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May 12, 2023

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

Dear :

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"). As detailed below and in the accompanying Table A² (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.

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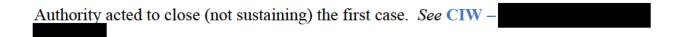
been affirmed in relevant part by the Ninth Circuit, and with the RJD and Five Prisons Remedial Plans. *See* Dkts. 3059, 3060, 3217, 3218, 3393; *Armstrong v. Newsom*, 58 F.4th 1283, 1288 (9th Cir. Feb. 2023).

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

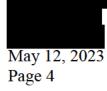
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Investigators also disregarded important video evidence that corroborated the allegations of misconduct. In one case, the video collected by the investigator shows that two officers admitted repeatedly on BWC to conducting a search of a mentally ill man's cell to retaliate against him; the investigation report did not mention any of this video . In another case, an officer's BWC captures him telling footage. See LAC 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 – 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 -

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 —

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





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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 196³ 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":

- 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).
- 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).
- 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).
- 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).
- 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).

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

- 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).
- 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).
- 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-model (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- (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- (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- (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- (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- (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- (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** (see 602 at 3) In this case, discussed below, Mr. reported he was suicidal to Officer 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 created an opportunity for Mr. 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 –

[;] **LAC** – ; **RJD** – ; **COR** – ;

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 –). 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 – ; LAC –
; <u>RJD</u> –). 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 –
; COR – ; LAC –). (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—

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. 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.

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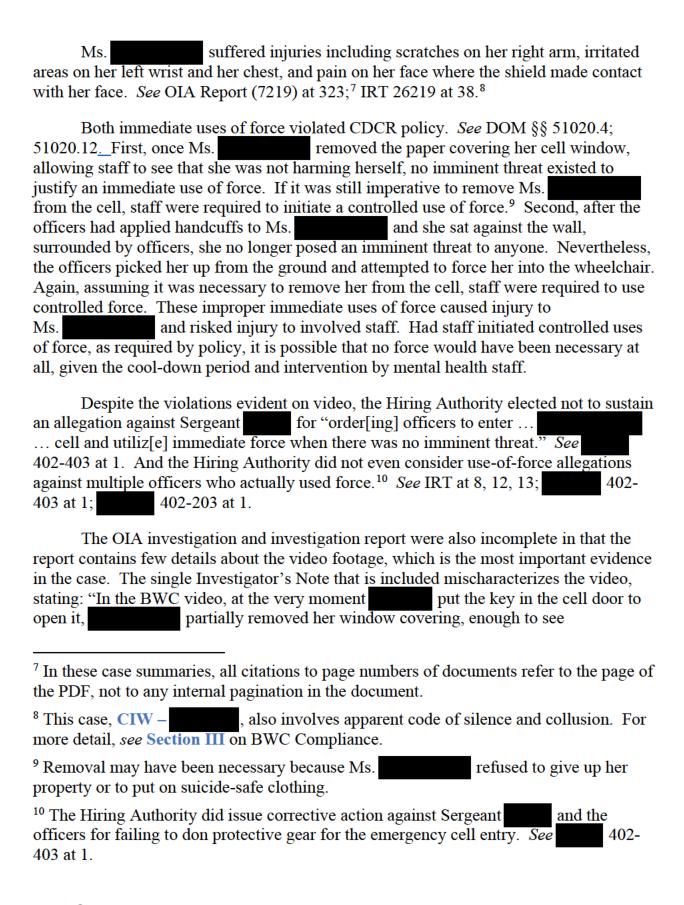
⁶ The statute of limitations is one year from the date of discovery. Defendants only include a case in a quarterly production once it has been closed for 30 days. And the quarterly production may not occur for as much as three months after that 30-day period.

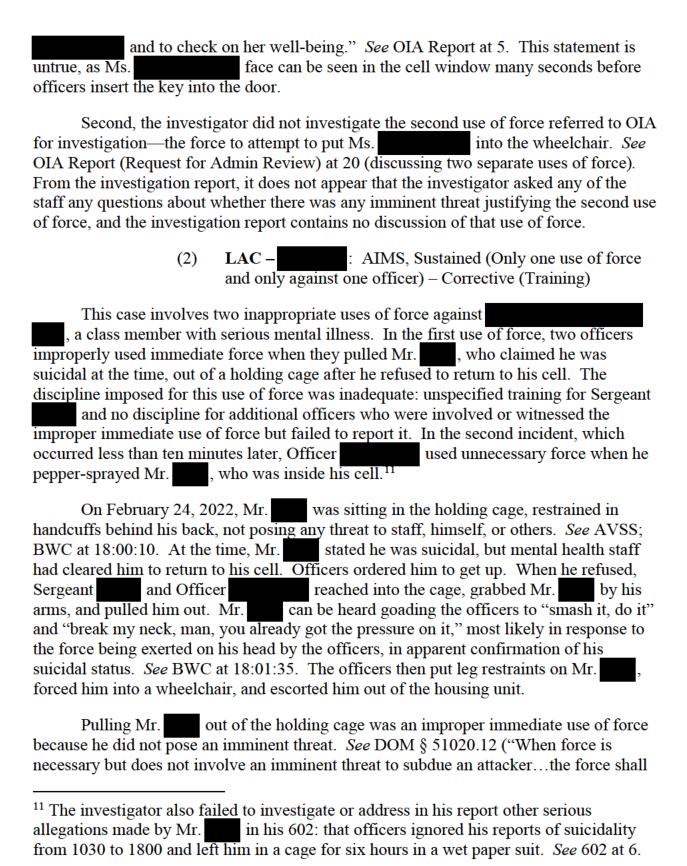
2.		g Authorities Failed to Hold Staff Accountable When the onderance of Evidence Shows Misconduct
	(1)	CIW – : OIA, Sustained a lesser charge regarding protective gear – Corrective (Training; LOI)
		ing Authority failed to hold any staff accountable despite clear s initiated two improper immediate uses of force against.
Unit ordered an emer watch at the time, he Ms. he more than 20 second immediate cell entry significant force to p additional improper The IERC independ Authority requested	ergency ad bloc ad remo ds befo y and ex place M immed lently re l and O firming	diate use of force to extract Ms. from the cell. ecognized these two use-of-force violations, and the Hiring IA conducted an administrative investigation. Yet despite the the violations, the Hiring Authority did not sustain any use-of-
eliminated prior to e officers—reached the window, meaning start 9:23:18. Ms.	entry. Ane cell in the had to see	As the cell entry team—Sergeant and three other front, Ms. can be seen with her face in the at least partially removed the window covering. See BWC 2 at said "I'm right here. Hello, I'm right here. [Unintelligible] me. I'm right here, hello." Just before the officers enter the gain visible through the window. Id. 9:23:36.
pose any imminent immediate force to j wheelchair. Sergea up on us, get her in thirty seconds until	against threat. pick M nt that wh the offi	screamed, "This is a suicide watch inmate, she has boarded

two doses of involuntary medication, and the situation eventually

Ms.

deescalated.





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. 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 received unspecified training on extractions. See IERC documents at 10 ("On 9/4/22 training was provided to Officer 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. out of the holding cage (Sergeant and Officer). Officer 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 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 and the others involved in this incident that the violation was not serious. 12 In the second use of force, Officer pepper-sprayed Mr. while he was inside his cell, after Mr. allegedly spit on officers. See BWC at 18:07:07. Prior to the incident, officers were uncuffing Mr. through the cell's tray slot. Before the restraints were removed, Officer unholstered his pepper spray. See BWC at 18:07:02. Once officers removed the restraints, Mr. 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 then immediately pepper-sprayed Mr. use of force was unnecessary. Once the restraints were removed, the officers could have avoided any threat posed by Mr. threat of being spit on, by moving away from the cell door. If Mr. continued to spit or engage in other conduct that required intervention, officers then could have initiated a

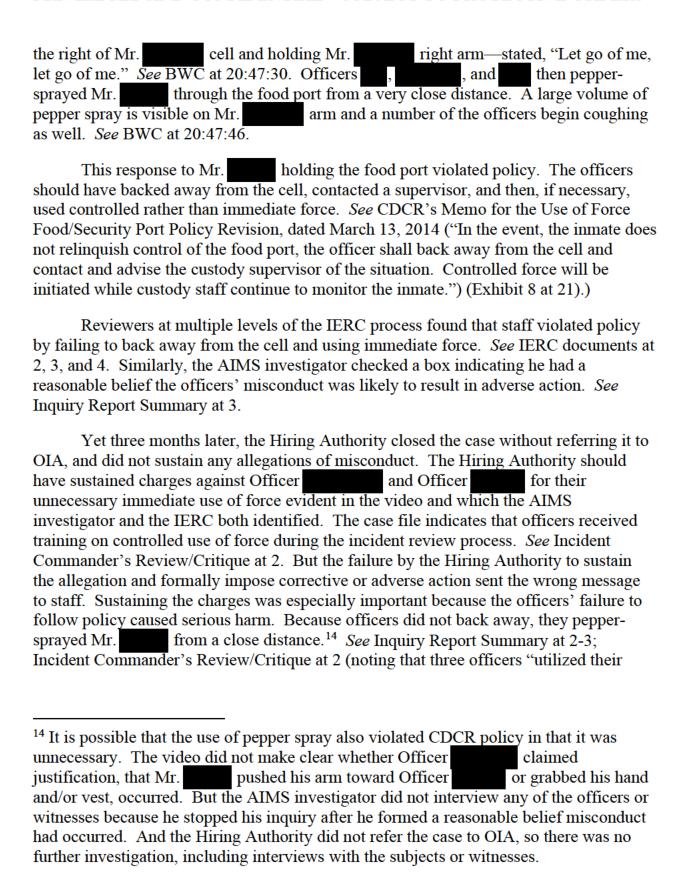
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¹² From the file produced to Plaintiffs, it is not clear that the corrective action against Sergeant was even placed in his personnel file, meaning it could not be used as a basis for progressive discipline.

was locked in his cell and not posing an imminent

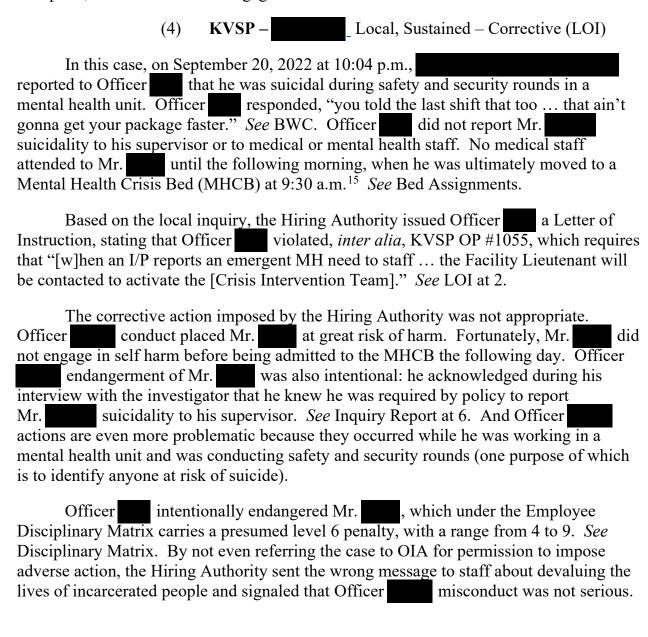
controlled use of force, as Mr.

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 and CDCR's repeated failure to hold him accountable. In one case, also involving a mentally ill individual, Officer 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 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) AIMS, Not Sustained LAC -This case involves an inappropriate immediate use of force against a class member with serious mental illness. Despite the IERC and AIMS investigator identifying the misconduct, the Hiring Authority improperly failed to 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 , Officer (the same officer as in the prior case, LAC -), and three other officers escorted Mr. 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. left his right arm in the food port and declared that he was "holding this slot." See BWC right hand, while Officer at 20:47:12. In response, Officer held Mr. right arm. While the officers attempted to placed a handcuff on Mr. gain control of the port and handcuff Mr. , Officer —who was standing to ¹³ The investigator included this use of force in the review of BWC, noting that unholstered his MK 9 OC canister, aimed his MK 9 at deployed a one-second burst of OC to 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. . See 7219 at 9.

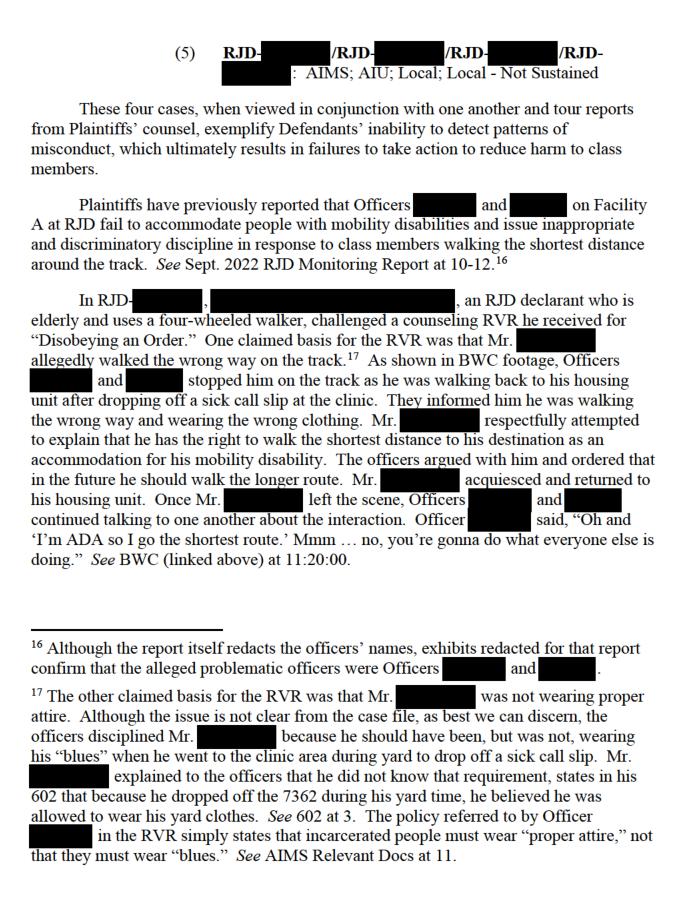


MK-9 Streamers closer than 6 feet, which is the Department's recommended minimum distance, to deploy MK-9 Streamers").

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.



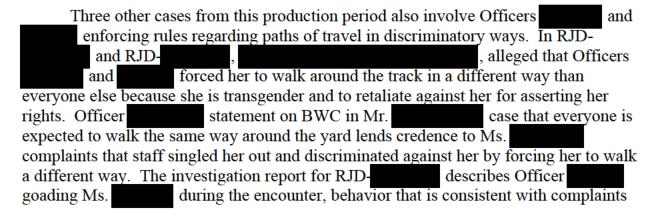
¹⁵ Mr. medical records, which the investigator did not review, show that he did not interact with any healthcare staff until the following morning.

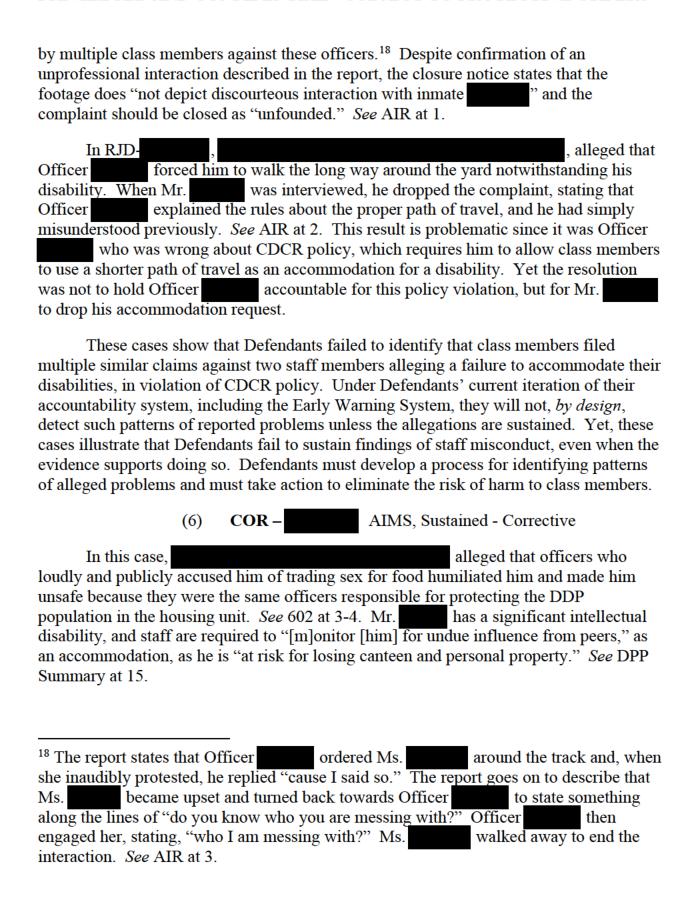


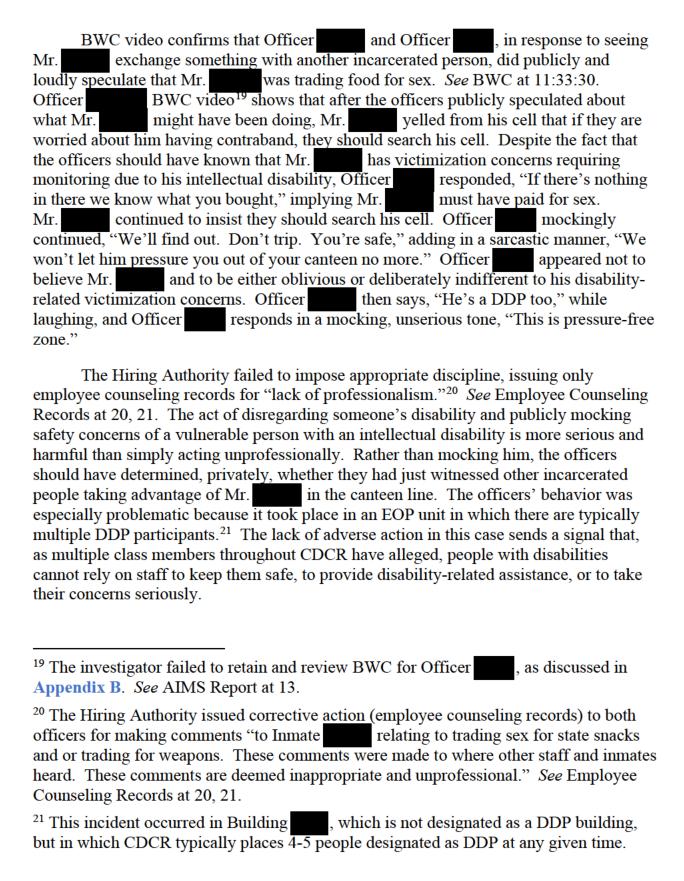
The video confirms that Officers and either do not understand their responsibility to accommodate class members, or have chosen not to do so in defiance of that responsibility. CDCR policy requires that staff "utilize sound correctional decision making in determining the reasonableness of the [incarcerated 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. 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).







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

In this case, on November 23, 2022, the Hiring Authority sustained an allegation that Officer 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. 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 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

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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).

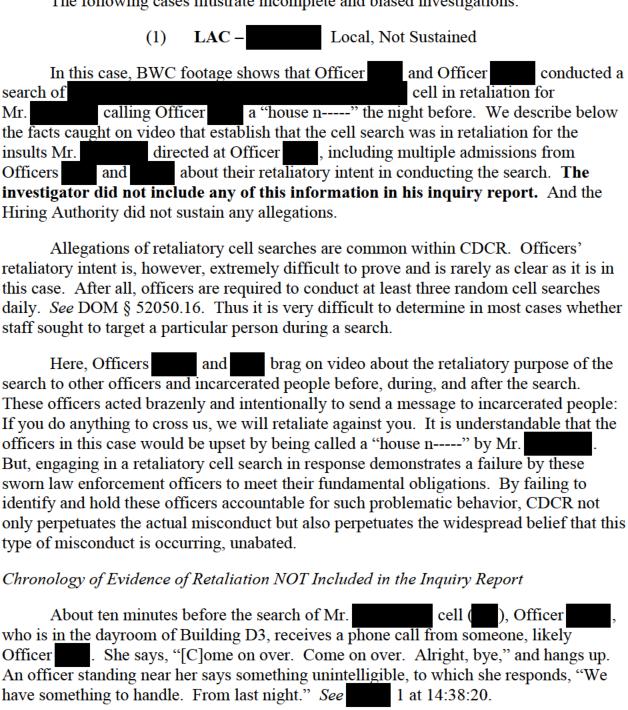
Similarly, many investigations reviewed by Plaintiffs' counsel, across multiple quarterly reports, appear focused on simply discovering enough evidence to dispel with the allegation, rather than uncovering the evidence necessary to determine whether staff misconduct occurred. Multiple examples of investigators requesting and reviewing only one minute of footage exemplify this point. (See KVSP -; 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 – 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 – : KVSP -; **LAC** – ; **CIW** –

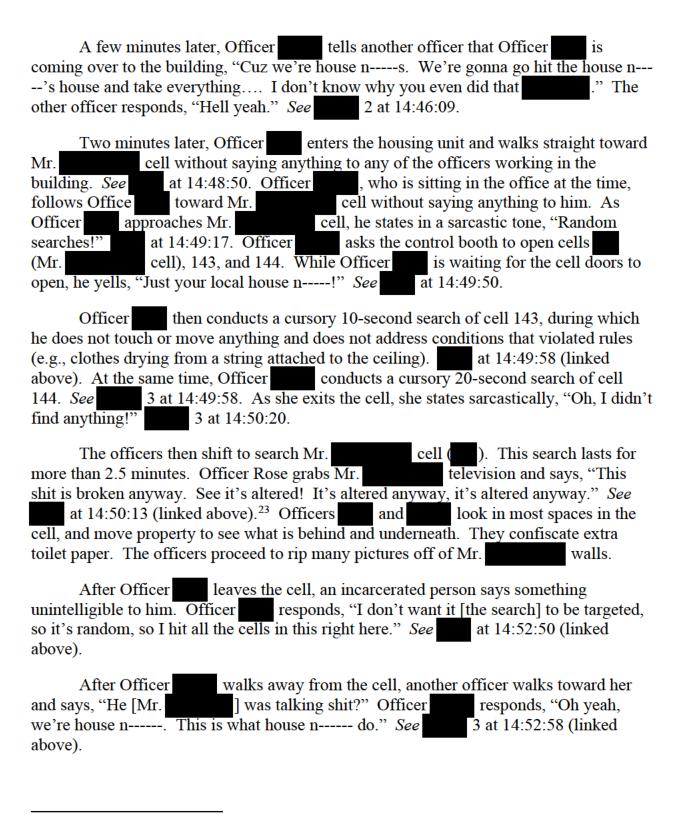
The investigation process will not work if investigators disbelieve incarcerated people from the outset and if investigations focus on disproving allegations rather than gathering the information necessary to prove the allegation true. The investigators' role in these cases must be to identify and review 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.

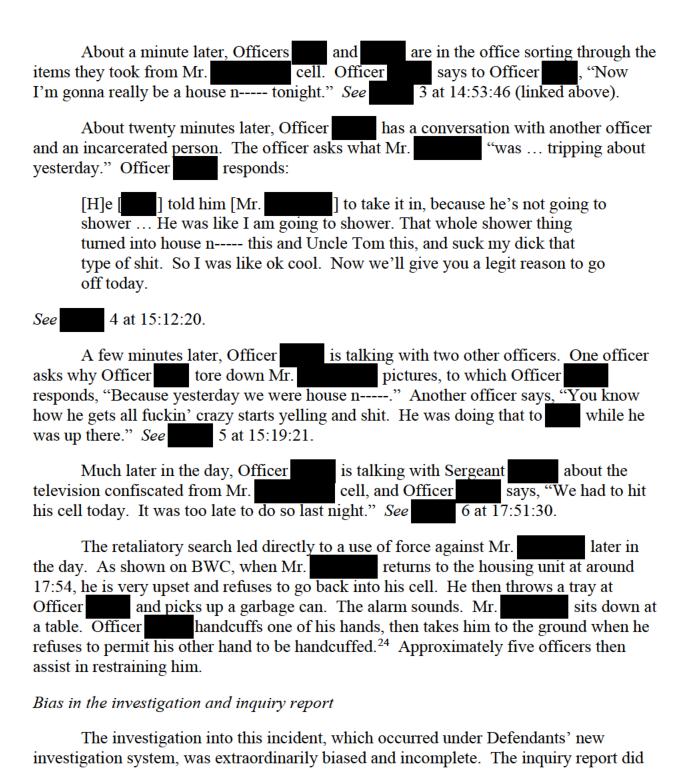
The following cases illustrate incomplete and biased investigations:





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

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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. 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 (" and 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. with a search receipt in compliance with policy.

The investigator did not interview Officer or Officer 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 and 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

²⁵ The investigator did note that Officer 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 came to Building D3 for this specific search. *See* Inquiry Report at 3.

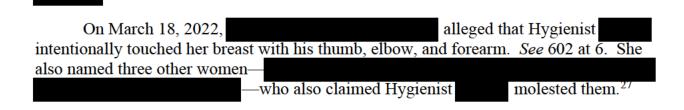
²⁶ Failure to intervene in or attempt to stop misconduct by another employee directed at an incarcerated person (D30, 56<u>7</u>89); Intimidation, threat, or assault without the intent to inflict serious injury toward an inmate (D15, 34<u>5</u>678); Disruptive, offensive, or vulgar conduct which discredits the department (D14, 2<u>3</u>456); Failure to observe and perform within professional standards (D25, <u>3</u>456789); Intentional failure to report misconduct by another employee (B1, 2<u>3</u>45); Unauthorized use of department position (D8, 1<u>2</u>3); Discourtesy (D1, <u>1</u>23456); and Failure to observe and perform within the scope of training, post orders, duty statements, department policy, or operational procedures (D26, 12345).

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 – AIMS; PREA; AIMS - Not Sustained

These cases involve credible consistent allegations that Dental Hygienist 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 vague, self-serving denials. Ultimately, Hygienist 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.



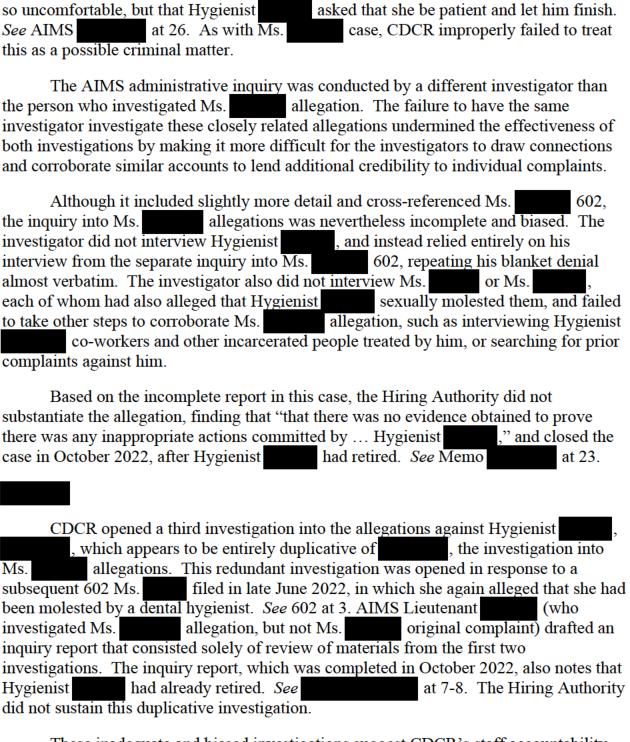
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²⁷ It appears that in May and June 2022, Ms. and Ms. filed separate 602s about being molested by Hygienist . See at 9-12. **Defendants**

This matter should have been, but was not, treated as a criminal investigation, given that Ms. alleged Hygienist committed sexual battery. Cal. Penal Code 243.4. AIMS instead conducted an administrative inquiry, and the investigator interviewed Hygienist potentially undermining any criminal proceedings.
This inquiry into Ms. Complaint was profoundly incomplete and biased. The inquiry makes no mention of the related allegation of Ms. One of the three other women who Ms. Identified in her complaint. The report further glosses over very serious allegations by the other three women, stating only: "Correctional Lieutenant conducted an interview with wherein explained that inappropriately touched her while receiving dental care conducted an interview with and wherein they reiterated what they authored in their grievances explaining that they had been inappropriately touched by " See 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- (discussed below). 28
In contrast to the cursory review of the womens' accounts, the report includes much greater detail regarding the interview with Hygienist assertion of blanket, unsupported denials: "explained during any procedure, there are staff members walking around the immediate area but no one directly supervising him. It is never in a position that would allow him to inappropriately touch inmates. If the did touch an inmate inappropriately, he was unaware. It has always acted in a professional manner with all inmates and is unsure as to why the allegations were made." See
have not produced any investigation files regarding these two complaints. Please produce these investigation files.
explained that inappropriately touched her while receiving dental care. Indicated purposely touched her breast with his elbow and forearm, when applying a bib across her chest. Indicated by inmates, to prevent staff from violating their personal space. According to applied the bib to her chest, at which time, and thumb rubbed against her breast. Indicated actions upset her and she elected to not return for any follow-up dental appointments. Indicated actions upset her and she elected to not return for any follow-up dental appointments. Indicated and time the incident occurred. In CIW correctional Treatment Center (CTC), dental office. Indicated and time the incident occurred. In CIW could not identify any witnesses." See 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 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. and the other women were seen by Hygienist. The investigator did not attempt to identify any other incarcerated women treated by Hygienist 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. in which she reported consistent allegations against Hygienist.
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 retired. See at 1; AIMS at 26.
CDCR opened a separate investigation——based on Ms. allegation that Hygienist—also molested Ms
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 : 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 alleged the last time she was at her dental cleaning appointment, she became upset. As Mr. removed the paper bib, he asked her if she was alright and patted her on the shoulder. Inmate 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 at 18-19.

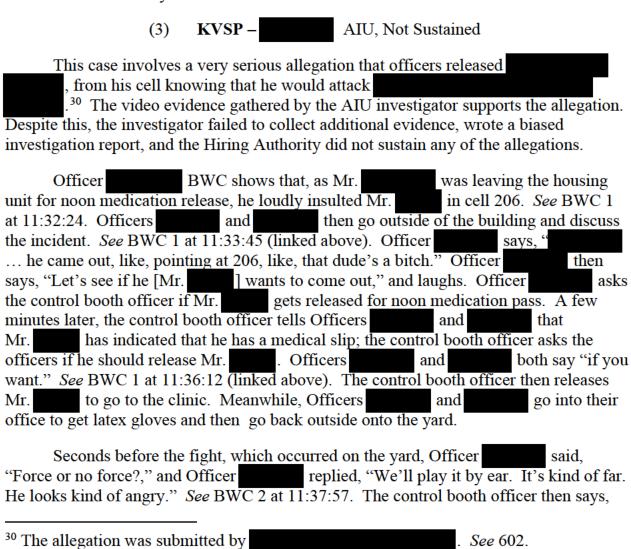
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These inadequate and biased investigations suggest CDCR's staff accountability process is still not working to protect incarcerated women who report sexual misconduct by staff. Four women made plausible and consistent allegations that Hygienist had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

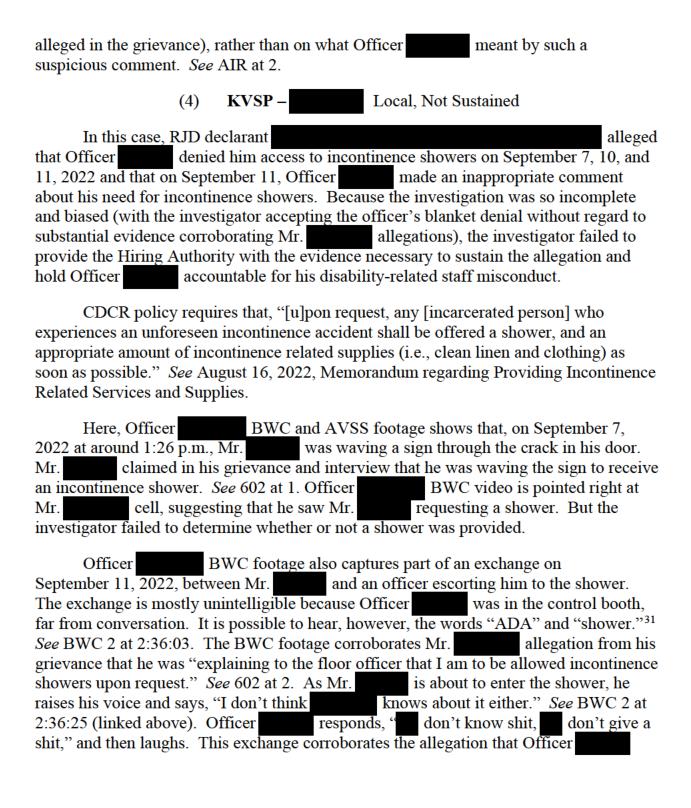
as potentially criminal, failed to conduct complete and unbiased investigations, failed to ensure a single investigator investigated all of the related allegations to ensure the best possible chance of corroboration of relevant evidence, and failed to complete the investigations before the staff member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

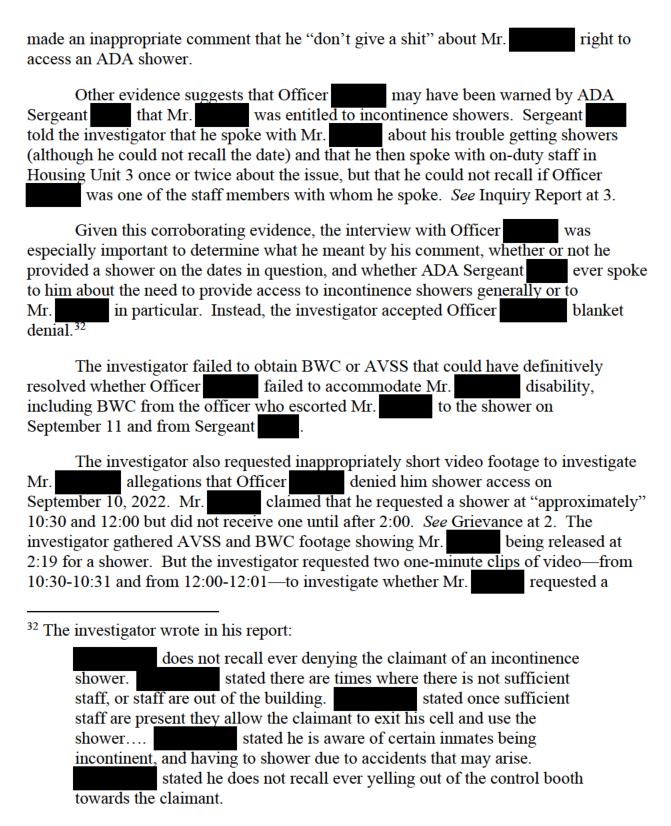


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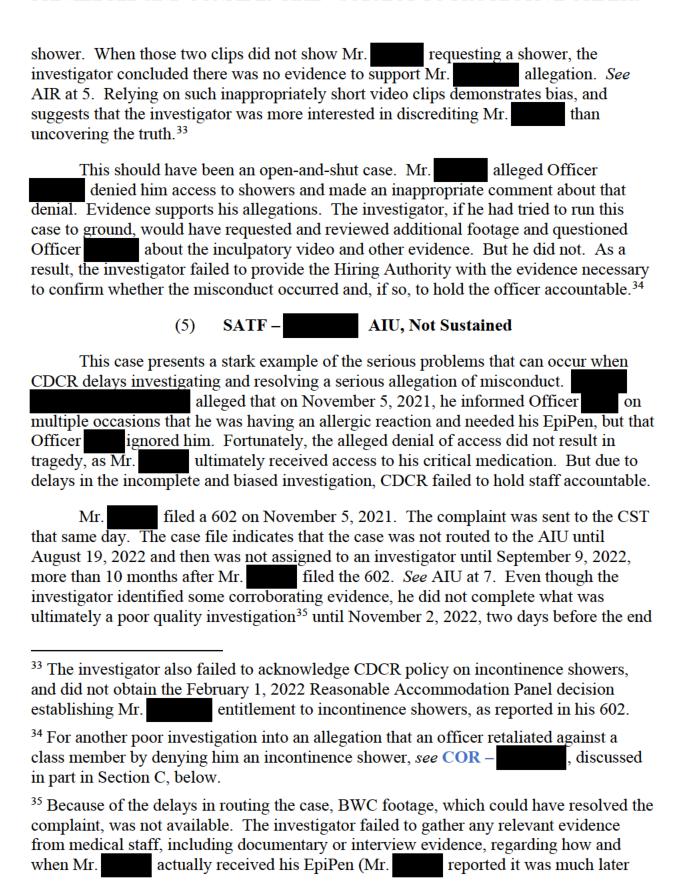
"He looks like he's on a mission." A few seconds later, after Mr. and Mr. start fighting, the officers say, "Ooh yeah there you go." Someone sounds an alarm. Officers and then walk to the location of the fight. According to the incident reports, staff had to fire a block gun round, which hit Mr. to stop the fight. As a result, Mr. 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. <i>See</i> Progress Note-LVN dated June 22, 2022.
About ten minutes later, Officer and Officer 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 says, "It smelled like rain and then it rained." See BWC 3 at 11:56:43. Finally and most tellingly, while Officer was conducting count, he stopped at cell 109 to talk with the two people in that cell, who were laughing. In response, Officer said in a sarcastic tone that "he [Mr.] 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 and engaged in misconduct that resulted in the need to discharge a weapon that hit Mr. 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 or 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 and were aware of the brewing dispute between Mr. and Mr. 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 comment to the residents of cell 109, the investigator focused on the fact that Officer did did not laugh about the incident (as



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



See AIR at 4.



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." 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.

RJD –

_ AIMS, Not Sustained

In this case, 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. , 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. 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.

that day). Instead the investigator chose to focus on irrelevant and superfluous comments designed only to discredit the character of Mr. and exonerate Officer and exonerate Officer example, he included statements from an officer who had no personal knowledge of the alleged incident but described as always giving officers a hard time and seeking attention by boarding up and causing trouble," that "when did not get the answers he wanted, would board up every time," and that Officer was "professional with all inmates." From another officer with no knowledge of the incident, the investigator included a statement that "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. 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. not being let out for scheduled encounters, including once for an interview with Plaintiffs' counsel. See August 12, 2022 email from (stating that Plaintiffs' to "refused" her visit with Plaintiffs' counsel, counsel were initially told that Ms. 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, "Officer intentionally refuses to let [out for medical ducats and tells medical he refused."³⁷ The incomplete investigation in Ms. 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'

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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.

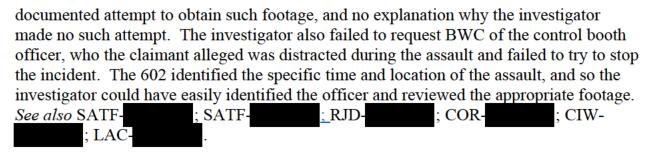
counsel per the Remedial Plans. RJD Remedial Plan, § IV; Five Prisons Remedial Plan, § V; see also Feb. 10 Report at 45-49 (reporting on Defendants' failure to retain, review, and produce relevant video evidence). Defendants' response to the February 10 report acknowledged "issues with the timeliness"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

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 , the incident occurred on September 18, 2021 and the claimant SATFpromptly 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 ; RJDalso SATF-; SATF-; COR-: COR-

In other cases, investigators continue to fail review relevant video footage, without appropriate justification. For example, in COR-states, 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

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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.



Investigators also fail to make a sufficient effort to identify the time, date, and locations of relevant video footage. For example, in KVSP-level, 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.) 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- ; COR-

CDCR continues to fail to produce all relevant video. In CIWincident 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-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-type ; LAC-type

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	Closed	Closed	Open Not	Open			
Received	On Time	Late	Yet Late	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%

[4294034.1] 38

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 – , 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 LAC – 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. 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 (who participated in the search) and Officer , Officer reactivates his camera without announcement. See BWC at 15:19:18. The inquiry report in that case ignored that Officer camera was deactivated without justification. Officer 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.

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-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-discussed, 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-discussed, BWC⁴⁵ 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).

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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- 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

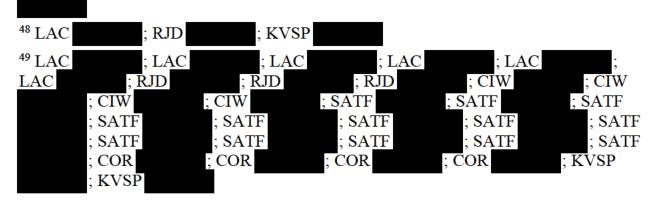
Pursuant to the parties' agreement, we expect to receive a response to this report from Defendants by June 16, 2023. Plaintiffs will continue to work with Defendants and the Court Expert to attempt to bring Defendants into compliance with the Court's Orders and the Remedial Plans.

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%). In 35 of the cases (6.7%), Hiring Authorities sustained allegations against at least one staff member. In those cases with a sustained allegation, Hiring Authorities imposed adverse action against at least one staff member in only 3 cases. In the remaining 32 cases with a sustained allegation, Hiring Authorities imposed corrective action or took no action. 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%

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 ; KVSP



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

APPENDIX B

KVSP

	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).
	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. 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. See discussion in report.
COR	
	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.
	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. 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.
	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.
	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.
	See discussion in report.
	See discussion in report.
LAC	
	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.
	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** 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. 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. 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. 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.
	See discussion in report.
	See case writeup.
<u>RJD</u>	
	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.
	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.
	See case writeup.
<u>CIW</u>	
	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.
	The investigator reviewed available BWC footage for one of the
	subject officers from 1320 to 1400, as the claimant estimated the
	5 do jest officers from 1520 to 1400, as the claimant estimated the
	incident occurred at 1333. However, the footage did not show any
	incident occurred at 1333. However, the footage did not show any interaction between the claimant and either the subject officer or
	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
	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
	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
	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
	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
	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 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.
	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

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.
See case writeup.