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[redacted]

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Re: *Armstrong v. Newsom*: Plaintiffs' Review of CDCR's Accountability System
Our File No. 0581-03

Dear [redacted]:

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

[1] For RJD and SATF, the production included documents for cases closed between September 1-December 1, 2022. For KVSP and COR, the production included documents for cases closed between October 2, 2022-January 1, 2023. For LAC and CIW, the production included documents for cases closed between August 2-October 31, 2022.

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

been affirmed in relevant part by the Ninth Circuit, and with the RJD and Five Prisons Remedial Plans. *See* Dkts. 3059, 3060, 3217, 3218, 3393; *Armstrong v. Newsom*, 58 F.4th 1283, 1288 (9th Cir. Feb. 2023).

Plaintiffs identify multiple failures at every step in Defendants' accountability process.

First, Defendants are failing to identify staff misconduct complaints. As shown in **Section I**, the Centralized Screening Team ("CST"), the linchpin of the process for identifying and routing staff misconduct complaints for investigation, is routinely failing to identify when staff misconduct has been alleged. Even when staff misconduct complaints are identified, the CST is also failing to appropriately route serious allegations to the Office of Internal Affairs ("OIA") for investigation pursuant to the Allegation Decision Index ("ADI"). Thirty percent of the 602s reviewed by Plaintiffs' counsel were inappropriately deemed "routine" grievances instead of staff complaints and were sent back to the prison by the CST. Given that CST determined 31,710 grievances to be routine, this means as many as 9,000 staff complaints may have gone unidentified. Many alleged serious staff misconduct and should have been referred to OIA. The first step in ensuring a functioning accountability system is the appropriate and consistent identification of complaints of staff misconduct. It is also essential to ensure that the most serious allegations of misconduct are investigated by OIA. These two related failures by the CST represent serious non-compliance with the Remedial Plans.

Beyond these concerning procedural problems, the cases discussed in this report continue to show that Defendants are failing to ensure complete and unbiased investigations necessary to discover whether staff misconduct has occurred and are failing to hold staff accountable for serious staff misconduct when confirmed. Further, multiple cases reviewed during this quarter show how Defendants' accountability system fails to detect reported patterns of serious non-compliance. The failure to identify problematic patterns of complaints, combined with the failure to confirm violations in individual cases, results in Defendants missing the important opportunity to self-correct and take action to prevent future harms from occurring, leaving Defendants seemingly unaware of serious problems hiding in plain sight. In one disturbing example, different OIA/AIMS investigators each conducted deeply flawed and incomplete investigations into consistent allegations from multiple women that a dental hygienist at CIW had sexually assaulted them during dental exams. None of the allegations produced thus far have been sustained. The dental hygienist suspiciously retired the day before the Hiring

Authority acted to close (not sustaining) the first case. *See* **CIW –** [redacted]

Investigators also disregarded important video evidence that corroborated the allegations of misconduct. In one case, the video collected by the investigator shows that two officers admitted repeatedly on BWC to conducting a search of a mentally ill man's cell to retaliate against him; the investigation report did not mention any of this video footage. *See* **LAC –** [redacted]. In another case, an officer's BWC captures him telling an *Armstrong* class member that he did not "give a shit" about his need for incontinence showers. Yet the investigator failed to reconcile this comment or gather the additional evidence necessary to show whether the officer had denied the class member timely incontinence showers, as alleged. *See* **KVSP –** [redacted]. In another case, BWC footage shows that two officers may have released an incarcerated person from his cell knowing that he would assault another incarcerated person. Notwithstanding comments in the video suggesting the subject officers knew exactly what they were doing, the investigator did not interview either of them. Instead, the investigator narrowly construed the claim to disprove that one of the officers laughed about the assault (as was alleged in the 602) and ignored evidence that the comment itself, whether or not he was laughing when he said it, suggested that the officer knew the attack would occur. *See* **KVSP –** [redacted].

The cases also show that Hiring Authorities continue to fail to hold staff accountable for misconduct when the evidence establishes misconduct occurred, including in cases involving uses of force. In one case, officers entered a cell and used significant force because the occupant was on suicide watch and had purportedly boarded up the windows. The Hiring Authority failed to sustain allegations of an improper immediate use of force, even though the supposed impetus for the force—the window coverings—had all been removed well before the officers entered the cell and used force. *See* **CIW –** [redacted].

Plaintiffs were able to identify problems with investigations and discipline in cases involving allegations of serious staff misconduct despite the fact that Defendants have produced almost no Allegation Inquiry Unit ("AIU") investigations to Plaintiffs. Even though the AIU has completed more than 2,100 investigations, 80% of those cases are sitting on the Hiring Authorities' desks, awaiting final resolution. Due to Hiring Authority delays, the most serious allegations of misconduct to work their way through the reformed staff misconduct complaint process have not yet been finally resolved and produced to Plaintiffs. Of the 519 cases produced this quarter, only 24 were AIU cases.

The Hiring Authorities' substantial delays in resolving cases are undermining the accountability system by delaying the imposition of corrective and disciplinary action and interfering with ability of the parties to determine the impact of negotiated reforms on the most serious cases. Despite still not receiving cases that have been closed under the new AIU process, the same actors responsible for the serious problems with investigations and discipline identified in this report play key roles in the reformed process.

Plaintiffs look forward to engaging with Defendants and the Court Expert on remedies to address ongoing problems identified in this report.

Sincerely,

ROSEN BIEN
GALVAN & GRUNFELD LLP

/s/ [redacted]

By: [redacted]

cc: [redacted]

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I. DEFENDANTS ARE FAILING TO IDENTIFY STAFF MISCONDUCT COMPLAINTS

The Centralized Screening Team ("CST") is not properly screening grievances to identify if they raise allegations of staff misconduct and, if so, whether the staff misconduct allegation is on the Allegation Decision Index ("ADI"), and thus must be routed to the Allegation Investigation Unit ("AIU") for investigation.

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

The CST should 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 officer engaged in "behavior that results in a violation of law, regulation, policy, or procedure, or actions contrary to an ethical or professional standard." Cal. Code Regs. Tit. 15, § 3486(c)(22).

Documents from recent quarterly productions show that the CST is routing as "routine" 602s that contain clear allegations of staff misconduct. Plaintiffs reviewed the random sample of 200 "routine" grievances from class members at the six prisons that the CST determined do not allege staff misconduct. Defendants produced grievances from Q3 2022 (produced on January 10, 2023) and Q1 2023 (produced on April 12, 2023). **In 60 out of 196[3] cases (or 30%)**, Plaintiffs disagree with the CST determination that the class members did not allege staff misconduct. According to data produced by Defendants to Plaintiffs, since June 1, 2022, the CST has determined that 31,710 grievances were "routine." If the 30% error rate applied across these decisions, it is possible that CDCR has not investigated more than 9,000 allegations of staff misconduct.

In nearly every case where Plaintiffs disagreed with the CST, the staff misconduct allegation was clear and unambiguous. Some of the CST's mistakes were egregious; a number of the 602s that the CST routed as routine not only contained allegations of staff misconduct (and therefore should have at least been investigated by local investigators), but also included allegations of staff misconduct on the Allegation Decision Index ("ADI"), and therefore should have been investigated by the Allegation Investigation Unit ("AIU") of OIA.

[3] Defendants produced duplicate copies of three 602s for these two quarters, and also produced a blank 602, which we omit from the count.

The following examples are illustrative of 602s that the CST erroneously classified as "routine":

- [redacted] – The person alleges that two housing officers directed an incarcerated person to threaten to "slice you with razors as soon as I catch you outside the cell," unless he withdrew 602 complaints he filed against officers. The CST misclassified this serious allegation of staff misconduct as "routine," even though it falls under multiple ADI categories—including retaliation, code of silence, endangerment, and threats/intimidation/assault. *See* Retaliation (1); Code of Silence (1), (3), (4); Other Misconduct (2), (4).

- [redacted] – The person alleges two officers used excessive or unnecessary force against him by twisting his arms while dragging him out of his wheelchair, without first trying to deescalate the situation. He also claims that during his RVR hearing he was denied hearing aids, which he needs for effective communication. These are both staff misconduct allegations, and the use-of-force allegation is on the ADI. *See* Use of Force (2).

- [redacted] – The person names four officers he alleges conspire with incarcerated persons to assault people in retaliation for filing 602s against the officers. This staff misconduct allegation falls under multiple ADI categories—including retaliation, code of silence, endangerment, and threats/intimidation/assault. *See* Retaliation (1); Code of Silence (1), (3), (4); Other Misconduct (2), (4).[4]

- [redacted] – The person alleges that officers falsified paperwork stating he is SNY, when he is not and never has been, which puts his safety in jeopardy when he is housed in facilities for people with SNY status. He also alleges officers fabricated an RVR against him. These staff misconduct allegations fall under multiple ADI categories—including endangerment, creating an opportunity and motive for other incarcerated people to harm him, and falsifying an RVR. *See* Dishonesty (2); Integrity (1); Other Misconduct (2).

- [redacted] – The person alleges that a specific officer targets Black people on the yard, and issued him an RVR to keep him from transferring to a lower level prison because he is Black, an allegation of discrimination based on race that is on the ADI. *See* Discrimination/Harassment (3).

[4] This grievance is mislabeled as [redacted] on the PDF in the Q3 2022 production.

- [redacted] – The person alleges that an officer fabricated an RVR against him for battery, and mocked his religion. Both of these staff misconduct allegations are on the ADI. *See* Dishonesty (2); Discrimination/Harassment (1).

- [redacted] – The person alleges that an officer was not wearing his BWC, and that staff improperly confiscated his legal documents. These are both allegations of staff misconduct, and the allegation of non-compliance with BWC activation requirements is on the ADI. *See* Dishonesty (1).

- [redacted] – The person alleges that, during a search, transportation officers destroyed his wheelchair and stole his incontinence supplies, cane, wheelchair gloves, and wheelchair seat pad.

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

Plaintiffs conducted a non-exhaustive review of cases filed on 602s by class members at the six prisons after May 31, 2022 that CST routed to the institution for investigation by an LDI. This was not a comprehensive review of the CST's screening of staff misconduct allegations under CDCR's new investigation system. Yet it revealed 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 for investigation by an LDI, rather than by the AIU.

As with the grievances misclassified as "routine," many of these cases clearly and unambiguously fall on the ADI. The following examples are illustrative of cases routed for local inquiries that should have been routed to the AIU for an investigation:

- COR-[redacted] (*see* 602 at 5) – The person alleges that, when he returned to his housing unit from suicide watch, an officer mocked him by acting out the motion of cutting himself while laughing, in order to antagonize him. This allegation falls under multiple ADI categories, including making insults based upon a mental health condition, and creating a motive for an incarcerated person to harm themselves. *See* Discrimination/Harassment (1); Integrity (1).

- SATF-[redacted] (see 602 at 17-18)– The person alleges that an officer bullied and harassed him because of his developmental disability, including by only allowing him five minutes to shower, and searching his cell for no reason. He also alleges the officer turned off his BWC when searching his cell. The allegations of harassment based on a disability and non-compliance with BWC activation requirements are both on the ADI. *See* Discrimination/Harassment (3); Dishonesty (1).

- RJD-[redacted] (*see* 602 at 9-11) – The person alleges that an officer opened his door in a manner that caused his hand to be trapped and cut his finger to the bone, and that another officer saw that he was bleeding profusely, but refused to activate her alarm to call for a medical emergency. These allegations of endangerment and misconduct resulting in significant injury are on the ADI. *See* Other Misconduct (2), (3).

- CIW-[redacted] (*see* 602 at 6-9) – The person alleges that numerous officers peeked into her cell whenever she puts up a privacy sheet to get undressed or use the bathroom, and that an officer used excessive force on her during a pat-down search, injuring her knee. Both the use-of-force and the sexual harassment allegations are on the ADI. *See* Staff Sexual Misconduct (3); Use of Force (2).

- LAC-[redacted] (*see* 602 at 9-10) – The person alleges that after he went "man down," he was ignored for ten minutes before he was found on the cell floor, and that the officers then carried him down the stairs in an unprofessional manner, causing him to hit his head and his back on the stairs. These allegations of endangerment are on the ADI. *See* Other Misconduct (2).

- KVSP-[redacted] (*see* 602 at 1-2) – The person alleges that, when he told an officer he needed time to locate witnesses and prepare for a hearing on an RVR she issued to him, the officer threatened to retaliate against him by giving him another RVR. *See* Code of Silence (3); Other Misconduct (4).

- LAC-[redacted] (*see* 602 at 11-14) – The person alleged that an officer will only help Black people with cell moves, and tells Hispanic people who report issues with their cellmates to work it out themselves. Both the allegations of race discrimination and of endangerment for not taking safety concerns seriously are on the ADI. *See* Discrimination/Harassment (3); Other Misconduct (2).

- **KVSP –** [redacted] (*see* 602 at 3) – In this case, discussed below, Mr. [redacted] reported he was suicidal to Officer [redacted] during safety and security rounds, but the officer did not report his suicidality to his supervisor or to medical or mental health staff. The allegation that Officer [redacted] created an opportunity for Mr. [redacted] to harm himself and endangered him is on the ADI, but was routed to an LDI by the CST. *See* Integrity (1); Other Misconduct (2).

The CST is essential to Defendants' accountability system. If the CST is unable to properly identify and route staff misconduct allegations, Defendants will be non-compliant with the Remedial Plans. And CDCR's court-ordered accountability system will fail.

II. 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' counsel closely reviewed 61 cases: 10 cases from LAC, 10 cases from CIW, 10 cases from RJD; 11 cases from SATF; 10 cases from COR; and 10 cases from KVSP.[5] 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.

Below, Plaintiffs describe 18 cases that illustrate serious, ongoing problems regarding Defendants' accountability system. There are cases where: (1) the Hiring Authority either failed to sustain misconduct or failed to impose appropriate discipline for sustained misconduct; or (2) an incomplete and/or biased investigation interfered with the ability of a decision maker to determine whether misconduct occurred. Some cases evidence both types of problems.

A. Hiring Authorities Remain a Significant Barrier to Accountability

Plaintiffs' review of cases for this quarter reveals an ongoing failure of Hiring Authorities to sustain serious allegations supported by a preponderance of the evidence and a failure to impose appropriate discipline when they do sustain allegations. As discussed in more detail in **Appendix A**, the productions covered by this Report included 519 unique cases. Hiring Authorities imposed adverse action in only 3 cases (0.6%). Meanwhile, Plaintiffs reviewed only a subset of cases, but identified at least 7 cases with problematic Hiring Authority decision making. (*See* **CIW –** [redacted]; **LAC –** [redacted]; **LAC –** [redacted]; **KVSP –** [redacted]; **RJD –** [redacted]; **COR –** [redacted];

[5] Plaintiffs selected the cases using a variety of criteria, including, but not limited to, whether: CDCR referred the case to OIA for investigation or direct adverse action; AIU investigated the case; 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.

LAC – [redacted]). In 4 of these cases, the Hiring Authority did not sustain one or more serious allegations of misconduct even though the preponderance of the evidence showed that the misconduct occurred. (*See* **CIW –** [redacted]; **LAC –** [redacted]; **LAC –** [redacted]; **RJD –** [redacted]**).** In 4 of these cases, the Hiring Authority sustained an allegation of misconduct, but did not impose appropriate discipline to punish the misconduct or failed to impose discipline timely. (*See* **LAC –** [redacted]; **KVSP –** [redacted]; **COR –** [redacted]; **LAC –** [redacted]). (Note that these numbers add up to more than 7 cases, as some cases contained multiple types of problems.)

In addition, and as discussed below, Hiring Authorities are also causing significant delays in reviewing completed investigations.

Plaintiffs remain seriously concerned that, despite the many changes to the staff misconduct investigation and disciplinary process, Defendants fail to self-identify and take concrete action in response to Hiring Authorities who are exercising poor discretion over accountability and that there is currently no requirement that Hiring Authorities take timely action on completed investigations. Defendants must address these problems to ensure the effectiveness of the accountability process.

1. Hiring Authorities Delayed in Reviewing Investigations

Despite improvements to the staff complaint process to ensure the swift and timely completion of investigations, within 90 or 180 days, Plaintiffs learned during this quarter that Hiring Authorities are now undermining those reforms by delaying in reviewing and taking accountability action on completed cases.

According to data produced by Defendants on May 2, 2023, eighty percent of investigations that the AIU has completed are currently waiting for Hiring Authority action. As Defendants acknowledged at a meeting on March 28, 2023, these are investigations that the AIU has completed and signed off on. Thus Hiring Authority review is the only thing standing in the way of implementing important corrective or disciplinary action that can reduce future harms to class members.

As of April 30, 2023, the AIU, which began accepting cases on June 1, 2022, has completed 2,189 investigations. **1,762 (80%) of those completed investigations are pending resolution with the Hiring Authorities**. This problem is particularly acute at COR (89% of completed investigations pending with Hiring Authority), RJD (88%), and SATF (93%).

	Not Sustained	Sustained	Pending	Total	% Pending
CIW	46	6	46	98	46.9%
COR	54	0	456	510	89.4%
KVSP	79	8	150	237	63.3%
LAC	150	5	254	409	62.1%
RJD	54	1	400	455	87.9%
SATF	29	5	446	480	92.9%
Total	412	25	1,752	2,189	80.0%

Hiring Authority delays undermine improvements to the accountability process and must be addressed. First, the delays jeopardize the ability of Hiring Authorities to impose adverse action. When Hiring Authorities wait until the end of the statute of limitations to review investigations, they are unable to request additional investigation, if needed, which limits their ability to hold staff accountable for misconduct. *See* **SATF –** [redacted]. Second, long delays cause a disconnect between the conduct CDCR is trying to eliminate and the action taken in response, which undermines any deterrent effect of accountability. Lastly, these delays interfere with Defendants' ability to make necessary improvements to the process. Waiting until the end of the statute of limitations to resolve cases means that investigation files are produced to Plaintiffs' counsel and the Court Expert as long as 16 months after the incident occurred.[6] It is difficult to reform a system, and to determine whether any reforms are having a positive impact, if cases are delayed and the parties must wait a year and a half to review files.

The purpose of negotiating shortened timelines to complete investigations was to ensure that CDCR could swiftly act to hold staff accountable for serious staff misconduct. The parties focused on eliminating delays in investigations because that is where delays were occurring. Now, it appears those delays have simply been transferred to a different part of the process – Hiring Authority decision making. **There is currently no requirement in the process to ensure that Hiring Authorities timely complete their reviews. This problem must be addressed.**

[6] The statute of limitations is one year from the date of discovery. Defendants only include a case in a quarterly production once it has been closed for 30 days. And the quarterly production may not occur for as much as three months after that 30-day period.

2. Hiring Authorities Failed to Hold Staff Accountable When the Preponderance of Evidence Shows Misconduct

(1) **CIW –** [redacted]: OIA, Sustained a lesser charge regarding protective gear – Corrective (Training; LOI)

In this case, the Hiring Authority failed to hold any staff accountable despite clear video evidence that officers initiated two improper immediate uses of force against [redacted].

The improper uses of force occurred after medical staff in the Psychiatric Inpatient Unit ordered an emergency cell entry because Ms. [redacted], who was on suicide watch at the time, had blocked view into her cell window. BWC footage shows that Ms. [redacted] had removed the window coverings, and officers were aware of that, more than 20 seconds before officers entered the cell. Even though the reason for the immediate cell entry and extraction was no longer extant, staff still entered and used significant force to place Ms. [redacted] in restraints. Thereafter, staff initiated an additional improper immediate use of force to extract Ms. [redacted] from the cell. The IERC independently recognized these two use-of-force violations, and the Hiring Authority requested and OIA conducted an administrative investigation. Yet despite the video evidence confirming the violations, the Hiring Authority did not sustain any use-of-force charges against any involved staff.

BWC footage confirms that the impetus for the emergency cell extraction was eliminated prior to entry. As the cell entry team—Sergeant [redacted] and three other officers—reached the cell front, Ms. [redacted] can be seen with her face in the window, meaning she had at least partially removed the window covering. *See* BWC 2 at 9:23:18. Ms. [redacted] said "I'm right here. Hello, I'm right here. [Unintelligible] I'm right here can you see me. I'm right here, hello." Just before the officers enter the cell, Ms. [redacted] is again visible through the window. *Id.* 9:23:36.

Eventually, Ms. [redacted] sat on the floor of her cell, handcuffed behind her back with her back against the wall. *See* BWC 3 at 9:26:42. At that point, she did not pose any imminent threat. Nevertheless, Sergeant [redacted] ordered the officers to use immediate force to pick Ms. [redacted] off of the ground and place her in a wheelchair. Sergeant [redacted] screamed, "This is a suicide watch inmate, she has boarded up on us, get her in that wheelchair!" Ms. [redacted] resisted these efforts for about thirty seconds until the officers gave up and left her on the floor, where she gasped for breath from an apparent asthma attack. Over the next half hour, staff gave Ms. [redacted] two doses of involuntary medication, and the situation eventually deescalated.

Ms. [redacted] suffered injuries including scratches on her right arm, irritated areas on her left wrist and her chest, and pain on her face where the shield made contact with her face. *See* OIA Report (7219) at 323;[7] IRT 26219 at 38.[8]

Both immediate uses of force violated CDCR policy. *See* DOM §§ 51020.4; 51020.12. First, once Ms. [redacted] removed the paper covering her cell window, allowing staff to see that she was not harming herself, no imminent threat existed to justify an immediate use of force. If it was still imperative to remove Ms. [redacted] from the cell, staff were required to initiate a controlled use of force.[9] Second, after the officers had applied handcuffs to Ms. [redacted] and she sat against the wall, surrounded by officers, she no longer posed an imminent threat to anyone. Nevertheless, the officers picked her up from the ground and attempted to force her into the wheelchair. Again, assuming it was necessary to remove her from the cell, staff were required to use controlled force. These improper immediate uses of force caused injury to Ms. [redacted] and risked injury to involved staff. Had staff initiated controlled uses of force, as required by policy, it is possible that no force would have been necessary at all, given the cool-down period and intervention by mental health staff.

Despite the violations evident on video, the Hiring Authority elected not to sustain an allegation against Sergeant [redacted] for "order[ing] officers to enter … [redacted] … cell and utiliz[e] immediate force when there was no imminent threat." *See* [redacted] 402-403 at 1. And the Hiring Authority did not even consider use-of-force allegations against multiple officers who actually used force.[10] *See* IRT at 8, 12, 13; [redacted] 402-403 at 1; [redacted] 402-203 at 1.

The OIA investigation and investigation report were also incomplete in that the report contains few details about the video footage, which is the most important evidence in the case. The single Investigator's Note that is included mischaracterizes the video, stating: "In the BWC video, at the very moment [redacted] put the key in the cell door to open it, [redacted] partially removed her window covering, enough to see

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[7] In these case summaries, all citations to page numbers of documents refer to the page of the PDF, not to any internal pagination in the document.

[8] This case, **CIW –** [redacted], also involves apparent code of silence and collusion. For more detail, *see* **Section III** on BWC Compliance.

[9] Removal may have been necessary because Ms. [redacted] refused to give up her property or to put on suicide-safe clothing.

[10] The Hiring Authority did issue corrective action against Sergeant [redacted] and the officers for failing to don protective gear for the emergency cell entry. *See* [redacted] 402-403 at 1.

[redacted] and to check on her well-being." *See* OIA Report at 5. This statement is untrue, as Ms. [redacted] face can be seen in the cell window many seconds before officers insert the key into the door.

Second, the investigator did not investigate the second use of force referred to OIA for investigation—the force to attempt to put Ms. [redacted] into the wheelchair. *See* OIA Report (Request for Admin Review) at 20 (discussing two separate uses of force). From the investigation report, it does not appear that the investigator asked any of the staff any questions about whether there was any imminent threat justifying the second use of force, and the investigation report contains no discussion of that use of force.

(2) **LAC –** [redacted]: AIMS, Sustained (Only one use of force and only against one officer) – Corrective (Training)

This case involves two inappropriate uses of force against [redacted], a class member with serious mental illness. In the first use of force, two officers improperly used immediate force when they pulled Mr. [redacted], who claimed he was suicidal at the time, out of a holding cage after he refused to return to his cell. The discipline imposed for this use of force was inadequate: unspecified training for Sergeant [redacted] and no discipline for additional officers who were involved or witnessed the improper immediate use of force but failed to report it. In the second incident, which occurred less than ten minutes later, Officer [redacted] used unnecessary force when he pepper-sprayed Mr. [redacted], who was inside his cell.[11]

On February 24, 2022, Mr. [redacted] was sitting in the holding cage, restrained in handcuffs behind his back, not posing any threat to staff, himself, or others. *See* AVSS; BWC at 18:00:10. At the time, Mr. [redacted] stated he was suicidal, but mental health staff had cleared him to return to his cell. Officers ordered him to get up. When he refused, Sergeant [redacted] and Officer [redacted] reached into the cage, grabbed Mr. [redacted] by his arms, and pulled him out. Mr. [redacted] can be heard goading the officers to "smash it, do it" and "break my neck, man, you already got the pressure on it," most likely in response to the force being exerted on his head by the officers, in apparent confirmation of his suicidal status. *See* BWC at 18:01:35. The officers then put leg restraints on Mr. [redacted], forced him into a wheelchair, and escorted him out of the housing unit.

Pulling Mr. [redacted] out of the holding cage was an improper immediate use of force because he did not pose an imminent threat. *See* DOM § 51020.12 ("When force is necessary but does not involve an imminent threat to subdue an attacker…the force shall

[11] The investigator also failed to investigate or address in his report other serious allegations made by Mr. [redacted] in his 602: that officers ignored his reports of suicidality from 1030 to 1800 and left him in a cage for six hours in a wet paper suit. *See* 602 at 6.

be controlled."). He was refusing to return to his cell but staff cannot use immediate force solely to gain compliance with an order. *See* DOM § 51020.4 ("If it is necessary to use force solely to gain compliance with a lawful order, controlled force shall be used."). This improper force injured Mr. [redacted], causing him leg and arm pain. *See* 7219 at 9. Had the officers followed controlled use-of-force protocols, which include a cool-down period and consultation with mental health staff, it is possible that no force would have been needed.

Despite the clear policy violation, the Hiring Authority did not refer the case to OIA for an investigation or for authorization for direct adverse action. Instead, the Hiring Authority took action as to only one involved staff member—Sergeant [redacted]—who received unspecified training on extractions. *See* IERC documents at 10 ("On 9/4/22 training was provided to Officer [redacted] on DOM Section 51020.12.2.").

The Hiring Authority failed to impose appropriate discipline regarding five involved staff members, two of whom initiated the initial improper effort to pull Mr. [redacted] out of the holding cage (Sergeant [redacted] and Officer [redacted]). Officer [redacted] should have been held accountable for his improper immediate use of force, while the other three officers should have been held accountable for failing to report it. Second, the training provided to Sergeant [redacted] was not commensurate with the policy violation. The use of force was, at a minimum, an unnecessary use of force, which carries a base penalty of 2, and a range of 1-3. *See* Disciplinary Matrix. By only providing training, CDCR sent a message to Sergeant [redacted] and the others involved in this incident that the violation was not serious.[12]

In the second use of force, Officer [redacted] pepper-sprayed Mr. [redacted] while he was inside his cell, after Mr. [redacted] allegedly spit on officers. *See* BWC at 18:07:07. Prior to the incident, officers were uncuffing Mr. [redacted] through the cell's tray slot. Before the restraints were removed, Officer [redacted] unholstered his pepper spray. *See* BWC at 18:07:02. Once officers removed the restraints, Mr. [redacted] stood up and appeared to attempt to spit on officers through the perforated holes in the cell door. *See* BWC at 18:07:07. Officer [redacted] then immediately pepper-sprayed Mr. [redacted].

Officer [redacted] use of force was unnecessary. Once the restraints were removed, the officers could have avoided any threat posed by Mr. [redacted], including the threat of being spit on, by moving away from the cell door. If Mr. [redacted] continued to spit or engage in other conduct that required intervention, officers then could have initiated a

[12] From the file produced to Plaintiffs, it is not clear that the corrective action against Sergeant [redacted] was even placed in his personnel file, meaning it could not be used as a basis for progressive discipline.

controlled use of force, as Mr. [redacted] was locked in his cell and not posing an imminent threat to anyone. *See* DOM § 51020.4.

The case file produced to Plaintiffs references this second use of force in a few places.[13] But the file does not include any incident reports, IERC documents, inquiry reports, or discipline documents addressing the use of pepper spray. Based on the information available it appears this second use of force may have been both unnecessary and unreported. **Please provide to Plaintiffs' counsel any and all documents related to this use of force, including any inquiries or investigations into this incident.**

Plaintiffs have reported previously on serious misconduct by Officer [redacted], and CDCR's repeated failure to hold him accountable. In one case, also involving a mentally ill individual, Officer [redacted] used unnecessary and excessive force when he threw the person off the top bunk onto the concrete floor during an emergency cell rescue. *See* February 10 Report at 8. Officer [redacted] is also involved in the next case described below. That CDCR continues to fail to hold him accountable for misconduct highlights Defendants' longstanding failure to appropriately discipline repeat offenders.

(3) **LAC – [redacted]** AIMS, Not Sustained

This case involves an inappropriate immediate use of force against [redacted], a class member with serious mental illness. Despite the IERC and AIMS investigator identifying the misconduct, the Hiring Authority improperly failed to sustain Mr. [redacted] allegation. This case serves as yet another example of CDCR failing to hold officers accountable when they resort to using force far too quickly, when they inflame rather than deescalate situations, and when they cause harm to incarcerated people with disabilities.

As the video shows, Officer [redacted], Officer [redacted] (the same officer as in the prior case, **LAC – [redacted]**), and three other officers escorted Mr. [redacted], who had been placed on suicide watch, to a cell in Building D5. *See* BWC. Once he entered the cell and the escorting officers removed his handcuffs through the food port, Mr. [redacted] left his right arm in the food port and declared that he was "holding this slot." *See* BWC at 20:47:12. In response, Officer [redacted] held Mr. [redacted] right hand, while Officer [redacted] placed a handcuff on Mr. [redacted] right arm. While the officers attempted to gain control of the port and handcuff Mr. [redacted], Officer [redacted]—who was standing to

[13] The investigator included this use of force in the review of BWC, noting that "[redacted] unholstered his MK 9 OC canister, aimed his MK 9 at [redacted], and deployed a one-second burst of OC to [redacted] facial area," but did not indicate in any way that there was a problem with the use of force. *See* Inquiry Report Summary at 4. A 7219 in the file shows that staff used chemical agents against Mr. [redacted]. *See* 7219 at 9.

the right of Mr. [redacted] cell and holding Mr. [redacted] right arm—stated, "Let go of me, let go of me." *See* BWC at 20:47:30. Officers [redacted], [redacted], and [redacted] then pepper-sprayed Mr. [redacted] through the food port from a very close distance. A large volume of pepper spray is visible on Mr. [redacted] arm and a number of the officers begin coughing as well. *See* BWC at 20:47:46.

This response to Mr. [redacted] holding the food port violated policy. The officers should have backed away from the cell, contacted a supervisor, and then, if necessary, used controlled rather than immediate force. *See* CDCR's Memo for the Use of Force Food/Security Port Policy Revision, dated March 13, 2014 ("In the event, the inmate does not relinquish control of the food port, the officer shall back away from the cell and contact and advise the custody supervisor of the situation. Controlled force will be initiated while custody staff continue to monitor the inmate.") (Exhibit 8 at 21).)

Reviewers at multiple levels of the IERC process found that staff violated policy by failing to back away from the cell and using immediate force. *See* IERC documents at 2, 3, and 4. Similarly, the AIMS investigator checked a box indicating he had a reasonable belief the officers' misconduct was likely to result in adverse action. *See* Inquiry Report Summary at 3.

Yet three months later, the Hiring Authority closed the case without referring it to OIA, and did not sustain any allegations of misconduct. The Hiring Authority should have sustained charges against Officer [redacted] and Officer [redacted] for their unnecessary immediate use of force evident in the video and which the AIMS investigator and the IERC both identified. The case file indicates that officers received training on controlled use of force during the incident review process. *See* Incident Commander's Review/Critique at 2. But the failure by the Hiring Authority to sustain the allegation and formally impose corrective or adverse action sent the wrong message to staff. Sustaining the charges was especially important because the officers' failure to follow policy caused serious harm. Because officers did not back away, they pepper-sprayed Mr. [redacted] from a close distance.[14] *See* Inquiry Report Summary at 2-3; Incident Commander's Review/Critique at 2 (noting that three officers "utilized their

[14] It is possible that the use of pepper spray also violated CDCR policy in that it was unnecessary. The video did not make clear whether Officer [redacted] claimed justification, that Mr. [redacted] pushed his arm toward Officer [redacted] or grabbed his hand and/or vest, occurred. But the AIMS investigator did not interview any of the officers or witnesses because he stopped his inquiry after he formed a reasonable belief misconduct had occurred. And the Hiring Authority did not refer the case to OIA, so there was no further investigation, including interviews with the subjects or witnesses.

MK-9 Streamers closer than 6 feet, which is the Department's recommended minimum distance, to deploy MK-9 Streamers").

The failure to sustain the allegation undermined the progressive discipline system. By failing to document the officers' misconduct, the Hiring Authority made it impossible for their misconduct in this case to serve as the foundation for future more serious discipline, should the officers engage in similar misconduct.

(4) **KVSP –** [redacted] Local, Sustained – Corrective (LOI)

In this case, on September 20, 2022 at 10:04 p.m., [redacted] reported to Officer [redacted] that he was suicidal during safety and security rounds in a mental health unit. Officer [redacted] responded, "you told the last shift that too … that ain't gonna get your package faster." *See* BWC. Officer [redacted] did not report Mr. [redacted] suicidality to his supervisor or to medical or mental health staff. No medical staff attended to Mr. [redacted] until the following morning, when he was ultimately moved to a Mental Health Crisis Bed (MHCB) at 9:30 a.m.[15] *See* Bed Assignments.

Based on the local inquiry, the Hiring Authority issued Officer [redacted] a Letter of Instruction, stating that Officer [redacted] violated, *inter alia*, KVSP OP #1055, which requires that "[w]hen an I/P reports an emergent MH need to staff … the Facility Lieutenant will be contacted to activate the [Crisis Intervention Team]." *See* LOI at 2.

The corrective action imposed by the Hiring Authority was not appropriate. Officer [redacted] conduct placed Mr. [redacted] at great risk of harm. Fortunately, Mr. [redacted] did not engage in self harm before being admitted to the MHCB the following day. Officer [redacted] endangerment of Mr. [redacted] was also intentional: he acknowledged during his interview with the investigator that he knew he was required by policy to report Mr. [redacted] suicidality to his supervisor. *See* Inquiry Report at 6. And Officer [redacted] actions are even more problematic because they occurred while he was working in a mental health unit and was conducting safety and security rounds (one purpose of which is to identify anyone at risk of suicide).

Officer [redacted] intentionally endangered Mr. [redacted], which under the Employee Disciplinary Matrix carries a presumed level 6 penalty, with a range from 4 to 9. *See* Disciplinary Matrix. By not even referring the case to OIA for permission to impose adverse action, the Hiring Authority sent the wrong message to staff about devaluing the lives of incarcerated people and signaled that Officer [redacted] misconduct was not serious.

[15] Mr. [redacted] medical records, which the investigator did not review, show that he did not interact with any healthcare staff until the following morning.

(5) **RJD-[redacted]/RJD-[redacted]/RJD-[redacted]/RJD-[redacted]**: AIMS; AIU; Local; Local - Not Sustained

These four cases, when viewed in conjunction with one another and tour reports from Plaintiffs' counsel, exemplify Defendants' inability to detect patterns of misconduct, which ultimately results in failures to take action to reduce harm to class members.

Plaintiffs have previously reported that Officers [redacted] and [redacted] on Facility A at RJD fail to accommodate people with mobility disabilities and issue inappropriate and discriminatory discipline in response to class members walking the shortest distance around the track. *See* Sept. 2022 RJD Monitoring Report at 10-12.[16]

In RJD-[redacted], [redacted], an RJD declarant who is elderly and uses a four-wheeled walker, challenged a counseling RVR he received for "Disobeying an Order." One claimed basis for the RVR was that Mr. [redacted] allegedly walked the wrong way on the track.[17] As shown in BWC footage, Officers [redacted] and [redacted] stopped him on the track as he was walking back to his housing unit after dropping off a sick call slip at the clinic. They informed him he was walking the wrong way and wearing the wrong clothing. Mr. [redacted] respectfully attempted to explain that he has the right to walk the shortest distance to his destination as an accommodation for his mobility disability. The officers argued with him and ordered that in the future he should walk the longer route. Mr. [redacted] acquiesced and returned to his housing unit. Once Mr. [redacted] left the scene, Officers [redacted] and [redacted] continued talking to one another about the interaction. Officer [redacted] said, "Oh and 'I'm ADA so I go the shortest route.' Mmm … no, you're gonna do what everyone else is doing." *See* BWC (linked above) at 11:20:00.

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[16] Although the report itself redacts the officers' names, exhibits redacted for that report confirm that the alleged problematic officers were Officers [redacted] and [redacted].

[17] The other claimed basis for the RVR was that Mr. [redacted] was not wearing proper attire. Although the issue is not clear from the case file, as best we can discern, the officers disciplined Mr. [redacted] because he should have been, but was not, wearing his "blues" when he went to the clinic area during yard to drop off a sick call slip. Mr. [redacted] explained to the officers that he did not know that requirement, states in his 602 that because he dropped off the 7362 during his yard time, he believed he was allowed to wear his yard clothes. *See* 602 at 3. The policy referred to by Officer [redacted] in the RVR simply states that incarcerated people must wear "proper attire," not that they must wear "blues." *See* AIMS Relevant Docs at 11.

The video confirms that Officers [redacted] and [redacted] either do not understand their responsibility to accommodate class members, or have chosen not to do so in defiance of that responsibility. CDCR policy requires that staff "utilize sound correctional decision making in determining the reasonableness of the [incarcerated person]'s request, and understand they should provide reasonable accommodations without relying on a Chrono or medical prescription. Examples of accommodations may include, but are not limited to: providing the [incarcerated person] a shorter path of travel …" *See* Revised Durable Medical Equipment Policy (March 5, 2020) at 3.

The officers did not follow this policy, but their failure was not identified or addressed. As the Court Expert concluded in his Report Regarding Treatment of People with Disabilities at Substance Abuse Treatment Facility, sustainable compliance depends on individual officers understanding that it is their responsibility to provide needed accommodations. *See* Dkt. 3446 at 51. That will never occur if investigators fail to detect violations.

The counseling RVR issued to Mr. [redacted] had devastating consequences at his parole hearing. According to the hearing transcript obtained by Plaintiffs, the RVR was his only disciplinary infraction during his 12-year term of current incarceration, and was a significant factor in the commissioners' decision to deny parole. In announcing the Board's decision the commissioner states: "[W]e fast forward to this recent, uh, counseling chrono you received in February this year and you wanted to blame this staff member, uh, for falsely documenting your misconduct when it was clear, um, that you were violating the rules. **You know having the ability to take full responsibility for your negative actions is one of the main factors we as a panel consider when we're assessing whether someone has rehabilitated or not.** Unfortunately, um, after hearing your testimony today Mr. McPherson … you've fallen way short of that mark. So, you need more work and develop [sic] in this area." *See* Transcript at 78 (emphasis added).

Three other cases from this production period also involve Officers [redacted] and [redacted] enforcing rules regarding paths of travel in discriminatory ways. In RJD-[redacted] and RJD-[redacted], [redacted], alleged that Officers [redacted] and [redacted] forced her to walk around the track in a different way than everyone else because she is transgender and to retaliate against her for asserting her rights. Officer [redacted] statement on BWC in Mr. [redacted] case that everyone is expected to walk the same way around the yard lends credence to Ms. [redacted] complaints that staff singled her out and discriminated against her by forcing her to walk a different way. The investigation report for RJD-[redacted] describes Officer [redacted] goading Ms. [redacted] during the encounter, behavior that is consistent with complaints

by multiple class members against these officers.[18] Despite confirmation of an unprofessional interaction described in the report, the closure notice states that the footage does "not depict discourteous interaction with inmate [redacted]" and the complaint should be closed as "unfounded." *See* AIR at 1.

In RJD-[redacted], [redacted], alleged that Officer [redacted] forced him to walk the long way around the yard notwithstanding his disability. When Mr. [redacted] was interviewed, he dropped the complaint, stating that Officer [redacted] explained the rules about the proper path of travel, and he had simply misunderstood previously. *See* AIR at 2. This result is problematic since it was Officer [redacted] who was wrong about CDCR policy, which requires him to allow class members to use a shorter path of travel as an accommodation for a disability. Yet the resolution was not to hold Officer [redacted] accountable for this policy violation, but for Mr. [redacted] to drop his accommodation request.

These cases show that Defendants failed to identify that class members filed multiple similar claims against two staff members alleging a failure to accommodate their disabilities, in violation of CDCR policy. Under Defendants' current iteration of their accountability system, including the Early Warning System, they will not, *by design*, detect such patterns of reported problems unless the allegations are sustained. Yet, these cases illustrate that Defendants fail to sustain findings of staff misconduct, even when the evidence supports doing so. Defendants must develop a process for identifying patterns of alleged problems and must take action to eliminate the risk of harm to class members.

(6) **COR –** [redacted] AIMS, Sustained - Corrective

In this case, [redacted] alleged that officers who loudly and publicly accused him of trading sex for food humiliated him and made him unsafe because they were the same officers responsible for protecting the DDP population in the housing unit. *See* 602 at 3-4. Mr. [redacted] has a significant intellectual disability, and staff are required to "[m]onitor [him] for undue influence from peers," as an accommodation, as he is "at risk for losing canteen and personal property." *See* DPP Summary at 15.

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[18] The report states that Officer [redacted] ordered Ms. [redacted] around the track and, when she inaudibly protested, he replied "cause I said so." The report goes on to describe that Ms. [redacted] became upset and turned back towards Officer [redacted] to state something along the lines of "do you know who you are messing with?" Officer [redacted] then engaged her, stating, "who I am messing with?" Ms. [redacted] walked away to end the interaction. *See* AIR at 3.

BWC video confirms that Officer [redacted] and Officer [redacted], in response to seeing Mr. [redacted] exchange something with another incarcerated person, did publicly and loudly speculate that Mr. [redacted] was trading food for sex. *See* BWC at 11:33:30. Officer [redacted] BWC video[19] shows that after the officers publicly speculated about what Mr. [redacted] might have been doing, Mr. [redacted] yelled from his cell that if they are worried about him having contraband, they should search his cell. Despite the fact that the officers should have known that Mr. [redacted] has victimization concerns requiring monitoring due to his intellectual disability, Officer [redacted] responded, "If there's nothing in there we know what you bought," implying Mr. [redacted] must have paid for sex. Mr. [redacted] continued to insist they should search his cell. Officer [redacted] mockingly continued, "We'll find out. Don't trip. You're safe," adding in a sarcastic manner, "We won't let him pressure you out of your canteen no more." Officer [redacted] appeared not to believe Mr. [redacted] and to be either oblivious or deliberately indifferent to his disability-related victimization concerns. Officer [redacted] then says, "He's a DDP too," while laughing, and Officer [redacted] responds in a mocking, unserious tone, "This is pressure-free zone."

The Hiring Authority failed to impose appropriate discipline, issuing only employee counseling records for "lack of professionalism."[20] *See* Employee Counseling Records at 20, 21. The act of disregarding someone's disability and publicly mocking safety concerns of a vulnerable person with an intellectual disability is more serious and harmful than simply acting unprofessionally. Rather than mocking him, the officers should have determined, privately, whether they had just witnessed other incarcerated people taking advantage of Mr. [redacted] in the canteen line. The officers' behavior was especially problematic because it took place in an EOP unit in which there are typically multiple DDP participants.[21] The lack of adverse action in this case sends a signal that, as multiple class members throughout CDCR have alleged, people with disabilities cannot rely on staff to keep them safe, to provide disability-related assistance, or to take their concerns seriously.

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[19] The investigator failed to retain and review BWC for Officer [redacted], as discussed in **Appendix B**. *See* AIMS Report at 13.

[20] The Hiring Authority issued corrective action (employee counseling records) to both officers for making comments "to Inmate [redacted] relating to trading sex for state snacks and or trading for weapons. These comments were made to where other staff and inmates heard. These comments are deemed inappropriate and unprofessional." *See* Employee Counseling Records at 20, 21.

[21] This incident occurred in Building [redacted], which is not designated as a DDP building, but in which CDCR typically places 4-5 people designated as DDP at any given time.

(7) **LAC –** [redacted] Local, Sustained – LOI (but not issued)

In this case, on November 23, 2022, the Hiring Authority sustained an allegation that Officer [redacted] violated policy by reading a book in the dayroom while on duty. *See* Closure Memo. The case file produced to Plaintiffs did not contain any documents regarding corrective or adverse action imposed on Officer [redacted]. On March 1, 2023, Plaintiffs' counsel requested the missing disciplinary documents. On March 8, 2023, Defendants produced a memorandum from the Chief Deputy Warden at LAC that was dated March 7, 2023 (six days after Plaintiffs requested the missing documents). The memorandum, which was clearly drafted in response to Plaintiffs' request, states that a Letter of Instruction "was necessary," but would not be "issued due to the date of discovery going beyond 30 days." *See* Memo. This statement presumably is intended to reference DOM § 33030.8, which states that corrective action "must generally be issued within thirty (30) calendar days of discovering inappropriate behavior or poor performance." In fact, since the 30-day time period in Section 33030.8 is permissive, CDCR could still have issued the letter of instruction, but chose not to.

In this case, the Hiring Authority simply dropped the ball. The investigation was competent and the Hiring Authority made the right decision to sustain the allegation after reviewing the evidence. But the Hiring Authority failed at the last step of actually taking action to hold Officer [redacted] accountable. This failure undermines the progressive discipline system, in which corrective action is designed to serve as a foundation for more serious discipline if the officer later engages in similar misconduct.[22]

B. Investigators Conducted Incomplete and Biased Investigations that Interfered with Determining If Allegations Were True

In many of the cases reviewed by Plaintiffs (discussed below and in Table A), investigators failed to conduct complete and unbiased investigations. These investigative failures, especially failures to retain and review relevant video evidence, often made it difficult or impossible to determine whether the alleged misconduct occurred. These cases demonstrate that Defendants are not complying with the Remedial Plans.

Plaintiffs are optimistic that the parties have committed to working with the Court Expert to identify and eliminate ongoing investigation failures. At the heart of the

[22] *See* DOM § 33030.8 ("[B]ehaviors that resulted in corrective action … may be cited in an adverse action for subsequent violations to prove the employee knew about a statute, regulation, or procedure or to prove that the employee has engaged in a pattern of violating a statute, regulation, or procedure within the past year. Corrective actions may also be used to rebut the employee's claim that he/she did not know about a statute, regulation, or procedure and/or expectation.").

problem, a shift in the approach to conducting staff misconduct investigations must occur. The Office of the Inspector General ("OIG") said it best in reporting on a 2021 sentinel case review:

> "The manner in which the interviews were conducted and the way questions were posed to incarcerated persons leads us to conclude that the investigators did not believe the allegations made by the incarcerated person from the outset and that the **inquiry was not conducted in order to gather information relevant to the allegations made, but that it was conducted in such a way so as to reach a conclusion that the allegations were not true**." (*See* June 3, 2021, OIG Report on Sentinel Case 21-01, at 9, emphasis added).

Similarly, many investigations reviewed by Plaintiffs' counsel, across multiple quarterly reports, appear focused on simply discovering enough evidence to dispel with the allegation, rather than uncovering the evidence necessary to determine whether staff misconduct occurred. Multiple examples of investigators requesting and reviewing only one minute of footage exemplify this point. (*See* **KVSP –** [redacted]; *see also* Plaintiffs' November 2022 Report at 27). Cases where investigators narrowly construe allegations can only be described as an effort to prove them untrue, such as when an investigator dismissed a complaint because footage showed the officer was not in fact laughing, as alleged, when he made the inappropriate comment. (*See* **KVSP –** [redacted]). Multiple cases in which investigators accept blanket denials or excuse the conduct of subject officers in the face of, and without ever reconciling, video evidence to the contrary, also demonstrate how investigations are not focused on gathering evidence relevant to confirming allegations. (*See* **CIW –** [redacted]; **KVSP –** [redacted]; **LAC –** [redacted]; **CIW –** [redacted]).

The investigation process will not work if investigators disbelieve incarcerated people from the outset and if investigations focus on disproving allegations rather than gathering the information necessary to prove the allegation true. The investigators' role in these cases must be to identify and review the evidence necessary to confirm the allegation, if true, and to report specifically on how that evidence fails to confirm the allegation, if not. There is bias inherent in the process because all investigators work for CDCR and many have worked in prisons alongside or in roles very similar to those they are now responsible for investigating. **CDCR must actively work to eliminate bias in staff misconduct investigations.**

The OIG recently testified about issues related to eliminating bias from investigations during a March 6, 2023, California State Assembly Subcommittee hearing on Public Safety. Per the testimony of Amarik Singh, the OIG has recommended that CDCR set up a process to check for conflicts of interest in local inquiry cases, as there

was no such procedure in place for CDCR to identify locally designated investigators' potential conflicts before they are assigned to investigate their colleagues. Plaintiffs' counsel agrees with this recommendation. Yet **to Plaintiffs' counsel's knowledge, CDCR has not yet adopted that recommendation.**

The following cases illustrate incomplete and biased investigations:

(1) **LAC –** [redacted] Local, Not Sustained

In this case, BWC footage shows that Officer [redacted] and Officer [redacted] conducted a search of [redacted] cell in retaliation for Mr. [redacted] calling Officer [redacted] a "house n-----" the night before. We describe below the facts caught on video that establish that the cell search was in retaliation for the insults Mr. [redacted] directed at Officer [redacted], including multiple admissions from Officers [redacted] and [redacted] about their retaliatory intent in conducting the search. **The investigator did not include any of this information in his inquiry report.** And the Hiring Authority did not sustain any allegations.

Allegations of retaliatory cell searches are common within CDCR. Officers' retaliatory intent is, however, extremely difficult to prove and is rarely as clear as it is in this case. After all, officers are required to conduct at least three random cell searches daily. *See* DOM § 52050.16. Thus it is very difficult to determine in most cases whether staff sought to target a particular person during a search.

Here, Officers [redacted] and [redacted] brag on video about the retaliatory purpose of the search to other officers and incarcerated people before, during, and after the search. These officers acted brazenly and intentionally to send a message to incarcerated people: If you do anything to cross us, we will retaliate against you. It is understandable that the officers in this case would be upset by being called a "house n-----" by Mr. [redacted]. But, engaging in a retaliatory cell search in response demonstrates a failure by these sworn law enforcement officers to meet their fundamental obligations. By failing to identify and hold these officers accountable for such problematic behavior, CDCR not only perpetuates the actual misconduct but also perpetuates the widespread belief that this type of misconduct is occurring, unabated.

Chronology of Evidence of Retaliation NOT Included in the Inquiry Report

About ten minutes before the search of Mr. [redacted] cell ([redacted]), Officer [redacted], who is in the dayroom of Building D3, receives a phone call from someone, likely Officer [redacted]. She says, "[C]ome on over. Come on over. Alright, bye," and hangs up. An officer standing near her says something unintelligible, to which she responds, "We have something to handle. From last night." *See* [redacted] 1 at 14:38:20.

A few minutes later, Officer [redacted] tells another officer that Officer [redacted] is coming over to the building, "Cuz we're house n-----s. We're gonna go hit the house n-----'s house and take everything…. I don't know why you even did that [redacted]." The other officer responds, "Hell yeah." *See* [redacted] 2 at 14:46:09.

Two minutes later, Officer [redacted] enters the housing unit and walks straight toward Mr. [redacted] cell without saying anything to any of the officers working in the building. *See* [redacted] at 14:48:50. Officer [redacted], who is sitting in the office at the time, follows Office [redacted] toward Mr. [redacted] cell without saying anything to him. As Officer [redacted] approaches Mr. [redacted] cell, he states in a sarcastic tone, "Random searches!" [redacted] at 14:49:17. Officer [redacted] asks the control booth to open cells [redacted] (Mr. [redacted] cell), 143, and 144. While Officer [redacted] is waiting for the cell doors to open, he yells, "Just your local house n-----!" *See* [redacted] at 14:49:50.

Officer [redacted] then conducts a cursory 10-second search of cell 143, during which he does not touch or move anything and does not address conditions that violated rules (e.g., clothes drying from a string attached to the ceiling). [redacted] at 14:49:58 (linked above). At the same time, Officer [redacted] conducts a cursory 20-second search of cell 144. *See* [redacted] 3 at 14:49:58. As she exits the cell, she states sarcastically, "Oh, I didn't find anything!" [redacted] 3 at 14:50:20.

The officers then shift to search Mr. [redacted] cell ([redacted]). This search lasts for more than 2.5 minutes. Officer Rose grabs Mr. [redacted] television and says, "This shit is broken anyway. See it's altered! It's altered anyway, it's altered anyway." *See* [redacted] at 14:50:13 (linked above).[23] Officers [redacted] and [redacted] look in most spaces in the cell, and move property to see what is behind and underneath. They confiscate extra toilet paper. The officers proceed to rip many pictures off of Mr. [redacted] walls.

After Officer [redacted] leaves the cell, an incarcerated person says something unintelligible to him. Officer [redacted] responds, "I don't want it [the search] to be targeted, so it's random, so I hit all the cells in this right here." *See* [redacted] at 14:52:50 (linked above).

After Officer [redacted] walks away from the cell, another officer walks toward her and says, "He [Mr. [redacted]] was talking shit?" Officer [redacted] responds, "Oh yeah, we're house n------. This is what house n------ do." *See* [redacted] 3 at 14:52:58 (linked above).

[23] Viewed in context, this statement suggests that Officer [redacted] was pleased because the television was altered, giving him legitimate grounds to confiscate it.

About a minute later, Officers [redacted] and [redacted] are in the office sorting through the items they took from Mr. [redacted] cell. Officer [redacted] says to Officer [redacted], "Now I'm gonna really be a house n----- tonight." *See* [redacted] 3 at 14:53:46 (linked above).

About twenty minutes later, Officer [redacted] has a conversation with another officer and an incarcerated person. The officer asks what Mr. [redacted] "was … tripping about yesterday." Officer [redacted] responds:

> [H]e [redacted] told him [Mr. [redacted]] to take it in, because he's not going to shower … He was like I am going to shower. That whole shower thing turned into house n----- this and Uncle Tom this, and suck my dick that type of shit. So I was like ok cool. Now we'll give you a legit reason to go off today.

See [redacted] 4 at 15:12:20.

A few minutes later, Officer [redacted] is talking with two other officers. One officer asks why Officer [redacted] tore down Mr. [redacted] pictures, to which Officer [redacted] responds, "Because yesterday we were house n-----." Another officer says, "You know how he gets all fuckin' crazy starts yelling and shit. He was doing that to [redacted] while he was up there." *See* [redacted] 5 at 15:19:21.

Much later in the day, Officer [redacted] is talking with Sergeant [redacted] about the television confiscated from Mr. [redacted] cell, and Officer [redacted] says, "We had to hit his cell today. It was too late to do so last night." *See* [redacted] 6 at 17:51:30.

The retaliatory search led directly to a use of force against Mr. [redacted] later in the day. As shown on BWC, when Mr. [redacted] returns to the housing unit at around 17:54, he is very upset and refuses to go back into his cell. He then throws a tray at Officer [redacted] and picks up a garbage can. The alarm sounds. Mr. [redacted] sits down at a table. Officer [redacted] handcuffs one of his hands, then takes him to the ground when he refuses to permit his other hand to be handcuffed.[24] Approximately five officers then assist in restraining him.

Bias in the investigation and inquiry report

The investigation into this incident, which occurred under Defendants' new investigation system, was extraordinarily biased and incomplete. The inquiry report did

[24] Defendants produced the video for this incident, but not any investigation documents. Defendants later informed Plaintiffs that the use of force was still under investigation.

not include any of the inculpatory evidence discussed above, with one minor exception.[25] As is the case with many investigations reviewed by Plaintiffs' counsel, this investigation failed to focus on answering the ultimate question: is there evidence of retaliatory intent as alleged by the class member? Instead, the investigator presumed without supporting evidence that the search was "random and not completed for a punitive purpose." *See* HA Determination at 3; *id.* at 1 ("[redacted] and [redacted] enter the cells and begin conducting random searches."). The inquiry report thus focused almost exclusively on whether the officers only removed contraband and whether they provided Mr. [redacted] with a search receipt in compliance with policy.

The investigator did not interview Officer [redacted] or Officer [redacted] because, according to the investigator, "the reviewed video and departmental policies were sufficient to complete a transparent investigation." *See* Inquiry Report at 4. Given the substantial evidence that the search was retaliatory, the investigator should have interviewed Officers [redacted] and [redacted] about their actions and statements, and obtained a longer period of BWC for both officers, including going back to the time of the incident the night prior that (according to the officers' statements on camera to other incarcerated people and officers) was the motivation for the retaliatory cell search.

In addition, for reasons not clear from the case file, an AIU supervisor never reviewed the inquiry report. The purpose of that court-ordered requirement is to catch cases like this where the investigation is incomplete and biased.

Because the investigator failed to present relevant evidence to the Hiring Authority, the Hiring Authority did not sustain any allegations. Based on the evidence, however, the Hiring Authority could have sustained multiple allegations.[26]

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[25] The investigator did note that Officer [redacted] came from outside the housing unit to conduct the search. The investigator explained away this fact by stating that officers often help with searches in other buildings, but failed to inquire into why Officer [redacted] came to Building D3 for this specific search. *See* Inquiry Report at 3.

[26] Failure to intervene in or attempt to stop misconduct by another employee directed at an incarcerated person (D30, 56**7**89); Intimidation, threat, or assault without the intent to inflict serious injury toward an inmate (D15, 34**5**678); Disruptive, offensive, or vulgar conduct which discredits the department (D14, 2**3**456); Failure to observe and perform within professional standards (D25, **3**456789); Intentional failure to report misconduct by another employee (B1, 2**3**45); Unauthorized use of department position (D8, 1**2**3); Discourtesy (D1, **1**23456); and Failure to observe and perform within the scope of training, post orders, duty statements, department policy, or operational procedures (D26, **1**2345).

The investigative and disciplinary failures in this important case reflect the deep bias and incompetence that pervades CDCR's accountability system. Because these problems were discovered within the statute of limitations for imposing discipline, Plaintiffs' counsel notified Defendants who have reopened this case. **Please produce to Plaintiffs' counsel a copy of the reopened decision in this case, when complete.**

(2) **CIW –** [redacted] AIMS; PREA; AIMS - Not Sustained

These cases involve credible consistent allegations that Dental Hygienist [redacted] sexually molested four women during dental examinations, including by touching their breasts and placing his groin and chest on their bodies. Despite very similar and serious allegations from multiple women, CDCR did not open any criminal investigation and did not appear to even consider doing so.

Instead, as often occurs with related allegations, CDCR assigned the allegations to different investigators to separately investigate, thus diminishing the potential to draw connections in evidence gathered from other allegations that could lend credibility to the individual claims. The two investigators who were responsible for completing the investigations discussed in this report failed to gather obvious, relevant and potentially corroborating evidence. The inquiry reports were also biased in favor of the accused, glossing over the crucial details reported by the women, while devoting substantial space to Hygienist [redacted] vague, self-serving denials. Ultimately, Hygienist [redacted] retired one day before the Hiring Authority closed the first investigation. Viewed collectively, these investigations strongly suggest that CDCR did not take seriously these credible and consistent criminal allegations from multiple incarcerated women. This failure is especially concerning in light of recent news out of Central California Women's Facility that 22 women have come forward to report sexual assault by an officer employed at that prison for a decade. *See* Press Release on Internal Investigation into Charges of Sexual Misconduct.

[redacted]

On March 18, 2022, [redacted] alleged that Hygienist [redacted] intentionally touched her breast with his thumb, elbow, and forearm. *See* 602 at 6. She also named three other women—[redacted]—who also claimed Hygienist [redacted] molested them.[27]

[27] It appears that in May and June 2022, Ms. [redacted] and Ms. [redacted] filed separate 602s about being molested by Hygienist [redacted]. *See* [redacted] at 9-12. **Defendants**

This matter should have been, but was not, treated as a criminal investigation, given that Ms. [redacted] alleged Hygienist [redacted] committed sexual battery. Cal. Penal Code 243.4. AIMS instead conducted an administrative inquiry, and the investigator interviewed Hygienist [redacted], potentially undermining any criminal proceedings.

This inquiry into Ms. [redacted] complaint was profoundly incomplete and biased. The inquiry makes no mention of the related allegation of Ms. [redacted], one of the three other women who Ms. [redacted] identified in her complaint. The report further glosses over very serious allegations by the other three women, stating only: "Correctional Lieutenant [redacted] conducted an interview with [redacted] wherein [redacted] explained that [redacted] inappropriately touched her while receiving dental care…. [redacted] conducted an interview with [redacted] and [redacted] wherein they reiterated what they authored in their grievances explaining that they had been inappropriately touched by [redacted]." *See* [redacted] at 2. Significant key details are entirely omitted from the report. The omission is known because those details were described in greater detail by a different investigator in a later investigation, CIW-[redacted] (discussed below).[28]

In contrast to the cursory review of the womens' accounts, the report includes much greater detail regarding the interview with Hygienist [redacted], including his assertion of blanket, unsupported denials: "[redacted] explained during any procedure, there are staff members walking around the immediate area but no one directly supervising him. [redacted] is never in a position that would allow him to inappropriately touch inmates. If [redacted] did touch an inmate inappropriately, he was unaware. [redacted] has always acted in a professional manner with all inmates and is unsure as to why the allegations were made." *See* [redacted] at 2.

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have not produced any investigation files regarding these two complaints. Please produce these investigation files.

[28] "[redacted] explained that [redacted] inappropriately touched her while receiving dental care. [redacted] indicated [redacted] purposely touched her breast with his elbow and forearm, when applying a bib across her chest. [redacted] stated the bib is usually self-applied by inmates, to prevent staff from violating their personal space. According to [redacted], [redacted] applied the bib to her chest, at which time, [redacted] thumb rubbed against her breast. [redacted] indicated [redacted] actions upset her and she elected to not return for any follow-up dental appointments. [redacted] stated the incident occurred in CIW Correctional Treatment Center (CTC), dental office. [redacted] did not recall the specific date and time the incident occurred. [redacted] explained, her last dental visit with [redacted] occurred in January 2022. [redacted] could not identify any witnesses." *See* [redacted] at 7-8.

The investigator does not attempt to confirm, such as by interviewing other staff or observing the dental office, whether it is true that Hygienist [redacted] would have no opportunity to engage in the misconduct. It is worth noting that the type of sexual misconduct alleged here could very well occur quickly, with unsuspecting colleagues around, and in plain sight. The investigator did not review any records to determine whether and when Ms. [redacted] and the other women were seen by Hygienist [redacted]. The investigator did not attempt to identify any other incarcerated women treated by Hygienist [redacted], nor did the investigator attempt to determine whether additional prior complaints against him existed. The investigation also fails to mention a separate, March 21, 2022 interview with Ms. [redacted], in which she reported consistent allegations against Hygienist [redacted].[29]

Based on this cursory and biased inquiry report, the Hiring Authority did not sustain the allegation, and closed the investigation on September 2, 2022, one day after Hygienist [redacted] retired. *See* [redacted] at 1; AIMS [redacted] at 26.

[redacted]

CDCR opened a separate investigation—[redacted]—based on Ms. [redacted] allegation that Hygienist [redacted] also molested Ms. [redacted]. Ms. [redacted] separately filed her own 602 in June 2022. *See* 602 at 69. Ms. [redacted] allegations were very similar to Ms. [redacted]. She claimed that Hygienist [redacted] touched her breasts with his body during an examination for about five minutes during the twenty-minute teeth cleaning. Ms. [redacted] said that she asked Hygienist [redacted] to stop the procedure because she was

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[29] Ms. [redacted] provided significant detail in this interview, in which she also described the exam area, and explained that she came forward after speaking with other women who had similarly been touched inappropriately by Hygienist [redacted]:

> As he is putting the paper bib on, he is unnecessarily touching you, even if you try to put it on yourself to prevent him from touching you. Before the appointment is over he has touched me in some way, either with his elbow, arm or thumb, each time, it's so obvious." Inmate [redacted] alleged the last time she was at her dental cleaning appointment, she became upset. As Mr. [redacted] removed the paper bib, he asked her if she was alright and patted her on the shoulder. Inmate [redacted] stated, "I felt he knew what he was doing and this made me feel dirty. I asked myself how come I have not said something about this man after all these years…. He is at my side. He lowers the exam chair real low and he leans over me. He also uses the stool, which is higher than the exam chair allowing him to be right over my body.

See [redacted] at 18-19.

so uncomfortable, but that Hygienist [redacted] asked that she be patient and let him finish. *See* AIMS [redacted] at 26. As with Ms. [redacted] case, CDCR improperly failed to treat this as a possible criminal matter.

The AIMS administrative inquiry was conducted by a different investigator than the person who investigated Ms. [redacted] allegation. The failure to have the same investigator investigate these closely related allegations undermined the effectiveness of both investigations by making it more difficult for the investigators to draw connections and corroborate similar accounts to lend additional credibility to individual complaints.

Although it included slightly more detail and cross-referenced Ms. [redacted] 602, the inquiry into Ms. [redacted] allegations was nevertheless incomplete and biased. The investigator did not interview Hygienist [redacted], and instead relied entirely on his interview from the separate inquiry into Ms. [redacted] 602, repeating his blanket denial almost verbatim. The investigator also did not interview Ms. [redacted] or Ms. [redacted], each of whom had also alleged that Hygienist [redacted] sexually molested them, and failed to take other steps to corroborate Ms. [redacted] allegation, such as interviewing Hygienist [redacted] co-workers and other incarcerated people treated by him, or searching for prior complaints against him.

Based on the incomplete report in this case, the Hiring Authority did not substantiate the allegation, finding that "that there was no evidence obtained to prove there was any inappropriate actions committed by … Hygienist [redacted]," and closed the case in October 2022, after Hygienist [redacted] had retired. *See* Memo [redacted] at 23.

[redacted]

CDCR opened a third investigation into the allegations against Hygienist [redacted], [redacted], which appears to be entirely duplicative of [redacted], the investigation into Ms. [redacted] allegations. This redundant investigation was opened in response to a subsequent 602 Ms. [redacted] filed in late June 2022, in which she again alleged that she had been molested by a dental hygienist. *See* 602 at 3. AIMS Lieutenant [redacted] (who investigated Ms. [redacted] allegation, but not Ms. [redacted] original complaint) drafted an inquiry report that consisted solely of review of materials from the first two investigations. The inquiry report, which was completed in October 2022, also notes that Hygienist [redacted] had already retired. *See* [redacted] at 7-8. The Hiring Authority did not sustain this duplicative investigation.

These inadequate and biased investigations suggest CDCR's staff accountability process is still not working to protect incarcerated women who report sexual misconduct by staff. Four women made plausible and consistent allegations that Hygienist [redacted] had engaged in criminal sexual misconduct. CDCR did not treat the alleged misconduct

as potentially criminal, failed to conduct complete and unbiased investigations, failed to ensure a single investigator investigated all of the related allegations to ensure the best possible chance of corroboration of relevant evidence, and failed to complete the investigations before the staff member retired.

It is noteworthy that the OIG, in the context of investigating allegations by transgender women, found that women were reluctant to come forward and report sexual assault or harassment because "staff do not take their complaints seriously, do not conduct interviews in private settings, and ridicule incarcerated individuals for complaining." *See* September 2020 OIG Report, *Steps Toward Addressing Prison Conditions for Incarcerated Transgender, Nonbinary, and Intersex Individuals* at 27. If CDCR is serious about eliminating sexual misconduct in women's prisons, plausible, credible, and consistent reports of such misconduct – especially by multiple women -- must be taken seriously.

(3) **KVSP –** [redacted] AIU, Not Sustained

This case involves a very serious allegation that officers released [redacted], from his cell knowing that he would attack [redacted].[30] The video evidence gathered by the AIU investigator supports the allegation. Despite this, the investigator failed to collect additional evidence, wrote a biased investigation report, and the Hiring Authority did not sustain any of the allegations.

Officer [redacted] BWC shows that, as Mr. [redacted] was leaving the housing unit for noon medication release, he loudly insulted Mr. [redacted] in cell 206. *See* BWC 1 at 11:32:24. Officers [redacted] and [redacted] then go outside of the building and discuss the incident. *See* BWC 1 at 11:33:45 (linked above). Officer [redacted] says, "[redacted] … he came out, like, pointing at 206, like, that dude's a bitch." Officer [redacted] then says, "Let's see if he [Mr. [redacted]] wants to come out," and laughs. Officer [redacted] asks the control booth officer if Mr. [redacted] gets released for noon medication pass. A few minutes later, the control booth officer tells Officers [redacted] and [redacted] that Mr. [redacted] has indicated that he has a medical slip; the control booth officer asks the officers if he should release Mr. [redacted]. Officers [redacted] and [redacted] both say "if you want." *See* BWC 1 at 11:36:12 (linked above). The control booth officer then releases Mr. [redacted] to go to the clinic. Meanwhile, Officers [redacted] and [redacted] go into their office to get latex gloves and then go back outside onto the yard.

Seconds before the fight, which occurred on the yard, Officer [redacted] said, "Force or no force?," and Officer [redacted] replied, "We'll play it by ear. It's kind of far. He looks kind of angry." *See* BWC 2 at 11:37:57. The control booth officer then says,

[30] The allegation was submitted by [redacted]. *See* 602.

"He looks like he's on a mission." A few seconds later, after Mr. [redacted] and Mr. [redacted] start fighting, the officers say, "Ooh yeah there you go." Someone sounds an alarm. Officers [redacted] and [redacted] then walk to the location of the fight. According to the incident reports, staff had to fire a block gun round, which hit Mr. [redacted], to stop the fight. As a result, Mr. [redacted] suffered multiple injuries, and a 7219 documented blood on his right hand and knees, abrasions on his knees, and redness to the right side of his neck. *See* Progress Note-LVN dated June 22, 2022.

About ten minutes later, Officer [redacted] and Officer [redacted] are discussing the fight, and one of them jokes, "Boom pow right in the kisser." *See* BWC 3 at 11:53:15. A few minutes after that, Officer [redacted] says, "It smelled like rain and then it rained." *See* BWC 3 at 11:56:43. Finally and most tellingly, while Officer [redacted] was conducting count, he stopped at cell 109 to talk with the two people in that cell, who were laughing. In response, Officer [redacted] said in a sarcastic tone that "he [Mr. [redacted]] wanted to take the medical slip over there. Who am I to stop that?" *See* BWC 3 at 12:01:30 (linked above).

The video shows that the officers knew the risk and set in motion the chain of events that led to both men being out of their cells at the same time, facilitating the attack and resulting in staff needing to discharge a weapon. It also shows the officers slowly responding to the fight, and joking about the fight afterward with each other and with other incarcerated people.

This evidence, standing alone, may be sufficient to sustain allegations of misconduct, including negligent or intentional endangerment (D2, D3) and/or failure to observe and perform within the scope of training, post orders, duty statements, department policy, or operational procedures (D26). The video evidence also raises serious questions as to whether Officers [redacted] and [redacted] engaged in misconduct that resulted in the need to discharge a weapon that hit Mr. [redacted]. As such, the AIU investigator should have gone further and collected additional evidence either further supporting or appropriately dispelling with the problematic evidence uncovered thus far. Instead, the investigator stopped the investigation after viewing the video and without interviewing Officers [redacted] or [redacted] to ask relevant questions, including what they meant by their suspicious comments that preceded and followed the fight.

The AIU investigation report was also biased. The report omits that, before the fight, Officers [redacted] and [redacted] were aware of the brewing dispute between Mr. [redacted] and Mr. [redacted]. The investigator did not mention any of the officers' comments before the fight or most of their comments after the fight. And though the investigator did identify Officer [redacted] comment to the residents of cell 109, the investigator focused on the fact that Officer [redacted] did not laugh about the incident (as

alleged in the grievance), rather than on what Officer [redacted] meant by such a suspicious comment. *See* AIR at 2.

(4) **KVSP –** [redacted] Local, Not Sustained

In this case, RJD declarant [redacted] alleged that Officer [redacted] denied him access to incontinence showers on September 7, 10, and 11, 2022 and that on September 11, Officer [redacted] made an inappropriate comment about his need for incontinence showers. Because the investigation was so incomplete and biased (with the investigator accepting the officer's blanket denial without regard to substantial evidence corroborating Mr. [redacted] allegations), the investigator failed to provide the Hiring Authority with the evidence necessary to sustain the allegation and hold Officer [redacted] accountable for his disability-related staff misconduct.

CDCR policy requires that, "[u]pon request, any [incarcerated person] who experiences an unforeseen incontinence accident shall be offered a shower, and an appropriate amount of incontinence related supplies (i.e., clean linen and clothing) as soon as possible." *See* August 16, 2022, Memorandum regarding Providing Incontinence Related Services and Supplies.

Here, Officer [redacted] BWC and AVSS footage shows that, on September 7, 2022 at around 1:26 p.m., Mr. [redacted] was waving a sign through the crack in his door. Mr. [redacted] claimed in his grievance and interview that he was waving the sign to receive an incontinence shower. *See* 602 at 1. Officer [redacted] BWC video is pointed right at Mr. [redacted] cell, suggesting that he saw Mr. [redacted] requesting a shower. But the investigator failed to determine whether or not a shower was provided.

Officer [redacted] BWC footage also captures part of an exchange on September 11, 2022, between Mr. [redacted] and an officer escorting him to the shower. The exchange is mostly unintelligible because Officer [redacted] was in the control booth, far from conversation. It is possible to hear, however, the words "ADA" and "shower."[31] *See* BWC 2 at 2:36:03. The BWC footage corroborates Mr. [redacted] allegation from his grievance that he was "explaining to the floor officer that I am to be allowed incontinence showers upon request." *See* 602 at 2. As Mr. [redacted] is about to enter the shower, he raises his voice and says, "I don't think [redacted] knows about it either." *See* BWC 2 at 2:36:25 (linked above). Officer [redacted] responds, "[redacted] don't know shit, [redacted] don't give a shit," and then laughs. This exchange corroborates the allegation that Officer [redacted]

[31] The investigator should have requested the other officer's BWC to better capture this conversation.

made an inappropriate comment that he "don't give a shit" about Mr. [redacted] right to access an ADA shower.

Other evidence suggests that Officer [redacted] may have been warned by ADA Sergeant [redacted] that Mr. [redacted] was entitled to incontinence showers. Sergeant [redacted] told the investigator that he spoke with Mr. [redacted] about his trouble getting showers (although he could not recall the date) and that he then spoke with on-duty staff in Housing Unit 3 once or twice about the issue, but that he could not recall if Officer [redacted] was one of the staff members with whom he spoke. *See* Inquiry Report at 3.

Given this corroborating evidence, the interview with Officer [redacted] was especially important to determine what he meant by his comment, whether or not he provided a shower on the dates in question, and whether ADA Sergeant [redacted] ever spoke to him about the need to provide access to incontinence showers generally or to Mr. [redacted] in particular. Instead, the investigator accepted Officer [redacted] blanket denial.[32]

The investigator failed to obtain BWC or AVSS that could have definitively resolved whether Officer [redacted] failed to accommodate Mr. [redacted] disability, including BWC from the officer who escorted Mr. [redacted] to the shower on September 11 and from Sergeant [redacted].

The investigator also requested inappropriately short video footage to investigate Mr. [redacted] allegations that Officer [redacted] denied him shower access on September 10, 2022. Mr. [redacted] claimed that he requested a shower at "approximately" 10:30 and 12:00 but did not receive one until after 2:00. *See* Grievance at 2. The investigator gathered AVSS and BWC footage showing Mr. [redacted] being released at 2:19 for a shower. But the investigator requested two one-minute clips of video—from 10:30-10:31 and from 12:00-12:01—to investigate whether Mr. [redacted] requested a

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[32] The investigator wrote in his report:

> [redacted] does not recall ever denying the claimant of an incontinence shower. [redacted] stated there are times where there is not sufficient staff, or staff are out of the building. [redacted] stated once sufficient staff are present they allow the claimant to exit his cell and use the shower…. [redacted] stated he is aware of certain inmates being incontinent, and having to shower due to accidents that may arise. [redacted] stated he does not recall ever yelling out of the control booth towards the claimant.

See AIR at 4.

shower. When those two clips did not show Mr. [redacted] requesting a shower, the investigator concluded there was no evidence to support Mr. [redacted] allegation. *See* AIR at 5. Relying on such inappropriately short video clips demonstrates bias, and suggests that the investigator was more interested in discrediting Mr. [redacted] than uncovering the truth.[33]

This should have been an open-and-shut case. Mr. [redacted] alleged Officer [redacted] denied him access to showers and made an inappropriate comment about that denial. Evidence supports his allegations. The investigator, if he had tried to run this case to ground, would have requested and reviewed additional footage and questioned Officer [redacted] about the inculpatory video and other evidence. But he did not. As a result, the investigator failed to provide the Hiring Authority with the evidence necessary to confirm whether the misconduct occurred and, if so, to hold the officer accountable.[34]

(5) SATF – [redacted] AIU, Not Sustained

This case presents a stark example of the serious problems that can occur when CDCR delays investigating and resolving a serious allegation of misconduct. [redacted] alleged that on November 5, 2021, he informed Officer [redacted] on multiple occasions that he was having an allergic reaction and needed his EpiPen, but that Officer [redacted] ignored him. Fortunately, the alleged denial of access did not result in tragedy, as Mr. [redacted] ultimately received access to his critical medication. But due to delays in the incomplete and biased investigation, CDCR failed to hold staff accountable.

Mr. [redacted] filed a 602 on November 5, 2021. The complaint was sent to the CST that same day. The case file indicates that the case was not routed to the AIU until August 19, 2022 and then was not assigned to an investigator until September 9, 2022, more than 10 months after Mr. [redacted] filed the 602. *See* AIU at 7. Even though the investigator identified some corroborating evidence, he did not complete what was ultimately a poor quality investigation[35] until November 2, 2022, two days before the end

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[33] The investigator also failed to acknowledge CDCR policy on incontinence showers, and did not obtain the February 1, 2022 Reasonable Accommodation Panel decision establishing Mr. [redacted] entitlement to incontinence showers, as reported in his 602.

[34] For another poor investigation into an allegation that an officer retaliated against a class member by denying him an incontinence shower, *see* **COR – [redacted]**, discussed in part in Section C, below.

[35] Because of the delays in routing the case, BWC footage, which could have resolved the complaint, was not available. The investigator failed to gather any relevant evidence from medical staff, including documentary or interview evidence, regarding how and when Mr. [redacted] actually received his EpiPen (Mr. [redacted] reported it was much later

of the statute of limitations. The Hiring Authority then did not conduct a case conference until November 30, 2022, after the end of the limitations period. At that conference, the Hiring Authority determined that the investigation was insufficient. Because the statute of limitations had expired, however, the Hiring Authority concluded that "further investigation can no longer be requested."[36] *See* 402 at 5. Thus, the delays in this case completely undermined the investigation, making it impossible to obtain relevant evidence or to ensure appropriate accountability.

(6) **RJD –** [redacted] AIMS, Not Sustained

In this case, [redacted], an RJD declarant, alleged retaliation for filing a 602 staff misconduct complaint and for reporting ongoing staff misconduct to Plaintiffs' counsel. Specifically, she alleged that staff retaliated by denying her access to multiple medical and mental health encounters, listed the names of seven officers responsible, and attached 35 priority ducats to her 602, presumably to indicate the medical and mental health encounters she missed. The investigator conducted an inadequate and biased investigation. As a result, CDCR was unable to confirm whether staff at RJD interfered with access to ducated encounters – an allegation previously raised by Plaintiffs' counsel and by a different class member.

The investigator waited seven months to try to interview Ms. [redacted], and ultimately did not interview her because he was told by custody staff that she had "refused." The investigator did not attempt to confirm whether Ms. [redacted] was actually declining to be interviewed, even though her 602 alleged that custody staff was failing to let her out for scheduled healthcare encounters, and thus the same could be happening with respect to her 602 interview. The investigator also did not interview any of the seven staff members Ms. [redacted] listed in her 602, and did not request video footage

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that day). Instead the investigator chose to focus on irrelevant and superfluous comments designed only to discredit the character of Mr. [redacted] and exonerate Officer [redacted]. For example, he included statements from an officer who had no personal knowledge of the alleged incident but described "[redacted] as always giving officers a hard time and seeking attention by boarding up and causing trouble," that "when [redacted] did not get the answers he wanted, [redacted] would board up every time," and that Officer [redacted] was "professional with all inmates." From another officer with no knowledge of the incident, the investigator included a statement that "[redacted] carries himself professionally with all inmates." *See* AIU at 10.

[36] The Hiring Authority could still have ordered additional investigation and then imposed corrective action, even though the statute of limitations had expired.

corresponding to the dates/times of the ducated encounters which could have shown whether or not staff failed to allow her out of her cell.

The investigator instead concluded, based solely on an email from healthcare staff, that any missed appointments were scheduling errors. But that email indicates that the healthcare staff looked at only two weeks of appointments and did not look specifically into any of the ducat dates that Ms. [redacted] attached to her 602, which covered months. *See* AIMS Relevant Docs at 85; 7-76. He ultimately stopped the investigation because, according to him, "all measures were exhausted, as no subject or witnesses were able to be identified." *See* AIMS Report at 2.

The inadequate investigation into this complaint is especially concerning because Plaintiffs previously reported the exact problem of Ms. [redacted] not being let out for scheduled encounters, including once for an interview with Plaintiffs' counsel. *See* August 12, 2022 email from [redacted] to [redacted] (stating that Plaintiffs' counsel were initially told that Ms. [redacted] "refused" her visit with Plaintiffs' counsel, but when they visited her cell front that same day, she reported she had not refused but instead was not notified of the visit.) Also, a different class member has made the exact same allegation. *See* RJD Monitoring Tour Report dated March 15, 2023 at 46, [redacted] "Officer intentionally refuses to let [redacted]] out for medical ducats and tells medical he refused."[37] The incomplete investigation in Ms. [redacted] case makes it impossible to know whether the alleged misconduct occurred. It is also impossible to tell whether CDCR is aware of this concerning pattern of complaints regarding staff at RJD obstructing access to medical and mental health encounters and then documenting "refusals." This limits the Hiring Authority's ability to address this type of misconduct and to hold staff accountable.

C. Investigators Routinely Fail to Retain and Review Relevant Video Footage of Incidents

A recurring problem with Defendants' investigations is the failure to retain and review appropriate video footage. Prior to the Court's Orders, the lack of video evidence at the Six Prisons meant that most investigations boiled down to conflict between incarcerated people's allegations and staff's denials, often resolving in favor of staff's account of events. Video can provide objective evidence of what transpired between staff and incarcerated people, thereby providing the evidence necessary to overcome the presumption that the tie goes to staff. Video is therefore critical to ensure accountability. Investigators must retain, review, and produce relevant video evidence to Plaintiffs'

[37] This allegation was originally placed on the allegation logs, but then disappeared without an outcome listed. In Plaintiffs' most recent tour report, we requested that RJD immediately complete all the incomplete investigations and produce them to Plaintiffs.

counsel per the Remedial Plans. RJD Remedial Plan, § IV; Five Prisons Remedial Plan, § V; *see also* Feb. 10 Report at 45-49 (reporting on Defendants' failure to retain, review, and produce relevant video evidence). Defendants' response to the February 10 report acknowledged "issues with the timeliness" of video footage requests. *See* Defs.' Response at 8.

Defendants continue to fall short of basic requirements regarding BWC and AVSS footage.[38] Investigators regularly fail to request video within the 90-day retention period, causing the destruction of relevant video footage that is crucial to the outcome of the case. For example, in SATF-[redacted] (discussed above), an investigator was not assigned until 10 months after the complaint was filed. The investigator documented in the report that BWC footage was "not requested due to the allegation date was outside of the 90-day BWC and AVSS retention period." However, the delay was not the claimant's—it was CDCR's in failing to timely assign an investigator, and failing to preserve video footage after the claimant timely filed a 602. *See also* KVSP-[redacted]; KVSP-[redacted]; KVSP-[redacted].

In multiple cases, institutions referred an allegation of staff misconduct within the 90-day retention period, but video was not retained because of a double failure: the institution never took steps to preserve the video and the AIMS investigator did not initiate their investigation until after the retention period had lapsed. For example, in SATF-[redacted], the incident occurred on September 18, 2021 and the claimant promptly filed a 602 on September 20, 2021, alleging that staff delayed in responding to a medical emergency. Video footage could have definitively determined whether the allegation was true. SATF referred the case to AIMS on October 29, 2021. The AIMS investigator, who did not complete the investigation until August 12, 2022—almost a year after the 602—also failed to request footage within the 90-day retention period. *See also* SATF-[redacted]; SATF-[redacted]; RJD-[redacted]; COR-[redacted]; COR-[redacted].

In other cases, investigators continue to fail review relevant video footage, without appropriate justification. For example, in COR-[redacted], although the claimant's 602 states that "both 4A1-L-B section cameras" will corroborate his allegations that staff failed to intervene during an assault, the case file includes no such footage, no

[38] 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.

documented attempt to obtain such footage, and no explanation why the investigator made no such attempt. The investigator also failed to request BWC of the control booth officer, who the claimant alleged was distracted during the assault and failed to try to stop the incident. The 602 identified the specific time and location of the assault, and so the investigator could have easily identified the officer and reviewed the appropriate footage. *See also* SATF-[redacted]; SATF-[redacted]; RJD-[redacted]; COR-[redacted]; CIW-[redacted]; LAC-[redacted].

Investigators also fail to make a sufficient effort to identify the time, date, and locations of relevant video footage. For example, in KVSP-[redacted], the claimant alleged that the subject officer denied the claimant access to medical appointments on multiple occasions. The investigator stated that they did not request video footage because the claimant did not provide a specific date or dates for the incidents. However, the complaint (Log No. [redacted]) does provide a date the claimant was denied access to the CTC. Additionally, the investigator pulled the dates of the claimant's health care ducats and found records showing that the claimant missed two appointments. The investigator should have determined if the subject officer was working on those dates and, if so, pulled BWC footage. *See also* CIW-[redacted]; COR-[redacted]; COR-[redacted].

CDCR continues to fail to produce all relevant video. In CIW-[redacted], the incident concerned an allegation that an officer used excessive force on the claimant once she was on the ground. Per the inquiry report, CIW produced footage from six BWCs for this inquiry and the investigator reviewed at least three videos. CDCR produced only one BWC video to Plaintiffs' counsel. That single BWC video does not fully capture the incident that created the purported need for force, nor does it capture all of the force used. According to the officers' incident reports, the incident involved an atypical use of force: holding the claimant's hair to prevent her from banging her head on the ground. However, without video showing the entire view of the incident, it is impossible for Plaintiffs' counsel to assess whether staff used excessive force.

In COR-[redacted], CDCR produced no BWC footage to Plaintiffs' counsel. The class member alleged that an officer retaliated against him by not providing an incontinence shower. The case file contains contradictory statements about the availability of BWC footage showing the incident. In one inquiry note, the investigator claims that BWC footage "revealed [the officer] did not refuse [the claimant] showers, clean pair of boxer nor did he state he was retaliating towards [the claimant]." However, a subsequent inquiry note below states that "the wrong footage was downloaded," suggesting that the investigator's conclusion is based on the wrong footage. It is unclear how the BWC footage error was identified. The investigator reviewed BWC on November 7, 2022, within the 90-day retention period, but apparently did not identify the error in the footage (and that it did not show the incident in question) until later. By that

time, the 90-day retention period had run and the correct footage was not available. Yet the investigator's conclusion based on the wrong footage remained in the report, which both AIU and the Hiring Authority signed off on.

Finally, in other instances, CDCR did not produce all relevant to Plaintiffs' counsel in the initial productions, and Plaintiffs' counsel had to request those videos in supplemental productions. *See* LAC-[redacted]; LAC-[redacted]; LAC-[redacted]; KVSP-[redacted].

For additional summaries of Defendants' failures to properly retain, review, and produce relevant video evidence in compliance with the Remedial Plans, please see **Appendix B**.

D. AIU Investigations are Delayed

Hiring Authorities are not the only cause of investigation delays. AIU staff are also failing to complete investigations by the deadlines set in the Remedial Plans: 90 days for investigations conducted by custody supervisors (Sergeants and Lieutenants)[39] and 180 days for investigations conducted by Special Agents. The chart below shows that, for investigations the AIU received in June-December 2022,[40] **the AIU closed 46% of the investigations late**.

Month Received	Closed On Time	Closed Late	Open Not Yet Late	Open Already Late	Late	% Late	% On Time
June	99	154	1	0	254	61%	39%
July	121	106	4	3	234	47%	52%
August	132	119	0	1	252	48%	52%
September	98	103	1	1	203	51%	48%
October	144	170	1	8	323	55%	45%
November	155	60	0	16	231	33%	67%
December	203	52	5	39	299	30%	68%
Total	952	764	12	68	1,796	46%	53%

[39] The data shows that 87% of the AIU investigations to date have been assigned to custody supervisors.

[40] Plaintiffs only present the data for June-December 2022 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. Plaintiffs do note that the preliminary data from these months shows some potential improvement in completing investigations on time.

Plaintiffs acknowledge that the data is trending in a positive direction. But the substantial number of untimely investigations suggests, as Plaintiffs have been stating for more than a year, that Defendants have not staffed the AIU with adequate numbers of personnel.

III. OFFICERS ARE NOT COMPLYING WITH BWC POLICIES

Plaintiffs' counsel reviewed BWC footage from the productions covered in this report to assess officers' compliance with BWC policies and whether CDCR is holding officers accountable for non-compliance. Our review 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* February 10, 2023 Report at 49-52 (discussing similar problems with non-compliance). Defendants' BWC policies mandate that officers must keep their BWCs activated for the entirety of an officer's shift, except for specified deactivation events.[41] Officers must reactivate their cameras as soon as the deactivation event has concluded, and announce their reactivation.[42]

Plaintiffs reviewed each deactivation/reactivation for all unique BWC videos produced by Defendants to determine whether: (1) a deactivation may have been an intentional effort by the officer to interfere with the camera capturing misconduct ("code of silence"); (2) a deactivation appeared to be for an inappropriate deactivation event; and (3) the officer failed to announce the reason for the deactivation/reactivation.

A. Officers Appear to Be Intentionally Deactivating or Obstructing the Use of BWCs to Promote a Code of Silence

In one case following a use-of-force incident, the circumstances suggest officers used their BWCs in a way that advances a code of silence, and/or were colluding in report writing. This case, **CIW – [redacted]**, involves officers whispering inaudibly, a new—to Plaintiffs—form of interfering with BWC recording. As described above, staff

[41] *See* 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.

[42] Defendants' response claimed that "officers are not required to announce reactivations of BWCs." *See* Defs.' Response at 10. However, per Defendants' local operating procedures, "[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 Prison Remedial Plan Local Operations Procedures § VI.B.11 (LAC).

in this case improperly used immediate force to conduct a cell entry. After the incident, Sergeant [redacted] BWC shows him whispering inaudibly to another officer. *See* BWC at 9:40:19-9:40:55. The officers have no reason to whisper other than to conceal their statements from being recorded by BWC, as no other staff or incarcerated people are nearby. *See also id.* at 9:46:15-9:48:15 (Sergeant [redacted] repeatedly leaning in to whisper inaudibly to Sergeant [redacted]). On the video footage that is audible, Sergeant [redacted] discusses the use of force incident with custody staff, and a senior officer says "get that one on one (1:1) to write. Attest that she boarded up." *Id.* at 9:55:20. This statement suggests potential collusion in report writing, which is prohibited. *See* DOM § 51020.17.1.

In **LAC – [redacted]**, the sheer number of impermissible deactivations in a case involving obvious misconduct raises suspicions that officers may have been engaged in a code of silence. Even if not, the number of impermissible deactivations in a single case indicates that BWC noncompliance is pervasive. As discussed in the writeup above, the case involves officers retaliating against a class member by conducting a targeted cell search. Officers then use force when the class member comes back to the building and refuses to return to his cell.[43] Several different officers deactivate their cameras in impermissible circumstances before, during, and after the incident. Defendants reported that the investigation in to this case has been reopened and that should include impermissible BWC deactivations:

- In the middle of a discussion about the retaliatory cell search with Officer [redacted] (who participated in the search) and Officer [redacted], Officer [redacted] reactivates his camera without announcement. *See* BWC at 15:19:18. The inquiry report in that case ignored that Officer [redacted] camera was deactivated without justification. Officer [redacted] later reactivates BWC while already back in the program office. *See* BWC at 16:27:58.

- Later, in the middle of the use of force, a different officer reactivates BWC.[44] *See* BWC at 18:00:16.

- An officer who responded to the use of force from the yard deactivates their camera after the use of force, while walking back across the yard. *See* BWC at 18:05:27.

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[43] CDCR has stated the events in this case are under investigation. The investigator should also investigate officers' BWC noncompliance.

[44] The officer's BWC is also partially blurred throughout.

- A different officer is discussing the use of force with a supervisor (apparently a captain). In the middle of that conversation, the supervisor instructs the officer to dock his camera and get a spare. According to Defendants' operating procedures, a BWC will be docked at the end of a shift, if an officer is moving to a new post during the shift, if the camera becomes inoperable, or if the batteries run out. None of those circumstances appears to be present here. *See* BWC at 18:12:23.

- About 10 minutes after an officer leaves the scene of the use of force, he approaches four other officers outside the program building, who appear to be discussing the incident. That officer turns off his BWC as a sergeant points to the officer's BWC, and another officer also appears to deactivate their BWC. *See* BWC at 18:22:00-18:22:26.

B. Additional Improper Circumstances Violations

In several other cases, officers deactivated or reactivated their BWCs in improper circumstances. Investigators only noted BWC noncompliance in some of these cases, and Hiring Authorities did not take action in any cases discussed below. The following is not a comprehensive accounting.

In CIW-[redacted], discussed above, one of the officers' BWCs has no audio throughout a more than 20-minute video that involves use of force against an incarcerated person. In CIW-[redacted], an officer has their BWC covered for about three minutes. The investigator noted this issue, but the Hiring Authority took no action. In the same case, another officer reactivates their BWC without announcement while outside an incarcerated person's cell. *See* BWC at 17:58:16. *See also* LAC-[redacted], BWC[45] at 12:14:27-12:54:06 (reactivating BWC in the middle of completing paperwork, after having deactivated 40 minutes earlier to use the restroom).

The productions also show officers impermissibly deactivating BWCs for conversations with incarcerated people. In KVSP-[redacted], the officer is talking to an incarcerated person and says "deactivating camera for confidential interview." The person he is talking to responds, "Confidential interview? It's public information." BWC is deactivated for almost ten minutes. *See* BWC at 14:01:25-14:11:15. The deactivation occurs in a public space. An officer may only deactivate to interview a "current or potential confidential informant," or a person making a PREA complaint. Even if one of those very limited circumstances did apply here (and it is far from obvious either does), the deactivation was premature because the officer and incarcerated person

[45] In some of the converted videos linked here, the video freezes upon deactivation or reactivation.

were not in a confidential space. *See also* SATF-[redacted] at 9:04:10-9:24:21 (officer deactivated BWC, without announcement, for over 20 minutes after telling another officer "I'm gonna go talk to this fool real quick" and approaching an incarcerated person's cell).

Plaintiffs found additional violations, not discussed in this report, in which officers failed to announce deactivations and reactivations. It is worth noting that Defendants' BWC audit system would not identify many (if any) of these instances of BWC noncompliance, as few (if any) of the videos contain deactivations exceeding 1.5 hours.

IV. INFORMATION REQUESTS

- Defendants' response to Plaintiffs' February 10 report referred to numerous documents, including trainings, a lesson plan, and new policies. Defendants' response did not attach any documents. On March 21, 2023, Plaintiffs' counsel requested documents referenced in the response. To date, Defendants have produced no documents. On April 30, 2023, in response to a follow-up email, Defendants wrote only they "are still working on this request." Please produce the requested documents. If Defendants rely on documents to support their written response, Defendants should attach them to the response, or be prepared to promptly produce them afterward.

- In response to Plaintiffs' February 2023 report, Defendants reported that the LDI training schedule for 2023 includes biweekly training throughout the state conducted by senior OIA agents. As of March 2023, 95 staff members in OIA and 3053 staff members in DAI had received LDI training. By when do Defendants expect that all staff currently serving as LDIs will be trained? Plaintiffs reiterate the request for a copy of the recently updated LDI training.

- Please provide an update on the status of development of the OIA training course titled, "Preventing Bias in Investigations," which Defendants reported is being developed specifically to address and prevent bias in the investigative process. When will this training be completed? Who, aside from AIU investigators, will receive this training? How will this training be delivered to the field? Plaintiffs request the opportunity to comment on a draft of the training.

- Defendants reported that OIA and the Office of Legal Affairs (OLA) are working on a specific lesson plan for HAs that addresses many of the topics in Plaintiffs' letter. Please provide an update on the status of the development of this training. When will this training be completed? How will this training be delivered to the field? Plaintiffs request the opportunity to comment on a draft of the training.

- Defendants reported in their February report response that the Allegation Inquiry Report (AIR) review process began in May 2022 for the Six Prisons. This is the process whereby an additional level of review will identify any deficiencies in inquiry reports completed at the institutional level. Will this process be implemented statewide? Or will this process only exist for reports coming out of the Six Prisons?

- Defendants reported in their February report response that DAI will also be implementing a 10-day timeframe for LDI requests for AVSS/BWC footage. Has this standard been implemented yet? Has the LDI lesson plan been updated to reflect this standard? Please provide a copy of the lesson plan.

- Regarding the retention of video in AIU cases, Defendants report that AIU Managers are expected to triage incoming cases, submit requests for AVSS/BWC footage, and assign the investigation to an AIU investigator within 10 business days of receiving the complaint in AIU. Where is this expectation memorialized? Please provide a copy to Plaintiffs' counsel.

- Lastly, Plaintiffs' counsel requests information on whether CDCR has taken any concrete steps to address problematic decision-making by any of the Hiring Authorities or investigators responsible for cases identified in Plaintiffs' reports. If so, please explain what has been done.

V. CONCLUSION

Pursuant to the parties' agreement, we expect to receive a response to this report from Defendants by June 16, 2023. 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

The productions we reviewed included 519 unique and closed case files. Only 24 of these cases were investigated by the AIU (4.6%).[46] In 35 of the cases (6.7%), Hiring Authorities sustained allegations against at least one staff member.[47] In those cases with a sustained allegation, Hiring Authorities imposed adverse action against at least one staff member in only 3 cases.[48] In the remaining 32 cases with a sustained allegation, Hiring Authorities imposed corrective action or took no action.[49] The chart below breaks down the cases by institution.

	Cases	Sustained	Corrective Action	Adverse Action	% Sustained	% Adverse
LAC	121	7	6	1	6%	1%
RJD	57	4	3	1	7%	2%
CIW	33	4	4	0	12%	0%
SATF	167	13	13	0	8%	0%
COR	79	4	4	0	5%	0%
KVSP	62	3	2	1	5%	2%
Total	519	35	32	3	6.7%	.6%

[46] Broken down by prison: LAC (4); RJD (1); CIW (6); SATF (2); COR (1); KVSP (10)

[47] In 2 additional cases, a separate policy violation was discovered in the course of the investigation and sustained against at least one staff member: CIW [redacted]; KVSP [redacted]

[48] LAC [redacted]; RJD [redacted]; KVSP [redacted]

[49] LAC [redacted]; LAC [redacted]; LAC [redacted]; LAC [redacted]; LAC [redacted]; LAC [redacted]; RJD [redacted]; RJD [redacted]; RJD [redacted]; CIW [redacted]; CIW [redacted]; CIW [redacted]; CIW [redacted]; CIW [redacted]; SATF [redacted]; SATF [redacted]; SATF [redacted]; SATF [redacted]; SATF [redacted]; SATF [redacted]; SATF [redacted]; SATF [redacted]; SATF [redacted]; SATF [redacted]; SATF [redacted]; SATF [redacted]; COR [redacted]; COR [redacted]; COR [redacted]; COR [redacted]; KVSP [redacted]; KVSP [redacted]

APPENDIX B

KVSP

[redacted]	CDCR failed to retain video footage, apparently because the investigator failed to request video within the retention period. The claimant alleged that after he was placed in handcuffs, the subject officer lifted him up from the ground and then began punching him. Because of the IERC review, KVSP retained video of the period up to the time that the subject officer lifted claimant to his feet. However, the failure to retain video meant the investigator could not review video of the time period after claimant was on his feet (when the claimant alleged the officer punched him).
[redacted]	CDCR failed to retain video footage, apparently due to delays in the investigation and a failure to request video footage within the retention period. Video footage would have been determinative of all three allegations: (1) whether the subject officer refused to give the claimant a cell search receipt on May 12; (2) whether the subject subsequently harassed the claimant on the days he worked in the claimant's building from May 12 to May 19; and (3) whether the subject officer was texting in the dayroom.
[redacted]	CDCR failed to retain video footage, apparently due to delays in the investigation. Video footage likely would have been determinative of both allegations at hand: (1) whether one officer informed a sergeant about the claimant's safety concerns, and (2) whether the other officer kept opening the claimant's door, thereby exposing him to a possible attack.
[redacted]	See discussion in report.

COR

[redacted]	CDCR failed to retain and review BWC footage. The incident occurred on October 6, 2021 and the Hiring Authority referred the case for an AIMS investigation on November 9, 2021. However, for reasons unclear, the case was not assigned to the investigator until January 10, 2022. As a result, video was no longer available because that date was beyond the 90-day retention period. COR also failed to preserve the video upon referral to AIMS.
[redacted]	As discussed in more detail in the case writeup above, this case involved an interaction between a class member and two officers. The investigator only obtained video for one officer, which had

	been preserved in response to an independent request for the video. The investigator did not obtain video for the other officer, who primarily interacted with Mr. [redacted]. That video had not previously been preserved and, because the investigator did not timely request the video, it was destroyed by the time the investigator requested it.
[redacted]	The investigator failed to retain and review the BWC footage from the floor officer during the incident. That footage was relevant to determining whether the subject officer inappropriately allowed people to be outside of their cells before count had cleared, as the claimant and the subject officer had divergent accounts of the incident.
[redacted]	The investigator failed to take the basic step of confirming when the encounter between the lieutenant and the claimant took place. Had the investigator done so, the investigator could have identified BWC footage from other officers who may have witnessed the incident (as the lieutenant does not wear BWC) or AVSS of the encounter.
[redacted]	See discussion in report.
[redacted]	See discussion in report.

LAC

[redacted]	The investigator reviewed BWC and AVSS footage that confirmed the subject officer was reading a personal book and watching television in the dayroom. However, Defendants produced only the BWC footage and did not retain or produce AVSS footage to Plaintiffs because the investigator reviewed that footage "outside of the Audio/Video Surveillance System Evidence Request, CDCR 1027 process." Defendants did not even produce a memorandum explaining that AVSS footage was not retained until Plaintiffs' counsel requested the video. The AVSS footage is critical to determining what was occurring in the dayroom while the officer was reading a book and watching television, and the extent to which the officer's actions endangered incarcerated people.
[redacted]	The case file is unclear as to whether the investigator reviewed video footage beyond AVSS, which has no audio. The

	investigator's report vaguely states that they reviewed "footage from 1656 through 1704 hours of the alleged date." The investigator also states that "BWC and AVSS footages disclosed the allegation to be true." However, the only video request form in the case file is for AVSS and the only footage produced to Plaintiffs' counsel was AVSS that lacks audio. BWC footage with audio was critical to addressing the claimant's allegation that the officers not only denied him the incontinence shower, but also laughed at his request for an accommodation—an aspect of the complaint that the investigator ignored.

SATF

[redacted]	The investigator did not begin interviews until almost six months after case referral, after the 90-day retention period. Even so, SATF should have preserved the footage once the Hiring Authority determined the claimant alleged staff misconduct and referred the case to AIMS, which occurred on September 20, 2021 – well within the 90-day retention period for the August 26, 2021 incident. Video was critical to assessing the claimant's allegations that staff failed to protect the claimant while he was suicidal.
[redacted]	CDCR failed to retain AVSS footage. The incident occurred on October 22, 2021 and the claimant promptly filed a 602 on November 3, 2021. SATF then referred the allegation to AIMS on November 15, 2021. SATF should have preserved the video footage at that time, but failed to. The AIMS investigator then did not request AVSS footage until August 2022, over nine months after the incident. Although the incident involved a lieutenant who does not wear BWC, AVSS footage could have shown the events leading to the lieutenant pepper-spraying the claimant.
[redacted]	The claimant alleged that staff wrongly housed him with a person who later assaulted him. The investigator did not seek the sergeant's BWC footage, which might have shown the two incarcerated people being placed in the same housing unit.
[redacted]	The claimant alleged staff failed to respond to an attack on a different class member. The AVSS footage was about 30 seconds long and showed an incarcerated person hit the class member. The investigator concluded based on that video that no incarcerated person alerted staff to the incident. However, the investigator failed to request BWC footage—which would have included audio showing whether officers in the podium area heard the altercation and failed to respond. The two incarcerated people also remain

	engaged in a dispute when the AVSS ends, so the investigator should have reviewed a longer period of video footage to assess whether other residents later advised custody staff of the altercation.
[redacted]	See discussion in report.
[redacted]	See case writeup.

RJD

[redacted]	AIMS received the investigation on March 8, 2022, but the investigator did not conduct the first interview until September 9, 2022 and the investigator did not review any video.
[redacted]	The investigator failed to attempt to review any video to determine whether staff approached the claimant on February 1, 2022 and gave him the opportunity to attend committee—even though the investigator conducted the first interview on April 4, 2022, well within the 90-day retention deadline.
[redacted]	See case writeup.
[redacted]	See case writeup.
[redacted]	See case writeup.

CIW

[redacted]	The incident involved a lieutenant, who does not wear a BWC. However, both that lieutenant and the claimant indicated that a named sergeant may have witnessed the incident. The investigator should have, but failed to, request and review that sergeant's BWC.
[redacted]	The investigator reviewed available BWC footage for one of the subject officers from 1320 to 1400, as the claimant estimated the incident occurred at 1333. However, the footage did not show any interaction between the claimant and either the subject officer or the subject sergeant. The investigator should have reviewed additional BWC footage to determine when the interaction actually occurred or reinterviewed the claimant to determine if the interview could have occurred at a different time. The investigator also inexplicably requested AVSS footage of cell 147, even though the claimant was housed in cell 112 at the time of the incident.
[redacted]	See discussion in report.

	In addition, the inquiry report notes that the incident commander did not request preservation of the video footage of the incident, even though a use of force is a triggering event. From the case file produced to Plaintiffs, it does not appear that the Hiring Authority took any action to address this policy violation.
[redacted]	See case writeup.