%; 50% in last report), KVSP (45%; 23% in last report); SATF (36%; 40% in last report). Some of the cases pending with the Hiring Authority are very old. More than 350 of the still-pending cases were received by the AIU in December 2022-March 2023.

That Hiring Authorities are unable to handle the workload related to these investigations is unsurprising. The chart below shows the number of completed AIU investigations received by the Hiring Authorities at the Six Prisons from December 2022 to January 2023, along with a calculation, based on 250 working days per year, of the number of cases each Hiring Authority would need to resolve per day to keep up with the workload.

INSTITUTION	COMPLETED INVESTIGATIONS	CASES PER DAY
RJD	946	3.24
LAC	942	3.23
COR	746	2.55
SATF	735	2.52
KVSP	267	0.91
CIW	181	0.62

Given all of the other important duties that Hiring Authorities must perform to keep their prisons running, they do not have adequate time to give these cases the close reviews they require. To address a case, they must read the report, review the evidence (including video), and then conduct a 402/403 conference. Defendants have previously represented that a 402/403 conference for one case, standing alone, usually takes between 30 minutes and 2 hours. In light of this information and data, there are not enough hours in the day for the Hiring Authorities to resolve these cases and still manage their prisons. Moreover, this analysis does not even take into account the workload related to resolving inquiries conducted by LDIs, which also generally falls on the Hiring Authorities.

Plaintiffs have previously requested that Defendants move the responsibility for the accountability system from the institutional Hiring Authorities to personnel who have

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Defendants still contend the data is not accurate and (2) the status of Defendants' efforts to update AASTS to ensure the data is accurate.

the time, training, experience, independence, and seniority to perform it well. Defendants have previously stated that they could not do so because is essential that Hiring Authorities resolve cases affecting the institutions they run. Since May 2023, however, "Hiring Authorities from institutions with lower case numbers have been assigned to assist at institutions with higher case numbers to address the backlog of cases and to assist with the investigative review process or the disciplinary process, if applicable." *See* Defs.' Resp. to Pls.' Nov. 2023 Report at 3. The cases discussed in this Report reflect this change in practice, as nine of the cases were decided by Hiring Authorities other than the Hiring Authority at the institution from which the case arose.

This step by Defendants, to allow Hiring Authorities to make disciplinary decisions about staff working at other prisons, undermines Defendants' argument for why the responsibility for the accountability system must remain with the Hiring Authorities at specific institutions. **Accordingly, Plaintiffs again request that Defendants change the system to mandate that someone other than the institutional Hiring Authorities make decisions regarding how to resolve investigations. Plaintiffs also reiterate their request—which Defendants did not address in their Response to Plaintiffs' November 2023 Report—that Defendants set a deadline by which Hiring Authorities must resolve completed investigations.**

G. Officers Continue to Fail to Comply with BWC Policies

Plaintiffs' counsel reviewed BWC footage for the cases in Table A to assess officers' compliance with BWC policies and whether CDCR is holding officers accountable for non-compliance. Our review, even of this limited sample of cases, shows that staff continue to violate BWC policies and that investigators and Hiring Authorities often fail to take appropriate action when BWC videos reflect non-compliance. *See also* November 6 2023 Report at 50-51; August 11, 2023 Report at 37-42; May 12, 2023 Report at 45-48; February 10, 2023 Report at 49-52. Defendants' BWC policies mandate that officers must keep their BWCs activated for the entirety of an officer's shift, except

for specified deactivation events.[28] Officers must reactivate their cameras as soon as the deactivation event has concluded, and announce their reactivation.[29]

In at least one case, an officer's failure to comply with BWC policies prevented a full investigation into a use of force that injured a class member. In COR-[redacted], class member [redacted] alleged that officers used excessive force when bringing him to the ground while escorting him from an EOP group room. Mr. [redacted] sustained injuries to his face. *See* Exhibits at 35. However, Officer [redacted] (who initiated the force) had not reactivated his BWC after a strip search occurring some time earlier, preventing review of what happened before Officer [redacted] initiated force. *See* Investigation Report at 4. Officer [redacted] was present for the incident, but his back was turned when Officer [redacted] initiated force. *See* BWC at 10:53:18. Officer [redacted] also had reactivated his camera without announcement as he was opening a cage to escort Mr. [redacted] out of the EOP group room. *See* BWC at 10:52:57 (linked above). The context does not indicate that the escort followed immediately from a permissible deactivation event, so Officer [redacted]'s reactivation was impermissibly late. Only Officer [redacted] received an employee counseling record for his BWC noncompliance, and the record does not indicate that the Hiring Authority considered discipline against Officer [redacted] for his noncompliance or more serious discipline because Officer [redacted]'s noncompliance prevented a full investigation of the incident. *See* Exhibits at 58; 402/403 at 1, 5.

Officers continue to evade consequences for impermissible deactivations for "confidential interviews," as Plaintiffs have previously reported. *See, e.g.*, August 11, 2023 Report at 40-41; May 12, 2023 Report at 47-48. In KVSP-[redacted], class member

[28] *See* Connie Gipson, Clarification to the Body-Worn Camera Deactivation Events or Circumstances (November 7, 2022); Connie Gipson, Update to Body-Worn Camera Deactivation Events #2 (September 1, 2022); Connie Gipson, Update to Body-Worn Camera Deactivation Events (Aug. 19, 2021); *see, e.g.*, Operational Plan No. 28 § VI.B.10; Five Prisons Remedial Plan, Attachment B (Local Operations Procedure 944) § VI.B.10. Before deactivating their cameras, officers must announce the reason for the deactivation so that it is recorded by the BWC. Operational Plan No. 28 § VI.B.10; Local Operations Procedure § VI.B.10.

[29] Defendants' local operating procedures state, "[s]taff will make an audible statement when the body-worn camera has been reactivated." *See, e.g.*, BWC Operational Plan No. 28 § VI.B.11 (RJD); Five Prisons Remedial Plan, Local Operations Procedures § VI.B.11 (LAC). Plaintiffs note that Defendants' September 1, 2022 and November 7, 2022 Memos both fail to clarify that staff are required to make an audible statement when the body-worn camera has been reactivated. They should be revised to ensure staff understand this requirement.

[redacted] alleged that two sergeants and a lieutenant failed to allow Mr. [redacted] to sign a compatibility chrono to remain on Facility C. Instead, the supervisors falsely stated that Mr. [redacted] refused to sign the chrono and placed him in administrative segregation as a result. BWC shows Mr. [redacted] ask Sergeant [redacted] if he can sign the compatibility chrono, at which point Sergeant [redacted] deactivates his BWC for a "confidential interview." *See* BWC at 14:01:15. Another officer present keeps his BWC on the entire time, which shows Lt. [redacted] complete a lockup order despite Mr. [redacted]'s request to sign the compatibility chrono, as discussed further in Table A. *See* Investigation Report at 4. The case file contains no indication that the Hiring Authority (or investigator) evaluated Sergeant [redacted]'s misconduct. Interviews with class members about their safety concerns are not automatically assumed to be an interview with a "confidential informant."

In CIW-[redacted], the investigator also mistakenly assumed that an interview would be "considered confidential," and that the sergeant did not need to activate their BWC. *See* Inquiry Report at 5. As a result, the investigator did not even attempt to request the footage.

II. DEFENDANTS ARE FAILING TO PROPERLY IDENTIFY AND ROUTE STAFF MISCONDUCT COMPLAINTS

A. The CST is Inappropriately Routing Staff Misconduct Complaints as "Routine" Grievances

The CST continues to route as "routine" far too many grievances that contain clear allegations of staff misconduct. The CST may only classify a grievance as "routine" if it does not include an allegation of staff misconduct. A grievance contains a staff misconduct allegation if it alleges an employee engaged in "behavior that results in a violation of law, regulation, policy, or procedure, or actions contrary to an ethical or professional standard." *See* Cal. Code Regs. Tit. 15, § 3486(c)(22).

Plaintiffs reviewed the random sample of grievances for Q4 2024 from class members at the Six Prisons that the CST determined do not allege misconduct, which was produced by Defendants on January 4, 2024. In **22 out of 97[30] cases (or 23%)**, Plaintiffs disagree with the CST's determination that the grievance contains no staff misconduct allegation.[31] Once again, in nearly every case where Plaintiffs disagree with the CST, the

[30] Defendants' random sample produced for this quarter was missing three grievances, which we omit from the count.

[31] Plaintiffs are counting two grievances as correctly screened as "routine" by the CST that allege staff misconduct on their face, but where the allegations are factually impossible. The number of grievances with "factually impossible" allegations of staff

staff misconduct allegation is clear and unambiguous. In a majority of those cases, the complaint included allegations of staff misconduct on the ADI, and therefore should have been investigated by the AIU.

The very high error rate actually underestimates the problem. The sample produced by Defendants is diluted by the influx of 1824s into the staff complaint screening process. 1824s are more likely to present routine issues, as opposed to staff misconduct complaints. More than one-third of the Q4 2024 sample of "routine" grievances were submitted on 1824s (33 out of 97), and Plaintiffs only disagreed with the CST's determination regarding three of these 1824s (or 9%). If 1824s are excluded, Plaintiffs disagreed with the CST in **19 out of 64 cases (or 30%)**. This is unsurprising, as the vast majority of 1824s involve straightforward requests for lower bunks, durable medical equipment, and other disability accommodations, and incarcerated persons are more likely to raise a staff complaint on a 602. **For this reason, Plaintiffs again request that, moving forward, Defendants produce a sample of 150 grievances screened routine by the CST per quarter, and that at least 100 of those grievances be 602s.**

Plaintiffs' complete analysis of the Q4 2024 sample, including a full list of the grievances that the CST improperly routed as "routine," is included as **APPENDIX A**. **Plaintiffs request that Defendants provide their position on whether the CST improperly routed each of the 22 grievances described in APPENDIX A, and if not, the basis for their disagreement with Plaintiffs' position.**

The following examples are illustrative of complaints that the CST erroneously classified as not including an allegation of staff misconduct:

- [redacted] – The person alleges officers did not intervene when another incarcerated person assaulted him, and then forced him to sign a "get along" chrono even though the assailant threatened to assault him again in front of the officers. This allegation of endangerment and creating an opportunity for an incarcerated person to harm another is on the ADI. *See* Other Misconduct (2); Integrity (1).
- [redacted] – The person alleges that an officer refused to allow him to take an incontinence shower and questioned whether he was allowed to use the top tier shower because of his disability. *See* Discrimination/Harassment (3).
- [redacted] – The person alleges officers refused to investigate his safety concerns after he reported that he had been warned that people were "plotting my attack," refusing to interview his witness, and that his safety concerns were not addressed.

misconduct remains very low (only 2 of 97, or 2%). These two grievances were filed by the same person about one month apart, and raise the same allegations regarding the use of a "microwave weapon" by CDCR.

This allegation of endangerment and creating an opportunity for an incarcerated person to harm another is on the ADI. *See* Other Misconduct (2); Integrity (1).

- [redacted] – The person alleges that officers are retaliating against him for filing a 602 alleging excessive force against their co-worker by refusing to allow him to bring his pen and notepad to his mental health appointments, as his clinician requests. He was always permitted to do so until he filed the grievance, but "staff suddenly told me that I cannot take my writing material." *See* Retaliation (1), (2).

- [redacted] – The person alleges he is denied a work assignment because he is legally blind, even though he is able to work, and that "[t]here are nearly no 'ADA' inmates with paying job assignments." *See* Discrimination/Harassment (3).

- [redacted] – The person alleges that officers "keep harassing me, trying to force people I don't feel comfortable/safe w/ in my cell then writing me up," and explains he has been trying to reinstate his single cell status after being a victim of rape and transferring from another prison due to enemy concerns. This allegation of endangerment is on the ADI. *See* Other Misconduct (2).

- [redacted] – The person alleges that the mail room supervisor is interfering with his legal mail and refuses to send his 602s to the Office of Appeals. The allegation of interfering with reporting misconduct is on the ADI. *See* Code of Silence (4).

Our finding that Defendants are erroneously classifying many complaints as routine is consistent with data produced by Defendants which show a marked increase in the number of complaints that the CST is classifying as routine starting around September 2023. Though the overall number of grievances increased significantly at around that time, the number of grievances identified by the CST as containing an allegation of staff misconduct decreased dramatically at the same time.

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YEAR	MONTH REC'D	AIMS/AIU	HA/LDI	OIA	ROUTINE	TOTAL	TOTAL STAFF MISCONDUCT (AIMS/AIU + HA/LDS + OIA)
2022	**December**	350	340	4	2,913	3,607	694
2023	**January**	430	432	4	3,141	4,007	866
	February	419	323	7	2,452	3,201	749
	March	388	328	5	3,034	3,755	721
	April	310	316	1	2,942	3,569	627
	May	405	447	5	3,142	3,999	857
	June	486	382	7	3,803	4,678	875
	July	353	338	1	3,847	4,539	692
	August	299	317	0	4,888	5,504	616
	September	212	203	1	5,401	5,817	416
	October	228	209	1	5,741	6,179	438
	November	209	171	9	4,897	5,286	389
	December	260	220	0	4,830	5,310	480
2024	**January**	277	173	0	5,384	5,834	450
TOTAL		4,626	4,199	45	56,415	65,285	8,870

Defendants' data also shows the potential scope of the problem with the CST's improper routing decisions. In January 2024, at just the Six Prisons, there were 5,384 grievances that the CST classified as routine. Applying the 23% error rate Plaintiffs identified above would mean that the CST misrouted 1,238 staff misconduct complaints as routine grievances in January alone. In this hypothetical, the number of misrouted complaints would be almost three times more than the number of complaints that the CST identified as containing allegations of staff misconduct (1,238 v. 450).

The Office of the Inspector General has also confirmed serious problems with CDCR's routing of staff complaints. The OIG issued a scathing special report in which it found that CDCR had reclassified nearly 600 staff complaints (i.e., complaints that the CST had identified as staff complaints) into routine grievances because CDCR lacked the resources to investigate the claims. *See* OIG, Special Review: The Department Violated its Regulations by Redirecting Backlogged Allegations of Staff Misconduct to Be Processed as Routine Grievances, Jan. 29, 2024; Email from [redacted] to CDCR, Feb. 2, 2024.

In addition, the OIG published a series of "case block" reports that highlight additional problems with the CST's routing of staff complaints. In one case discussed by the OIG, an *Armstrong* class member who uses a wheelchair claimed that, among other allegations, a nurse left him on the floor of his cell for two hours while he was requesting assistance and told another nurse not to help him. The CST did not identify this staff misconduct allegation until the OIG elevated the case. The CST agreed to conduct a clarifying interview, but then backtracked based on a review of records that revealed that the nurse had documented that the class member had been disruptive and disrespectful

toward staff possibly on the day prior to the alleged incident. The CST routed the case as routine. As the OIG explained, "the screening team's explanation was unrelated to the incarcerated person's allegation that he was left on the floor for hours." *See* OIG, October 2023 Centralized Screening Monitoring Team Case Blocks, Dec. 2023, at 4-5.

Other cases discussed by the OIG reflected similar problems. *See* OIG, November 2023 Centralized Screening Monitoring Team Case Blocks, Jan. 2024, at 2-3 (CST routed as routine obvious excessive force allegations); *id.* at 3-4 (CST originally routed as routine clear allegations of excessive force and a related cover up); *id.* at 4-5 (CST only properly routed complaint—a doctor sexually harassed a patient and then discontinued pain medication when the patient reported the harassment—to AIU after OIG elevated the issue twice); *id.* at 6-7 (CST failed to recognize retaliation complaint—sergeant issued incarcerated person a counseling chrono in retaliation for prior grievance filed against the sergeant); *id.* at 7-8 (CST failed to recognize claim of disability discrimination).

B. The CST Is Improperly Routing Serious Staff Misconduct Complaints Back to Prisons Instead of the OIA

A non-exhaustive review of cases for this production period confirmed that, even where the CST correctly identifies an allegation of staff misconduct, the CST frequently does not recognize that the staff misconduct allegation is on the ADI, and thus improperly routes it back to the institution for an inquiry by an LDI, rather than to the OIA for an investigation by the AIU. **Plaintiffs request that Defendants indicate whether they agree that the CST improperly routed each of the grievances described in this section, and if not, the basis for their disagreement with Plaintiffs' position.**

The following are illustrative examples of cases routed for local inquiries that should have been routed to the AIU for investigation:

- RJD-[redacted] (*see* 602 at 2-3) – The person alleges that officers paid incarcerated persons to attack him ("to jump [me], to have [me] rolled up"), and that the officers spread the false rumor that he is a "snitch" because he has filed staff complaints in the past. This allegation falls under multiple ADI categories, including retaliation, code of silence, endangerment, and creating a motive for incarcerated persons to harm another. *See* Retaliation (1), (2); Code of Silence (1); Integrity (1); Other Misconduct (2).

- SATF-[redacted] (*see* 602 at 10-11) – The person alleges a correctional counselor told him "she is tired of me and is going to have my DPV status taken away" by asking medical staff to review footage of him being assaulted by other incarcerated persons. The correctional counselor told him that since he was able to defend himself, his vision disability code should be taken away. He alleges that

"this is manipulation" and "disability-based discrimination" by the correctional counselor "so she can ship me out to a non DPV prison." *See* Discrimination/Harassment (2), (3).

- LAC-[redacted] (*see* 602 at 6-7) – The person alleges officers refused to contact medical staff after his neighbor called out that he needed medical assistance, and that the officers delayed for 15 to 20 minutes before checking on him and still refused to call for medical staff when they finally did. This endangerment allegation is on the ADI. *See* Other Misconduct (2).

- RJD-[redacted] (*see* 602 at 2-3) – The person alleges he reported suicidality to the housing officers during third watch, but his cries for help were ignored, with several officers telling him that "my concerns would have to wait until the following morning because they were all too busy writing reports." This endangerment allegation is on the ADI. *See* Other Misconduct (2).

- LAC-[redacted] (*see* 602 at 1-2) – The person alleges that an officer is "trying to degrade me" in front of other incarcerated persons, ridiculing him for not getting into a fight to make him "look a punk" so somebody will "hit me in the face." He alleges the officer is acting in retaliation for him filing staff complaints against the officer. This allegation falls under multiple ADI categories, including retaliation for using the grievance process and creating a motive for incarcerated people to harm others. *See* Retaliation (2); Integrity (1).

- KVSP-[redacted] (*see* 602 at 7-8) – The person alleges two officers "intentionally harass[ed] and discriminat[ed] against" him by not allowing him to pick up his incontinence supplies, an allegation of disability discrimination that is on the ADI. *See* Discrimination/Harassment (3).

- CIW-[redacted] (*see* 602 at 8-11) – The person alleges that an officer issued her a false RVR in retaliation for filing staff complaints against the officer, which is on the ADI. *See* Retaliation (1), (2); Dishonesty (2).

The OIG, in its review of the CST, has identified similar problems. For example, in one case reviewed by the OIG, the CST originally routed to an LDI allegations that a nursing assistant told a suicidal person to kill himself and to stop asking for help if he wanted to die, and called him a "scumbag." *See* OIG, November 2023 Centralized Screening Monitoring Team Case Blocks, at 3; *see also id.* at 6 (CST originally routed complaint—nursing assistant swore at an incarcerated person and told him to kill himself, resulting in a suicide attempt the next day—to LDI, rather than to AIU). The CST only routed the allegations to the AIU after the OIG elevated the case.

III. CONCLUSION

Pursuant to the parties' agreement, we expect to receive a response to this report from Defendants by March 15, 2024. 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.

APPENDIX A

Cases highlighted in yellow are cases that the CST improperly routed as routine because the complaints contained allegations of staff misconduct.

Prod. No.	Last Name	CDCR No.	Grievance No.	Type of Grievance	Date Rec'd	Summary of Allegation	Alleges Staff Misc.	On ADI?	Factually Imposs.?	Clarifying Interview Required?
1	[redacted]	[redacted]	[redacted]	1824	12/26/2023	Requesting a different type of trach tie to hold tracheal tube in place	No			
2	[redacted]	[redacted]	[redacted]	1824	12/14/2023	Requesting pocket talker	No			
3	[redacted]	[redacted]	[redacted]	1824	10/9/2023	Requesting compression stockings	No			
4	[redacted]	[redacted]	[redacted]	602	12/21/2023	Officers intentionally gave him contaminated food that made him sick	Yes	No	No	
5	[redacted]	[redacted]	[redacted]	602	12/11/2023	CDCR did not send records to sentencing court	No			
6	[redacted]	[redacted]	[redacted]	602	10/6/2023	Credits not calculated properly	No			
7	[redacted]	[redacted]	[redacted]	1824	11/22/2023	After he was granted MSF placement, the CC-I denied him a gate pass because of his disability	Yes	Discrimination/ Harassment (3)	No	
8	[redacted]	[redacted]	[redacted]	602	10/16/2023	Requesting assignment to vocational electronics; on wait list for months.	No			
9	[redacted]	[redacted]	[redacted]	GRIEVANCE MISSING		EXCLUDE FROM SAMPLE				

Prod. No.	Last Name	CDCR No.	Grievance No.	Type of Grievance	Date Rec'd	Summary of Allegation	Alleges Staff Misc.	On ADI?	Factually Imposs.?	Clarifying Interview Required?
10	[redacted]	[redacted]	[redacted]	1824	10/13/2023	Requesting talking books; waiting for months since he was approved.	No			
11	[redacted]	[redacted]	[redacted]	602	10/30/2023	CO refuses to put in work order to fix the power in his cell because of the CO's animosity to him ("this is staff misconduct for hating on me"); this is not the first time the CO refused to put in work orders because the CO "don't like me"	Yes	No	No	
12	[redacted]	[redacted]	[redacted]	602	11/13/2023	Disputing Classification Committee findings	No			
13	[redacted]	[redacted]	[redacted]	1824	11/3/2023	Requesting ADA Bag to carry items w/ walker	No			
14	[redacted]	[redacted]	[redacted]	602	11/8/2023	Reporting missing property.	No			
15	[redacted]	[redacted]	[redacted]	602	10/6/2023	Requesting cheaper and better canteen items	No			
16	[redacted]	[redacted]	[redacted]	602	12/11/2023	Two Sergeants lied on responses to his 602 and refused to check BWC footage. One of the Sergeants was not wearing her BWC.	Yes	Dishonesty (1)	No	
17	[redacted]	[redacted]	[redacted]	602	10/12/2023	Reporting delay in receiving tablet	No			

Prod. No.	Last Name	CDCR No.	Grievance No.	Type of Grievance	Date Rec'd	Summary of Allegation	Alleges Staff Misc.	On ADI?	Factually Imposs.?	Clarifying Interview Required?
18	[redacted]	[redacted]	[redacted]	1824	10/11/2023	Requesting hearing aids	No			
19	[redacted]	[redacted]	[redacted]	602	11/15/2023	Her Gender Identity Questionnaire (GIQ) was "altered" by a Lieutenant to say she is male/not transgender. She requests that it be changed back so that her gender identity is accurate.	Yes?	Discrimination/ Harassment (3)?	No	Yes, to clarify that she is alleging that the Lieutenant who "altered" her GIQ did so with a discriminatory motive.
20	[redacted]	[redacted]	[redacted]	602	10/25/2023	Requesting indigent envelopes and reporting that LAC is not allowing people to get them	No			
21	[redacted]	[redacted]	[redacted]	602	12/11/2023	Reporting delay in receipt of property.	No			
22	[redacted]	[redacted]	[redacted]	1824	10/12/2023	Requesting CART as an accommodation for hearing disability.	No			
23	[redacted]	[redacted]	[redacted]	1824	12/12/2023	Requesting to move from lower bunk	No			
24	[redacted]	[redacted]	[redacted]	1824	11/6/2023	Requesting Halal diet	No			
25	[redacted]	[redacted]	[redacted]	1824	10/27/2023	Requesting batteries for TENS unit	No			

Prod. No.	Last Name	CDCR No.	Grievance No.	Type of Grievance	Date Rec'd	Summary of Allegation	Alleges Staff Misc.	On ADI?	Factually Imposs.?	Clarifying Interview Required?
26	[redacted]	[redacted]	[redacted]	602	11/2/2023	Reporting problem making phone calls and requesting that pin be reset	No			
27	[redacted]	[redacted]	[redacted]	602	11/17/2023	Reporting delay in receipt of property.	No			
28	[redacted]	[redacted]	[redacted]	602	10/18/2023	Reporting delay in receipt of property.	No			
29	[redacted]	[redacted]	[redacted]	602	12/8/2023	Reporting lost property.	No			
30	[redacted]	[redacted]	[redacted]	Citizen's Complaint	11/27/2023	Staff acted w/ deliberate indifference during the Nov. 2023 power outage at RJD. They were forced to live in inhumane conditions, and staff refused to provide them information about what was happening or how long the power would be out.	Yes	No	No	
31	[redacted]	[redacted]	[redacted]	602	10/2/2023	Officer did not intervene when an incarcerated person assaulted him, and then forced him to sign a "get along" chrono even though the assailant threatened to assault him again in front of the officers.	Yes	Other Misconduct (2); Integrity (1)	No	

Prod. No.	Last Name	CDCR No.	Grievance No.	Type of Grievance	Date Rec'd	Summary of Allegation	Alleges Staff Misc.	On ADI?	Factually Imposs.?	Clarifying Interview Required?
32	[redacted]	[redacted]	[redacted]	602	10/13/2023	Case worker refused to provide his C-files for Olson review for two months and then yelled at him "this isn't open line" when he went to her office to ask about it, even though she had just answered a Black incarcerated person's questions	Yes	Discrimination/ Harassment (3)?	No	Yes, to clarify if he is alleging the discourteous behavior was motivated by race, in light of his comparison with the case worker's different treatment of a Black person
33	[redacted]	[redacted]	[redacted]	1824	11/3/2023	Requesting new headphones	No			
34	[redacted]	[redacted]	[redacted]	1824	10/23/2023	Requesting wedge pillow	No			
35	[redacted]	[redacted]	[redacted]	1824	10/3/2023	Requesting extra blanket	No			
36	[redacted]	[redacted]	[redacted]	602	10/19/2023	Requesting canteen items	No			
37	[redacted]	[redacted]	[redacted]	1824	11/20/2023	Requesting new power cord for C-PAP machine	No			

Prod. No.	Last Name	CDCR No.	Grievance No.	Type of Grievance	Date Rec'd	Summary of Allegation	Alleges Staff Misc.	On ADI?	Factually Imposs.?	Clarifying Interview Required?
38	[redacted]	[redacted]	[redacted]	602	12/12/2023	(1) The Control Officer refused to allow him to take an incontinence shower and questioned whether he was allowed to use the top tier shower because of his disability; and (2) The Control Officer also uses her state phone for personal calls while on duty, and often is not monitoring the housing unit while on duty, in violation of policy.	Yes	Discrimination/ Harassment (3)	No	
39	[redacted]	[redacted]	[redacted]	1824	10/9/2023	Requesting locker to be raised off the ground because it is hard to bend down to reach it	No			
40	[redacted]	[redacted]	[redacted]	602	10/20/2023	Officers refused to investigate his safety concerns after he reported he had been warned that people were "plotting my attack," refusing to interview his witness, and his safety concerns were not addressed.	Yes	Other Misconduct (2); Integrity (1)	No	

Prod. No.	Last Name	CDCR No.	Grievance No.	Type of Grievance	Date Rec'd	Summary of Allegation	Alleges Staff Misc.	On ADI?	Factually Imposs.?	Clarifying Interview Required?
41	[redacted]	[redacted]	[redacted]	602	10/19/2023	Objecting to withdrawal of money from his trust account to pay his restitution and fines	No			
42	[redacted]	[redacted]	[redacted]	1824	11/6/2023	Requesting headphones to go over hearing aids	No			
43	[redacted]	[redacted]	[redacted]	602	10/30/2023	Reporting problem with canteen	No			
44	[redacted]	[redacted]	[redacted]	602	11/6/2023	Property officer is harassing him because he is EOP, including by manipulating him into giving up his TV while in the ASU, and then trying to prevent him from getting a new one.	Yes	Discrimination/ Harassment (2)	No	

Prod. No.	Last Name	CDCR No.	Grievance No.	Type of Grievance	Date Rec'd	Summary of Allegation	Alleges Staff Misc.	On ADI?	Factually Imposs.?	Clarifying Interview Required?
45	[redacted]	[redacted]	[redacted]	602	11/30/2023	Escort officers are retaliating against him for filing a 602 alleging excessive force against their co-worker by refusing to allow him to bring his pen and notepad to mental health appointments, as his clinician requests. He was always allowed to do so until he filed the 602, but "staff suddenly told me that I cannot take my writing material."	Yes	Retaliation (1),(2)	No	
46	[redacted]	[redacted]	[redacted]	Citizen's Complaint	12/8/2023	Sergeant was discourteous when he did not immediately respond when his name was called, threatening him with an RVR and becoming verbally aggressive to him.	Yes	No		
47	[redacted]	[redacted]	[redacted]	1824	12/11/2023	Requesting DME for hearing disability	No			
48	[redacted]	[redacted]	[redacted]	1824	11/13/2023	Requesting special cuffing chrono	No			
49	[redacted]	[redacted]	[redacted]	602	10/6/2023	Reporting conspiracy to use "microwave weapon"	Yes		Yes	

Prod. No.	Last Name	CDCR No.	Grievance No.	Type of Grievance	Date Rec'd	Summary of Allegation	Alleges Staff Misc.	On ADI?	Factually Imposs.?	Clarifying Interview Required?
50	[redacted]	[redacted]	[redacted]	602	11/7/2023	Reporting conspiracy to use "microwave weapon"	Yes		Yes	
51	[redacted]	[redacted]	[redacted]	602	10/10/2023	Officers are stealing food that is meant for incarcerated people.	Yes	No	No	
52	[redacted]	[redacted]	[redacted]	602	11/6/2023	Disputing calculation of credits	No			
53	[redacted]	[redacted]	[redacted]	602	10/5/2023	Reporting that items have gone missing from his outgoing mail	No			
54	[redacted]	[redacted]	[redacted]	1824	11/27/2023	Requesting replacement for broken DME	No			
55	[redacted]	[redacted]	[redacted]	1824	11/13/2023	Requesting removal of lower bunk chrono	No			
56	[redacted]	[redacted]	[redacted]	1824	10/26/2023	Requesting headphones for tablet	No			
57	[redacted]	[redacted]	[redacted]	602	10/3/2023	Officer made false statements on an RVR, as the officer was not actually present and did not observe the alleged misconduct, but falsely claimed that he did.	Yes	Dishonesty (2)	No	
58	[redacted]	[redacted]	[redacted]	602	10/27/2023	Objecting to CDCR's mail policy	No			
59	[redacted]	[redacted]	[redacted]	602	12/6/2023	Reporting delay in repairing toilet	No			
60	[redacted]	[redacted]	[redacted]	602	10/25/2023	Reporting delay in receiving tablet.	No			

Prod. No.	Last Name	CDCR No.	Grievance No.	Type of Grievance	Date Rec'd	Summary of Allegation	Alleges Staff Misc.	On ADI?	Factually Imposs.?	Clarifying Interview Required?
61	[redacted]	[redacted]	[redacted]	1824	11/21/2023	He has been denied a work assignment even though he is physically able to work because he is legally blind: "I'm being discriminated against as a legally blind person who wants to work like regular able bodied inmates.... There are nearly no 'ADA' inmates with paying job assignments."	Yes	Discrimination/ Harassment (3)	No	
62	[redacted]	[redacted]	[redacted]	1824	11/7/2023	Officer threatened him with an RVR because he was changing his diaper when the officer looked into his cell.	Yes	Discrimination/ Harassment (3); Other Misconduct (4)	No	
63	[redacted]	[redacted]	[redacted]	1824	10/27/2023	Requesting alarm watch due to hearing loss	No			
64	[redacted]	[redacted]	[redacted]	1824	12/11/2023	Requesting pocket talker	No			
65	[redacted]	[redacted]	[redacted]	1824	11/20/2023	Requesting orthopedic shoes	No			
66	[redacted]	[redacted]	[redacted]	602	10/30/2023	Objecting to RVR on procedural grounds.	No			
67	[redacted]	[redacted]	[redacted]	602	10/3/2023	Objecting to withdrawal of money from his trust account to pay his fines	No			

Prod. No.	Last Name	CDCR No.	Grievance No.	Type of Grievance	Date Rec'd	Summary of Allegation	Alleges Staff Misc.	On ADI?	Factually Imposs.?	Clarifying Interview Required?
68	[redacted]	[redacted]	[redacted]	NOT A GRIEVANCE (LETTER TO THE US DEP'T OF TREASURY THAT WAS RETURNED TO SENDER)		EXCLUDE FROM SAMPLE				
69	[redacted]	[redacted]	[redacted]	602	10/30/2023	Objecting to refusal to deliver incoming mail that was found to contain sexually explicit material	No			
70	[redacted]	[redacted]	[redacted]	602	10/4/2023	Officer stole his mail rather than delivering it to the mail room to be sent to intended recipient	Yes	No	No	
71	[redacted]	[redacted]	[redacted]	602	12/5/2023	Kitchen did not serve hot links to his building because they ran out	No			
72	[redacted]	[redacted]	[redacted]	602	12/15/2023	Objecting to denial of request for kosher diet	No			
73	[redacted]	[redacted]	[redacted]	1824	11/13/2023	Requesting wheelchair footrests	No			

Prod. No.	Last Name	CDCR No.	Grievance No.	Type of Grievance	Date Rec'd	Summary of Allegation	Alleges Staff Misc.	On ADI?	Factually Imposs.?	Clarifying Interview Required?
74	[redacted]	[redacted]	[redacted]	602-HC	10/20/2023	(1) "Cos keep harassing me, trying to force people I don't feel comfortable/safe w/ in my cell then writing me up." He has been trying to reinstate his single cell status after being a victim of rape and transferring from another prison due to enemy concerns; and (2) He fell off the top bunk and had to go to the hospital after officers grabbed him and "threatened me to go to the top bunk or else I'll face consequences."	Yes	Other Misconduct (2)	No	
75	[redacted]	[redacted]	[redacted]	602	10/31/2023	Objecting on procedural grounds to SHU term	No			
76	[redacted]	[redacted]	[redacted]	602	11/14/2023	Objecting on procedural grounds to SHU term	No			
77	[redacted]	[redacted]	[redacted]	602	10/31/2023	Reporting unsanitary conditions due to birds living in the cell block.	No			
78	[redacted]	[redacted]	[redacted]	1824	11/14/2023	Request for ortho consult due to broken braces	No			

Prod. No.	Last Name	CDCR No.	Grievance No.	Type of Grievance	Date Rec'd	Summary of Allegation	Alleges Staff Misc.	On ADI?	Factually Imposs.?	Clarifying Interview Required?
79	[redacted]	[redacted]	[redacted]	602	12/4/2023	Objecting to restrictive housing placement	No			
80	[redacted]	[redacted]	[redacted]	602	11/15/2023	Reporting that shower is filthy	No			
81	[redacted]	[redacted]	[redacted]	602	10/25/2023	His family visiting request forms were lost by the correctional counselor, causing him to be denied family visiting for four straight months.	No			
82	[redacted]	[redacted]	[redacted]	1824	10/31/2023	Requesting walker and cane	No			
83	[redacted]	[redacted]	[redacted]	1824	12/26/2023	Requesting release date and to see case manager	No			
84	[redacted]	[redacted]	[redacted]	602	11/9/2023	Reporting that a book he ordered was never delivered to him	No			
85	[redacted]	[redacted]	[redacted]	602	12/5/2023	Requesting laundry	No			
86	[redacted]	[redacted]	[redacted]	602	10/23/2023	Disputing facts underlying RVR.	No			
87	[redacted]	[redacted]	[redacted]	1824	11/28/2023	Requesting seated walker	No			
88	[redacted]	[redacted]	[redacted]	602	11/7/2023	Officer is retaliating against him for filing a 602	Yes	Retaliation (2)	No	Yes, but only to clarify what action the person alleges was retaliatory.

Prod. No.	Last Name	CDCR No.	Grievance No.	Type of Grievance	Date Rec'd	Summary of Allegation	Alleges Staff Misc.	On ADI?	Factually Imposs.?	Clarifying Interview Required?
89	[redacted]	[redacted]	[redacted]	1824	11/27/2023	Request for single-cell housing because his incontinence is causing issues with cellmates.	No			
90	[redacted]	[redacted]	[redacted]	602	12/18/2023	Requesting replacement TV for one broken by custody, without alleging they violated policy	No			
91	[redacted]	[redacted]	[redacted]	602	12/18/2023	Reporting broken microwave	No			
92	[redacted]	[redacted]	[redacted]	602	10/31/2023	Officers disrespected and harassed him while he was doing his assigned job duties by saying he looked suspicious and falsely accusing him of stealing trays from the dining hall	Yes	No		
93	[redacted]	[redacted]	[redacted]	602	11/30/2023	Requesting that his phone pin be reset	No			
94	[redacted]	[redacted]	[redacted]	602	11/1/2023	Mail room supervisor is interfering with his legal mail and refusing to send his 602s to the Office of Appeals.	Yes	Code of Silence (4)	No	

Prod. No.	Last Name	CDCR No.	Grievance No.	Type of Grievance	Date Rec'd	Summary of Allegation	Alleges Staff Misc.	On ADI?	Factually Imposs.?	Clarifying Interview Required?
95	[redacted]	[redacted]	[redacted]	602	11/7/2023	Objecting to policy of handcuffing people for medical escorts rather than using waist restraints	No			
96	[redacted]	[redacted]	[redacted]	602	12/6/2023	Property was lost when she was moved to MHCB	No			
97	[redacted]	[redacted]	[redacted]	602	12/4/2023	Reporting that he was supposed to only receive 90 day restriction on tablet use during ASU term	No			
98			[redacted]	NO GRIEVANCE (LOG NO. CREATED IN ERROR)		EXCLUDE FROM SAMPLE				
99	[redacted]	[redacted]	[redacted]	602	10/30/2023	Disputing trust account withdrawal	No			
100	[redacted]	[redacted]	[redacted]	602	12/1/2023	Objecting to quality of food	No			

APPENDIX B

KVSP

[redacted]	The class member filed a 602 on August 13, 2022 alleging that staff failed to address his safety concerns. AIU assumed responsibility for the case on September 7, 2022, within the 90-day retention period. Yet AIU did not assign an investigator to the case until November 20, 2022, and the investigator was unable to review any BWC footage because none had been retained. For more information on this case, see writeup for **KVSP-**[redacted].
[redacted]	The class member alleged that a sergeant deactivated his BWC and threatened the class member. The class member specifically identified two officers whose BWCs may have captured the conversation, but the investigator reported reviewing footage from only one officer, and Defendants produced footage from only that one officer. The investigator should have reviewed footage from all potential witnesses to assess whether the alleged conduct occurred.

COR

[redacted]	The class member alleged that staff used excessive force against him. The investigator failed to request sufficient video footage to investigate the allegation, as the subject officer's BWC does not capture the actions of all officers involved in the incident. The investigator should have requested AVSS to gain a more comprehensive view of the force used.

LAC

[redacted]	The investigator failed to investigate the status of Officer [redacted]'s BWC footage. The investigator requested the BWC footage, but learned that "the footage for [redacted]'s assigned BWC was worn by an unidentified officer, who appeared to be assigned in another housing unit." Once on notice of this potential BWC issue, the investigator took no further steps to ascertain why Officer [redacted] was wearing the wrong BWC or whether that footage was still available. For further discussion, see case writeup for **LAC-**[redacted].
[redacted]	See discussion above for **LAC-**[redacted].

[redacted]	The class member alleged that two staff members had a personal relationship that caused the involved lieutenant to threaten the class member to withdraw a staff misconduct complaint. Even though the class member promptly filed the 602 after the alleged events and an AIU investigator was assigned within the retention period, CDCR failed to retain the relevant video.
[redacted]	The class member alleged that an officer was harassing him on the basis of race and filed a 602 the same day. CDCR referred the case to AIU promptly, but failed to assign an investigator until the 90-day retention period had lapsed, causing the destruction of any relevant video.
[redacted]	The class member alleged that an officer degraded him after the class member did not fight another incarcerated person. The Hiring Authority ordered corrective action based on the BWC footage that the investigator reviewed, but the BWC footage was not retained and thus not produced to Plaintiffs.

SATF

[redacted]	The investigator did not appear to review video from the IERC process, including the class member's videotaped interview about the allegations and the class member's injuries.
[redacted]	The class member alleged that the officers involved deactivated their BWCs during the interaction. The investigator failed to seek BWC footage, which would have proved or denied whether this in fact occurred. The case file and report include no indication that the investigator requested video footage.
[redacted]	The class member alleged that the subject officer issued a retaliatory RVR after a verbal disagreement. It is unclear why the AIU investigator was unable to review BWC footage. Although the investigator requested BWC over 90 days after the incident, the BWC was retained for the class member's RVR hearing. The Hearing Officer at the RVR relied on the BWC footage in question, so it should have remained in CDCR's possession and the investigator should have reviewed it to determine what occurred.
[redacted]	See discussion above for **SATF-**[redacted].
[redacted]	The grievance raised allegations about events over a series of identified dates between December 5, 2022 and December 18, 2022. However, the AIU investigator failed to review and CDCR

	failed to produce BWC footage from nearly all of the identified dates.

RJD

[redacted]	See case writeup for **RJD-**[redacted].

CIW

[redacted]	The class member alleged that the subject officer falsified an RVR on the date that the class member filed the 602. Even though the RVR date was obvious and therefore so was the date of the incident, the investigator claimed that they could not determine the date of the alleged incident, and thus failed to request video footage.
[redacted]	See discussion in report for **CIW-**[redacted].