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PRIVILEGED AND CONFIDENTIAL

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[redacted]

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Re: *Armstrong v. Newsom*: Plaintiffs' August 2025 Review of CDCR's Accountability System at the Six Prisons
Our File No. 0581-03

Dear [redacted]:

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

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

Plaintiffs have again found substantial evidence that CDCR's accountability system is failing to identify and confirm violations and to hold staff accountable for misconduct. Plaintiffs' counsel looks forward to discussing these cases with Defendants in September 2025. We remain hopeful that the parties will be able to implement

remedies to the system to address these longstanding systemic failures, and to improve accountability for staff misconduct.

Sincerely,

ROSEN BIEN
GALVAN & GRUNFELD LLP

/s/ [redacted]

By: [redacted]

[redacted]

cc: [redacted]

TABLE OF CONTENTS

Page

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

A. Failure of the Accountability System to Prevent Ongoing Harm Caused by ADA Sergeants at SATF

Each quarter, Plaintiffs' counsel identify a number of cases that demonstrate a failure to sustain disability-related violations, which in turn results in class members being discouraged from requesting disability accommodations and other help from staff. Because the misconduct is not identified and no corrective action is taken, CDCR misses the opportunity to "correct" staff behavior and prevent misconduct from occurring again. Defendants will never be able to achieve compliance with the *Armstrong* Remedial Plans, the *Armstrong* Court's Orders and the ADA, so long as staff continue to doubt people's disabilities and discourage access to disability accommodations without being held accountable, as seen in the two cases below. This is especially true where, as here, there is a pattern of discourtesy by an ADA Sergeant that, because it is never called out and stopped, has been effectively condoned by CDCR and persists to this day.

This is exactly the type of problematic pattern of violations that the Court sought to stop in issuing the original accountability orders, by requiring "Defendants to develop effective internal oversight and accountability procedures to ensure that Defendants learned what was taking place in their facilities, in order to find violations, rectify them and prevent them from recurring in the future, without involvement by Plaintiffs' counsel or the Court." August 22, 2012 Order, Dkt. 2180, at 10 (describing intent of January 18, 2007 Injunction). Unfortunately, these cases illustrate that, nearly two decades after the Court's 2007 Injunction, that is still not occurring.

1. SATF-[redacted] – Local, Not Sustained

In our most recent report, we wrote about Sergeant [redacted], an ADA Compliance Sergeant at SATF, being discourteous to a class member, telling the class member that he "whine[s] about everything," and questioning the class member's disability. *See* Plaintiffs' May 2025 Review of CDCR's Accountability System at the Six Prisons at 9-10 (May 9, 2025) (discussing SATF-[redacted], *see* BWC). The class member's allegation in that case was not sustained, even though video footage clearly demonstrated that Sergeant [redacted] was discourteous. Therefore nothing was done—not even training—to prevent this ADA Sergeant, who is the person people are supposed to turn to for disability-related help, from continuing to be discourteous towards people with disabilities. This quarterly production includes two more cases involving Sergeant [redacted] being discourteous, including telling other officers that he is going to retaliate against a class member for requesting disability accommodations. Once again, the violations were not confirmed and, as a result, Sergeant [redacted] was not held accountable and nothing was done to put a stop to his ongoing harmful behavior to class members.

In the first case (SATF-[redacted] ([redacted]) alleged that, while receiving over-the-ear-headphones as a disability accommodation, Sergeant [redacted] told him that "people like [him] are full of shit." *See* 602 at 1. Although the BWC footage does not show Sergeant [redacted] making that statement verbatim, it does show him making unprofessional and rude statements amounting to skepticism about Mr. [redacted] need for the disability accommodation. The 29-second BWC clip shows Sergeant [redacted] handing Mr. [redacted] a form to sign for his headphones while saying, "If it were up to me, I wouldn't be giving them to you, but it is what it is." *See* BWC 1 at 8:57:11. Mr. [redacted] does not respond to that comment, and after signing the form to confirm that he received the headphones, he starts to walk away. Sergeant [redacted] says to the building officer, "A lot of fucking bullshit man … that motherfucker, dude, I'm gonna get that [dude]." *See* BWC 1 (linked above) at 8:57:27; *see also*, Investigation Report at 3. The BWC clip ends in the middle of Sergeant [redacted] inappropriate comments. The investigation report accurately documents these comments, and the investigator correctly identified that Sergeant [redacted] made a threat of retaliation due to a request for a disability accommodation, which is serious staff misconduct on the Allegation Decision Index (ADI), and escalated the case to the AIU. *See* Investigation Report at 3 ("The ASM may meet the criteria for retaliation on the ADI, therefore the author has elected to stop the inquiry and forward all exhibits to AIU for an appropriate routing during decision."). Despite the video evidence confirming that Sergeant [redacted] acted discourteously and threatened to retaliate against Mr. [redacted] for requesting a disability accommodation, the allegations were not sustained. *See* Closure Document at 1.

In short, a class member reported that an ADA Compliance Sergeant questioned his need for a disability accommodation, and the video evidence confirmed that this is what happened. Yet despite the evidence showing that Sergeant [redacted] did question Mr. [redacted] disability, and even threatened to "get that [dude]" because he doubted that Mr. [redacted] actually needed the disability accommodation, Mr. [redacted] was told that his allegation of misconduct was not sustained. Further, no action was taken to address ongoing rude and disrespectful behavior towards people with confirmed disabilities by this supervisor with ADA-specific duties. This sequence of events undermines class members' faith in the accountability system.[1]

In the second case (SATF-[redacted] Sergeant [redacted] is approached by [redacted] ([redacted]) while he is at the officer's station. As Mr. [redacted]

[1] Although the investigator appropriately routed the allegation of "retaliation" to the AIU, it is unlikely to lead to a sustained finding because Sergeant [redacted] statement to another officer alone—without a further action against Mr. [redacted] likely does not amount to retaliation for requesting a disability accommodation. But regardless, CDCR took no action in response to a pattern of disrespect towards people with disabilities by an ADA staff member.

later explains in the clip, that day is the anniversary of the death of Mr. [redacted] daughter, and he is struggling mentally. *See* BWC 2 at 8:59:01. He requests access to a phone to call his family because the phone access on the tablets is not working. Sergeant [redacted] tells Mr. [redacted] to go to the program office to see if they will help him. *See* BWC 2 (linked above) at 8:59:02. Mr. [redacted] explains his reason for needing the phone and states that he is having a hard time coping, but Sergeant [redacted] appears to be dismissive of Mr. [redacted] concern and tells him it is up to the lieutenant whether they give him a phone call. *See* BWC 2 (linked above) at 8:59:45. Sergeant [redacted] says if they give Mr. [redacted] a phone call, then everyone has to get one. *See* BWC 2 (linked above) at 8:59:59. This comment upsets Mr. [redacted] and he walks away from Sergeant [redacted]

Plaintiffs' counsel do not necessarily question anything that happened up to this point. The misconduct comes when the upset class member appropriately walks away from the encounter and, even after knowing that Mr. [redacted] is not doing well coping with the anniversary of his daughter's death, Sergeant [redacted] yells, "And then walk away while I'm walking to you. That's why you ain't gonna get shit." *See* BWC 2 (linked above) at 9:00:05. Sergeant [redacted] antagonizing comment, directed at a class member in an EOP unit who was struggling to cope, jeopardized the safety and security of the institution, and could have easily resulted in a dangerous use of force had Mr. [redacted] not refrained from reacting. Sergeant [redacted] then tells another incarcerated person to tell Mr. [redacted] to go to the program office and "tell him to stop tripping." *See* BWC 2 (linked above) at 9:00:15. The investigator described this interaction in the investigation report, including Sergeant [redacted] discourteous comment that Mr. [redacted] is "not going to get shit," yet the Hiring Authority did not sustain the allegation. *See* Closure Documents at 1.

It is extremely concerning that an ADA sergeant would speak to and about class members in this manner. ADA sergeants should be resolving class members' concerns, not creating more problems for them. These interactions are especially problematic because face-to-face interim accommodation interviews are now conducted with anyone who submits a disability request and, at SATF, these interviews are conducted by ADA sergeants. During Plaintiffs' June 2025 SATF monitoring tour, class members on certain yards reported that they avoid submitting 1824s because it means that they must interact with an ADA sergeant like Sergeant [redacted] As evident in the first case, even a simple request for over-the-ear-headphones is met with skepticism and dismissiveness, even when the class member is entitled to the accommodation per CDCR policy. Sergeant [redacted] pattern of unprofessional behavior deters class members from requesting disability accommodations. **In light of this pattern, we request that CDCR remove Sergeant [redacted] from the ADA Compliance Sergeant position.**

These three cases involving Sergeant [redacted] (one from the previous quarter and two from this quarter) underscore serious issues with Defendants' accountability system.

At least three different class members have now reported Sergeant [redacted] discourteous behavior, and the BWC footage from each of these incidents confirms the class members' reports. But CDCR has failed to sustain the allegations and therefore has not taken any action to correct the behavior or hold Sergeant [redacted] accountable for his misconduct. CDCR's failure to sustain clear staff misconduct also thwarts the progressive discipline process; staff who commit repeated acts of similar misconduct, like Sergeant [redacted] cannot receive progressive discipline if the prior acts of misconduct are not sustained.

When staff members, especially designated ADA staff members, are skeptical of class members' disabilities and tell them they are whining when they make simple requests, it has a significant chilling effect on people with disabilities, who become less likely to request and receive accommodations. If class members are deterred in this manner, CDCR cannot comply with the requirements of the ADA and meet class members' disability needs. The pattern of cases against Sergeant [redacted] serve as a clear example of how CDCR's accountability system continues to fail class members.

2. SATF-[redacted] – Local, Not Sustained

In this case, [redacted] ([redacted]) alleged that ADA Sergeant [redacted] was disrespectful and failed to provide him an appropriate accommodation when Mr. [redacted] requested a replacement wheelchair. The Hiring Authority failed to sustain the allegation despite video evidence supporting the class member's claim.

On December 27, 2024, ADA Sergeant [redacted] delivered a replacement wheelchair to Mr. [redacted] Mr. [redacted] and an ADA worker are seen on video adjusting the wheelchair for a few minutes. Mr. [redacted] makes several comments during clip that the wheelchair seat is too high and cutting off circulation in his legs. *See* BWC at 11:57:30 and 11:58:03. After about five minutes of attempting to adjust the wheelchair, Mr. [redacted] turns the wheelchair around to show Sergeant [redacted] the problem with the wheelchair and explain his concerns. *See* BWC (linked above) at 11:59:00. An officer standing next to the entrance of the medical clinic turns to Sergeant [redacted] and sarcastically says, "They can pick and choose what they want, or what?" *See* BWC (linked above) at 11:59:14. The officer then walks away before receiving an answer. Sergeant [redacted] who sounds bothered by Mr. [redacted] comments, responds to Mr. [redacted] "Okay, I'm not a wheelchair expert. You asked for size 18, you got a size 18. You got what you asked for, so why don't you just settle with what you got. Why are you being so difficult? You are being difficult. I went all the way to Charlie yard to get that wheelchair for you." *See* BWC (linked above) at 11:59:30. Mr. [redacted] who maintains his calm demeanor, continues to explain that it is the wrong wheelchair, and Sergeant [redacted] raises his voice at Mr. [redacted] and says, "It's a loaner!" *See* BWC (linked above) at 11:59:57. Mr. [redacted] says that Sergeant [redacted] yelling at him is not going to work, and Sergeant [redacted] yells back, "Nah, because you're being difficult!" *See* BWC (linked above) at 12:00:00. Sergeant [redacted] continues to tell Mr. [redacted]

that he should settle for what he got: "I ain't looking at nothing. Whatever. I'm done. I'm done. Just stick with what you got man." *See* BWC (linked above) at 12:00:25. The interaction ends with Mr. [redacted] saying, "you're getting a phone call from the Warden today," to which Sergeant [redacted] laughs and says, "What are they gonna call and say hi? Am I supposed to get scared? Don't be threatening me with no Warden." *See* BWC (linked above) at 12:00:34. The yard officers, who have been sitting on a bench throughout the interaction, can be heard mocking Mr. [redacted] by making crying noises as he prepares to leave. *See* BWC (linked above) at 12:00:49.

It is concerning that yet another ADA sergeant at SATF is antagonizing a class member who is simply seeking reasonable accommodations. *See* **SATF-**[redacted] and **SATF-**[redacted] (discussing ADA Sergeant [redacted] unprofessional behavior towards class members). Interactions like this erode trust between people with disabilities and ADA staff, who are supposed to provide accommodations to class members, not mock and disrespect them. The Hiring Authority should have sustained this allegation of staff misconduct and, at a minimum, issued corrective action for Sergeant [redacted] the other officers who mocked Mr. [redacted] The fact that this interaction, where multiple officers face no consequences for making crying noises at a class member who calmly requests a disability accommodation, further demonstrates the serious problems with CDCR's staff discipline system.

B. Problems With Investigations and Discipline in Use-of-Force Cases

Plaintiffs' counsel continue to identify, every quarter, multiple serious use-of-force violations that have not been confirmed by CDCR. As a result, staff are not held accountable for serious violations and CDCR misses the opportunity to prevent future harm by the same officers.

The Office of Inspector General (OIG)'s reporting on CDCR's investigations into use-of-force allegations continues to be consistent with Plaintiffs' findings. On July 31, 2025, the OIG published a report assessing CDCR's performance in 13 use-of-force cases closed between January 1 and June 30, 2025. *See* OIG Force Investigation Review Team Case Summaries (July 2025). For each investigation, OIG evaluated whether OIA investigators conducted thorough and timely investigations, and whether Hiring Authorities made reasonable decisions about those completed investigations. OIG found that CDCR's overall performance was "inadequate" in 12 of 13 cases (the lowest rating). The OIG found major failures by both OIA investigators and Hiring Authorities in almost every case reviewed: OIA investigator performance was rated "inadequate" in 9 cases and "improvement needed" in 2 cases, and Hiring Authority performance was rated "inadequate" in 11 cases and "improvement needed" in one case. The failures OIG identified are consistent with those Plaintiffs have been reporting on for years, including investigations where key witnesses were not interviewed and/or video was not requested.

It is concerning that CDCR's court-ordered investigation and discipline system continues to fail to identify and hold officers accountable for dangerous, excessive and unnecessary uses of force that CDCR policies are designed to prevent. The following cases are illustrative.

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

The Hiring Authority in the Centralized Allegations Resolution Unit (CARU) failed to sustain an allegation of excessive force in this case, which included multiple officers punching a handcuffed class member in the head. **Video footage captured the officers striking the handcuffed class member in the head at least thirteen times over a 17-second period, and the officers admitted to punching him in the face in their incident reports.** Yet the allegations of excessive force were not sustained. It is deeply disturbing that the CARU reviewed an incident where officers repeatedly punched a handcuffed class member in the head and determined that their actions were within CDCR policy.

Officer [redacted] body-worn camera footage shows the initial escalation of the incident, and the use of force is most clear on the AVSS. The BWC footage, dated July 2, 2024, begins with a back-and-forth between [redacted] ([redacted]), who is in his cell with the food port open, and Officer [redacted]. *See* BWC at 8:35:19. The video does not show how the interaction began, but Officer [redacted] eventually asks whether Mr. [redacted] is having chest pains and Mr. [redacted] says that he is. *See* BWC at 8:35:37. Officer [redacted] then tells another officer to apply handcuffs to Mr. [redacted] to take him out of the cell because "we're going to stop playing these games today." *See* BWC at 8:35:43. The other officer applies handcuffs, and Mr. [redacted] cell door opens. *See* BWC at 8:35:50. Officer [redacted] tells Mr. [redacted] that he is going to escort him, but Mr. [redacted] tells Officer [redacted] to "move" and not to touch him or "it's going to be ugly." *See* BWC at 8:36:05. Officer [redacted] then immediately grabs Mr. [redacted] arm, saying "I'm going to escort you," and Mr. [redacted] pulls his arm away. *See* BWC at 8:36:10. Officer [redacted] responds by placing both hands on Mr. [redacted] arm and using immediate force, and multiple officers respond to the incident. *See* BWC at 8:36:12.

The AVSS shows Mr. [redacted] initially pull away from Officer [redacted] Officer [redacted] the officer who was standing next to him, and a third officer immediately respond. *See* AVSS at 8:36:10. They wrestle with Mr. [redacted] for a few seconds, stumble into Mr. [redacted] open cell and then pull him out. A fourth officer, Officer [redacted] sprints to the scene and immediately winds up and throws a punch to Mr. [redacted] face. *See* AVSS at 8:36:22. Two other officers arrive directly behind Officer [redacted] At this point, six officers are trying to take Mr. [redacted] to the ground. Officer [redacted] runs to the scene and immediately throws four punches to Mr. [redacted] face (five total head-strikes at this point). *See* AVSS at 8:36:23. Officer [redacted] then throws seven additional punches to Mr. [redacted] face (twelve total head-strikes at this point). *See* AVSS at 8:36:28. Then Mr. [redacted] is shoved face-first into the wall as he stumbles and loses his balance. *See*

AVSS at 8:36:31. As his face slides down the wall, with the weight of seven officers behind him, his head lands in a small white bucket. *See* AVSS at 8:36:32. Officers push Mr. [redacted] head into the bucket, and as his head slightly comes up for a moment, Officer [redacted] forces his head back into the bucket. *See* AVSS at 8:36:36. Another officer moves the bucket out of the way, but it appears that Mr. [redacted] chest is on another bucket. *See* AVSS at 8:36:38. At that point, with Mr. [redacted] head hovering in the air, Officer [redacted] sits up straight to wind up, drops his weight, and throws an elbow to the back of Mr. [redacted] head (thirteen total head-strikes at this point). *See* AVSS at 8:36:39. More officers then respond to the scene, and the interaction ends.

Officer [redacted] justified his nine total head-strikes in his incident report by claiming that he was "[f]earing for my partner's safety," so he "utilized physical force by utilizing my right hand in a forward strike motion impacting [redacted] [sic] facial area multiple times to stop the threat and overcome resistance." *See* Investigation Report at 5. Officer [redacted] claimed that he determined that "[e]ach strike did nothing to [redacted] as he continued with his aggressive behavior." *Id.* However, even though his numerous strikes to Mr. [redacted] face were admittedly not having the intended effect, Officer [redacted] continued striking him. He wrote that, "[h]aving negative results in my physical use of force as [redacted] continued aggressively resisting, I would strike [redacted] with an additional forward strike to the facial area." *Id.* Again, Officer [redacted] wrote that "my strikes had no effect on [redacted] *Id.* Once Mr. [redacted] fell down, Officer [redacted] reports that "[redacted] landed face down on his stomach." In fact, Mr. [redacted] landed face-first against the wall, then head-first into a bucket. Officer [redacted] then wrote that, "[redacted] appeared to try and turn his face towards me. Fearing [redacted] would spit me (sic), I utilized physical force by utilizing my right elbow in a forward strike motion contacting [redacted] facial area to stop the threat." *Id.* Officer [redacted] report that Mr. [redacted] tried turning his face towards Officer [redacted] does not appear to be consistent with the video evidence. Officer [redacted] who threw four punches in quick succession to Mr. [redacted] face, incorrectly wrote in this incident report that he threw a single punch, then reevaluated the situation and threw only one more punch. *Id.* at 5-6. The investigator noted this inconsistency in the investigation report. *Id.* at 6. Officers [redacted] and [redacted] both claimed that they did not know Mr. [redacted] was handcuffed when they began throwing punches at his face. *Id.* at 10, 11.

Allegations of excessive use-of-force should have been sustained against Officer [redacted] and Officer [redacted] Both officers responded to the incident and immediately threw punches to the face of the handcuffed class member. The fact that they did not know Mr. [redacted] was handcuffed (if true) does not make the level of force objectively reasonable. All movement in a [redacted] is done while people are handcuffed, so the officers should have known that Mr. [redacted] was handcuffed. Additionally, seven officers were surrounding Mr. [redacted] in an otherwise empty dayroom. Officers should not have thrown a single head-strike, let alone thirteen. The force used in this situation far exceeded any objectively reasonable amount of force needed to control Mr. [redacted] *See* 15 C.C.R. § 3268(a)(3) (defining "Excessive force" as "[t]he use of more

force than is objectively reasonable to accomplish a lawful purpose"). It is deeply concerning that the CARU reviewed this allegation and determined that this force was compliant with CDCR policy.

Officer [redacted] also did not try to de-escalate the situation before the need for force arose. From the early moments of the interaction captured on BWC, it appears that Officer [redacted] is aggravating the situation, saying that "we're going to stop playing these games today." Once the cell door opens, it is apparent that Mr. [redacted] is particularly frustrated with Officer [redacted] The other officer, who applied handcuffs to Mr. [redacted] and is standing directly next to Officer [redacted] could have escorted Mr. [redacted] to the clinic. But Officer [redacted] insisted on being the escort officer, igniting the incident.

This behavior is consistent with class members' reports about Officer [redacted] During Plaintiffs' May 2025 monitoring tour at Corcoran, numerous class members in the [redacted] reported that Officer [redacted] is disrespectful and escalates interactions into violent encounters. We relayed this finding to CDCR during the exit meeting because we were concerned that Officer [redacted] was creating an unsafe situation for class members and staff in the building. And we have previously written about Officer [redacted] using unnecessary and excessive force against class members in the [redacted] *See Armstrong v. Newsom*: Plaintiffs' November 2024 Review of CDCR's Accountability System at the Six Prisons at 29-31 (November 15, 2024) (describing COR–[redacted], where Officer [redacted] antagonizes an [redacted] class member then throws him backwards out of a chair in the dayroom onto the floor).

We remain concerned that officers' frequent disrespectful and confrontational behavior towards class members create the conditions for these dangerous uses of force to occur. This appears to be especially prevalent in Corcoran's [redacted] By failing to hold staff accountable for these incidents, CDCR sends a message to class members and staff that this behavior is acceptable, condoning an unsafe environment for all.

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

In this case, officers used unnecessary and excessive force against [redacted] ([redacted]), a class member with a mobility disability who uses a seated-walker to ambulate. The video of the incident shows officers responding to an in-cell fire as Mr. [redacted] exits the cell and heads directly to his walker, which is positioned right outside the cell door. *See* BWC at 7:21:01. Officer [redacted] cuffs one of Mr. [redacted] hands, and as he reaches to cuff Mr. [redacted] other hand behind his back, Mr. [redacted] throws his hands up and says, "I don't get cuffed like that!"[2] *See*

[2] According to Mr. [redacted] medical records, he had an active order for special cuffing due to right shoulder and left wrist pain at the time of the incident (August 5, 2024). *See* 7410 (May 1, 2024).

BWC at 7:21:05. Mr. [redacted] proceeds to quickly sit on his walker. Officer [redacted] immediately grabs Mr. [redacted] by the back of the neck, throws him and his walker to the ground, and lays on top of him for approximately 15 seconds before staff begin twisting Mr. [redacted] arms to handcuff him behind his back. *See* BWC at 7:21:09. While on the ground, Mr. [redacted] yells in pain and says that he has special cuffing, that his shoulder is torn, and that his wrist cannot be cuffed. *See* BWC at 7:21:15.

In his incident report, Officer [redacted] stated that he used force because "Inmate [redacted] (sic) was an immediate threat to staff and I, due to Inmate [redacted] resistive behavior that was unpredictable …." *See* Incident Report at 35. However, the video confirms that Mr. [redacted] was only "resisting" the application of handcuffs behind his back and asserting his right to special cuffing due to his disability (an accommodation to which he is entitled, according to SOMS). Regardless, once Mr. [redacted] sat on his walker, he could not reasonably be considered to pose an imminent threat. At the time of the incident, Mr. [redacted] was a nearly [redacted]-year-old man with a mobility disability sitting on a walker and wearing slides on his feet. The situation could have been easily resolved in a number of ways that did not require force—Officer [redacted] could have applied handcuffs to Mr. [redacted] in the front, asked another officer to bring over waist chains, or simply paused for a moment and asked Mr. [redacted] to submit to handcuffs. Immediate force was not necessary here. CDCR policy provides that immediate force can only be used to respond to situations "that constitute[] an imminent threat to institution/facility security or the safety of persons," including to "subdue an attacker, overcome resistance or effect custody." *See* DOM § 51020.4.

Despite clear video evidence that staff used force here when none was necessary—and, indeed, where force should have been avoided by accommodating Mr. [redacted] disability—no use of force violations were sustained, and no action was taken (not even training) to hold Officer [redacted] accountable for his misconduct or discourage officers from committing this type of misconduct in the future. *See* Closure Memo at 1.

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

In this case, officers failed to deescalate an incident that resulted in an improper use of immediate force. The BWC footage shows officers stopping [redacted] ([redacted]) as he is entering the dayroom because he has an old tablet model in his possession. *See* BWC at 6:12:45. The officers engage Mr. [redacted] for several minutes, telling him to give them the tablet or cuff up. *See* BWC at 6:12:55. Mr. [redacted] continually asks whether he can send the tablet home, and officers tell him that he cannot. *See* BWC at 6:12:56. Mr. [redacted] assures the officers several times that he will give them the tablet, but he keeps pleading his case. *See* BWC at 6:13:21. After several minutes, officers tell Mr. [redacted] to cuff up, and he finally relents when officers call a code for a "resistive inmate." Mr. [redacted] puts the tablet on the ground by the officers' office in plain view of the staff and begins walking back to his cell on the other side of the dayroom. *See* BWC at 6:14:46. The confrontation with staff had ended

at that point, and no imminent threat was present. The officers succeeded in their objective of getting the tablet back. If they wished to penalize Mr. [redacted] for taking the dispute that far or for disobeying the order to cuff up, they could have easily issued him an RVR.

Instead, the officers follow Mr. [redacted] back towards his cell to place him in restraints. *See* BWC at 6:14:46. Additional officers arrive to the dayroom, and they force Mr. [redacted] to cuff up behind his back, and in the process of doing so, fail to accommodate Mr. [redacted] mobility disability, which had been exacerbated by a recent surgery. *See* BWC at 6:15:38. The officers handcuff Mr. [redacted] behind his back as he screams in pain. The incident report written by one of the subject-officers states that force was used to restrain Mr. [redacted] because "[redacted] became resistive by moving side to side" and not allowing staff to cuff him. *See* Incident Report at 45. The investigator failed to interview any of the officers involved in the incident. The investigator also failed to state in his report that medical records confirm Mr. [redacted] arm fracture was reinjured in the use-of-force incident: "Patient was identified to have reinjury and deformity of left ulna. Reveals that hardware [a metal rod in his arm] is broken." *See* Progress Notes (dated June 19 and 20, 2023) at 13, 15. Despite an entirely avoidable and unnecessary use of force in this case (*see* DOM § 51020.4), causing significant pain and injury to the class member, no violations were found and nobody was held accountable.

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

In this case, officers once again escalate a situation into a dangerous use of force on [redacted] ([redacted]), a [redacted]-year-old class member in waist chains who uses a walker to ambulate. The initial interactions leading to the force can be seen on the escort officer's BWC. *See* Officer [redacted] BWC. Officer [redacted] applies waist chains on Mr. [redacted] through the food port of his cell and opens his cell door to begin escorting him. *See* BWC (linked above) at 9:23:23. As Mr. [redacted] is exiting his cell, he tells Officer [redacted] that the waist chains are "too tight on me again." *See* BWC (linked above) at 9:24:26. Nevertheless, he exits the cell and starts walking down the hallway of the [redacted] During the approximately 30-second escort, he says a number of times that the waist chains are too tight. Mr. [redacted] briefly stops walking at one point, adjusts the cuffs around his wrist, and requests to be taken back to his cell. *See* BWC (linked above) at 9:24:44. Mr. [redacted] takes a few more steps forward to continue the escort. When he stops again to adjust the waist chains, Officer [redacted] activates her alarm in response. *See* BWC at 9:24:53. Officer [redacted] then squeezes Mr. [redacted] arm more tightly, which further aggravates Mr. [redacted] *See* BWC at 9:24:57. As she is squeezing Mr. [redacted] arm, Officer [redacted] says, "Listen, you're going to let go, you're not gonna … you're gonna hold your thing," referring to his walker. *See* BWC (linked above) at 9:24:59. Mr. [redacted] interrupts her and says, "I'm not gonna hold a goddamn thing! Take me back to my goddamn cell."

As Mr. [redacted] begins to turn his walker around in the direction of his cell, Officer [redacted] grabs him with a second hand and forces Mr. [redacted] against the wall. *See* BWC (linked above) at 9:25:03. A group of officers then come running in response to the alarm, and they tackle Mr. [redacted] over his walker and into an open cell. The AVSS footage provides a clear view of the force. *See* AVSS at 9:25:05. Mr. [redacted] received an RVR for "Battery on a Peace Officer" for allegedly kicking his leg into Officer [redacted] leg when she pushed him into the wall. *See* Investigation Report at 4. In the Incident Report, Officer [redacted] alleged that she used force because "[redacted] became resistive from the escort and [was] threatening to break the waist chains off his body." *See id*. The video evidence does not appear to show Mr. [redacted] threatening to break the waist chains off his body, as Officer [redacted] claimed.

This entire interaction started because Mr. [redacted] handcuffs were applied too tightly. At no point did Officer [redacted] stop to check whether Mr. [redacted] handcuffs could be loosened, offer to take him back to his cell, or call for an additional escort officer to support her. Instead, she escalated the situation. The responding officers' decision to tackle Mr. [redacted]—a man in waist chains with a mobility disability—over his walker and onto the floor was unsafe. Policy requires that officers attempt to deescalate situations to avoid using force. *See* DOM § 51020.5 at 2 ("Whenever possible, verbal persuasion should be attempted in an effort to mitigate the need for force."). Yet neither the Hiring Authority nor the IERC identified any issues with the use of force. *See* Closure Memo at 1; IERC at 1-10. Although Mr. [redacted] received an RVR because his leg came into contact with Officer [redacted] when she pushed him into the wall, neither officer was held accountable for their misconduct.

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

In this case, a sergeant used unnecessary and excessive force to drag a class member to the ground on the yard, but was not held accountable by CDCR. The video footage shows [redacted] ([redacted]) exiting the clinic, and Sergeant [redacted] who is seated on the patio, tells him to "take it home." *See* BWC at 12:28:38. Mr. [redacted] mutters something inaudible to the sergeant and continues walking. *See* BWC at 12:28:48. Sergeant [redacted] stands up and approaches Mr. [redacted] in order to handcuff him, and Mr. [redacted] stops walking. *See* BWC at 12:28:50. Sergeant [redacted] tells Mr. [redacted] to drop the items that he is holding, and Mr. [redacted] laughs, looks away, and says that he is not dropping his stuff. *See* BWC at 12:28:57. Sergeant [redacted] takes an item out of Mr. [redacted] arms and hands them to a nearby officer, and another officer grabs another item from Mr. [redacted] hands. Sergeant [redacted] tells Mr. [redacted] to submit to restraints, but Mr. [redacted] passively refuses. *See* BWC at 12:29:05. Sergeant [redacted] suddenly grabs Mr. [redacted] by the arm and throws him to the ground with his entire body weight. *See* BWC at 12:29:08. At the moment force is used, Mr. [redacted] is not presenting an imminent threat, so the decision to use immediate force was unnecessary. Even if force was justified at that moment, the amount of force used was more than what was objectively reasonable under the

circumstances. *See* DOM 51020.4. Mr. [redacted] received an RVR for this incident for "Assault on a Peace Officer by Means Not Likely to Cause GBI." *See* Investigation Report at 3. The video footage of this incident does not support a finding that Mr. [redacted] assaulted an officer in this case. **CDCR should take action to re-review this serious RVR. Please report on the status of the review of the RVR received in this case.**

Sergeant [redacted] does not provide a compelling justification for the force in the incident report. His report is problematic for a number of reasons. First, the report includes information that does not appear to be consistent with the video. Specifically, he wrote that when he ordered Mr. [redacted] to submit to restraints, "[redacted] stopped, [and] demanded to speak with a Sergeant. [redacted] informed [redacted] he wasn't going to talk to a Sergeant as they were aware [redacted] had already spoke to multiple Sergeants regarding a bed move." *See* Investigation Report at 2. That conversation did not happen in the video. Second, Sergeant [redacted] claimed that he used force "due to [redacted] resistive action of tensing up his arm and refusing to let go of his items," causing Sergeant [redacted] to "fear[] [redacted] was possibly hiding a weapon," but nothing in the video supports Sergeant [redacted] speculation of the existence of a weapon. Mr. [redacted] was not reaching into his pockets or into his items, and he had willingly given up one of the items he had been holding a moment before force was used. Mr. [redacted] was not found to be in a possession of a weapon after the incident. Third, Sergeant [redacted] wrote in his incident report that "[redacted] had been refusing orders throughout to day to return to their assigned cell," which makes Sergeant [redacted] quick decision to use force appear like it may have been in response to Mr. [redacted] disobedience earlier in the day, as opposed to any imminent threat in that moment. In fact, Sergeant [redacted] and Mr. [redacted] had a disagreement earlier in the day. Mr. [redacted] reported during his interview that he had been walking from building to building trying to find a cellmate earlier that day. *See* Investigation Report at 6. Sergeant [redacted] had reportedly ordered him to return to his assigned building, and Mr. [redacted] refused. *Id*. In response, Sergeant [redacted] reportedly said that no one wants to house with Mr. [redacted] because he uses drugs. *Id*. Mr. [redacted] was offended by those comments, which likely impacted their interaction later in the day. Video of that prior interaction, however, was not included in the investigation file.

Two other officers' incident reports are similarly inconsistent with the video footage. First, in describing the events leading to the use of force, Officer [redacted] wrote, "As [redacted] was attempting to effect custody of [redacted] he began to physically resist …." *See* Incident Report at 28. But the video of the incident does not show Mr. [redacted] being physically resistive before Sergeant [redacted] throws him to the ground. Second, Officer [redacted] who was nearby when force was used, wrote in his report that Sergeant [redacted] "gave [redacted] a direct order to turn around and submit to handcuffs and observed [redacted] pull away." *See* Investigation Report at 3. But the video footage does not show Mr. [redacted] pulling away; he only refused to submit to handcuffs. None of the inconsistencies in Sergeant [redacted] Officer [redacted] or Officer [redacted] incident reports were identified in

the investigation report. And the Hiring Authority did not sustain any force violations in this case. *See* Closure Memo at 1.

C. Failures to Conduct Comprehensive and Unbiased Investigations

Plaintiffs continue to identify numerous cases every quarter where Defendants' investigators fail to conduct "comprehensive and unbiased investigations and ensure all relevant evidence is gathered and reviewed," including video evidence that likely would have resolved whether the alleged misconduct occurred. RJD Remedial Plan, § II.B; Five Prisons Remedial Plan, § II.B; *see also* Dkt. 3060, ¶ 5.c; Dkt. 3218, ¶ 5.c. In addition to investigation failures discussed above, we include the following illustrative examples.

The first two cases below involve serious allegations of disability-related staff misconduct that Defendants' accountability system failed to address. Both cases involved inadequate local investigations (or "inquiries") into the alleged misconduct. These cases are especially concerning given that these types of allegations, which are not on the ADI, are now going to be investigated through the routine grievance process, which has even fewer safeguards to ensure investigations are comprehensive and unbiased. Plaintiffs will be closely monitoring the implementation of this change.

1. RJD – [redacted] – Local, Not Sustained

Multiple class members filed complaints this quarter reporting that Sergeant [redacted] is threatening to issue RVRs to class members with mobility disabilities if they fail to stand during count. *See* [redacted] 1824 at 5; [redacted] 1824 at 5.

BWC footage confirms that staff are in fact requiring all non-DPW class members to stand during count. On BWC, staff can be seen conducting count and stopping at the cell of a [redacted] class member as identified by a "[redacted]" sign on the cell door of cell 120. *See* BWC at 4:33:15. (This is not one of the class members who filed an 1824 reporting the staff misconduct.) Only the officer's side of the conversation can be heard on the audio. He says, "Can you stand up?" followed by muffled dialogue from inside the cell. Staff replies, "Did you talk to medical about it?" followed by more muffled dialogue. Finally, staff replies, "Well follow up with medical about it. For right now you might be receiving an RVR for it." *See* BWC (linked above) at 4:33:52.

In addition, interviews conducted as part of the investigation confirm that, despite witnesses not wanting to formally lodge complaints against Sergeant [redacted] class members are in fact threatened with RVRs if they fail to stand. One class member witness who was interviewed for the investigations, [redacted], ([redacted]) states: "[F]or a while they weren't making ADA inmates stand, but they informed us if we aren't DPW then we need to stand if we are able to. My knees and stuff hurt, but I always comply with standing.… I would rather stand and get them away from my door quicker, instead of trying to argue it and them being at my door forever. I

don't like to draw attention to myself." *See* Investigation Report [redacted] at 5; Investigation Report [redacted] at 5. Similarly, class member [redacted] ([redacted]), who also did not want to make a staff complaint, states, "they weren't really pushing it too much but they have recently just started having us stand up." Mr. [redacted] states that the officers simply "tell the inmates that refuse to stand they're going to get a write up because that is policy," but it is "not a big deal." *Id.* at 4.

This investigation, through BWC and witness statements, revealed that a recent change in enforcing standing count procedures has led to widespread violations of the ADA and the *Armstrong* Remedial Plan (ARP) in this housing unit. The investigation confirms that staff are failing to accommodate class members who have difficulty standing, threatening RVRs for people who are not DPW, and requiring class members to speak to medical staff even if they are already clearly identified by CDCR as having a serious mobility disability. The investigation further revealed that class members in the unit were previously allowed to remain seated and thus may not understand that they should stand during count if they are able to do so without difficulty, even if they have a verified mobility disability.

The ARP requires staff to provide reasonable accommodations during standing count to class members with verified mobility disabilities, including by allowing people to sit on their bed or remain seated in their wheelchair next to their bed. *See* ARP § IV.I.6. The ARP does not require class members to be DPW to receive such an accommodation; it is only required that they have a verified disability that makes it difficult for them to stand. The investigation report cites to DOM Chapter 5, Article 16, 52020.5.2 Standing Count, which similarly requires that "[d]isabled incarcerated persons shall be reasonably accommodated, dependent on their disability," but does not limit accommodation to those with DPW designations only. *See* Investigation Report [redacted] at 7; Investigation Report [redacted] at 7.

Despite clear evidence that staff are violating the ARP and further evidence that staff are issuing—or threatening to issue—discriminatory RVRs to class members for seeking disability accommodations, no corrective or disciplinary action was taken. Instead, the cases were closed and staff were "exonerated." *See* Closure Memo [redacted] at 1; *see also* Closure Memo [redacted] at 1. Although the institution has discretion to strictly enforce the standing count requirements, if they decide to change how they enforce policies relating to disability accommodations, they should ensure the accuracy of their interpretation of the ARP and DOM and notify class members prior to the change.

Defendants missed a clear opportunity to provide corrective action to address an ongoing violation of the ARP, to prevent disability discrimination and the harm that results from the issuance of RVRs to class members who are unable to stand, and to clear up confusion among class members regarding increased enforcement of standing count procedures and an explanation that they should stand, if able to do so.

2. KVSP – [redacted] – Local, Not Sustained

[redacted] ([redacted]), a class member with disability-related incontinence, alleged that he was turned away for arriving late for his class by Counselor [redacted] even though he was late because he had to clean himself before attending class due to an incontinence accident. Mr. [redacted] also reported that his absence was incorrectly marked as a "refusal" to attend his assigned class, when in reality he wanted to attend but was not permitted to do so because he was late. *See* 602 at 1-2. The investigation confirmed that Counselor [redacted] denied Mr. [redacted] entry into the class due to his late arrival, and that she marked it as an "unexcused absence," but that it was entered into SOMS as a "refusal." *See* Investigation Report at 3. The investigation did not look into Mr. [redacted] claim that he was late to class due to his incontinence or other disability-related issues. Had the investigation determined that Mr. [redacted] was late to class due to an incontinence accident, the case should have resulted in corrective action to ensure that staff understand that disability accommodations must be provided to people who need extra time to get to class due to a disability. *See* ARP § I.14(d). Marking an absence for disability-related reasons as a "refusal" is particularly problematic, as refusals to attend an assigned program may result an RVR. Yet the investigation did not look into the misconduct alleged in Mr. [redacted] 602, preventing CDCR from determining what happened and taking appropriate action, if necessary, to hold staff accountable.

3. Failures to Obtain Relevant Video Evidence

Plaintiffs' counsel continue to identify a number of cases each quarter where video, essential to the investigation, was not retained. Despite CDCR policy that requires investigators to preserve footage within 10 days of the case being assigned, problems persist. *See* AIU Investigative Workflow; LDI Memo. Defendants now say a new intake unit within the AIU is responsible for requesting and collecting video footage within five days. Plaintiff's counsel acknowledge this development. Despite this, a sample of video retention cases from SATF reviewed this quarter shows how video retention failures in all but one case were due to administrative errors and other mistakes that would not necessarily be solved by accelerating the timeframe for requesting retention of video. Instead, video must be preserved for longer so that critical video evidence will be available to hold staff accountable for misconduct.

In SATF-[redacted], the class member alleged that an officer called him a derogatory name and inappropriately deactivated his BWC on November 9, 2023. The class member reported the misconduct on a 602 dated January 6, 2024, which was assigned to an AIU investigator on January 17, 2024 (69 days after the incident). *See* Investigation Report at 1. Yet the investigator failed to request footage from the time of the incident, incorrectly noting that the 90-day retention period had passed at the time the allegations were received: "No AVSS or BWC files were available for review because the ninety-day retention period was exceeded at the time the allegations were made." *See* Investigation Report at 2.

In SATF-[redacted], the class member alleged officers used unnecessary and excessive force and were discourteous during an incident on April 22, 2024. The class member reported the misconduct on a 602 the same day, and an AIU investigator was assigned to investigate the incident on May 15, 2024 (23 days after the incident). *See* Investigation Report at 1. However, the investigator noted, without any further explanation: "Due to administrative error the AVSS/BWC was not ordered within the video retention period." *See* Investigation Report at 3. **We ask that Defendants please explain what "administrative error" caused the failure to retain video in this case.**

In SATF-[redacted], the class member alleged that officers injured his arm and harassed him on March 27, 2024. The class member reported the misconduct on a 602 dated April 17, 2024, and an AIU investigator was assigned to the case on April 29, 2024 (21 days after the incident). *See* Investigation Report at 1-2. Confusingly, the investigator noted video of the incident was unavailable due to the incident being "voided" by the institution: "BWC/AVSS was requested for IRS log# 789873 however, the request was rejected by SATF Investigative Services Unit (ISU). The reason for rejection was due to the incident being voided by the institution. BWC/AVSS was not requested from the FAST team due to exceeding the ninety-day retention time." *See* Investigation Report at 3. It is not clear why the video would be unavailable even if the incident was "voided." Moreover, had the investigator requested video from the FAST team within 10 days, as outlined in departmental guidance, the video would have been available, as it was well within the 90-day retention period. *See* AIU Investigative Workflow (rev. March 2024) at 2 ("AVSS/BWC footage shall be requested within 10 days of assignment and before the time to request any further video has expired."). **Please explain why video was not available in this case, and what it means for video to be unavailable "due to the incident being voided by the institution."**

In SATF-[redacted], the class member alleged that officers acted inappropriately with her during a pat down on August 5, 2024. The allegation was assigned to an LDI on October 3, 2024 (59 days after the incident). *See* Allegation Inquiry Report at 1. The LDI failed to request and review footage from the incident because "Incarcerated Person (IP) [redacted] refused to be interviewed (Exhibit 5) there by not giving a time the incident occurred or what officers were involved." *See* Allegation Inquiry Report at 2. However, the time of the incident and names of the officers involved could be easily determined using the date provided by the class member. The LDI also reviewed two Incident Report Staff Narratives regarding an incident on August 5, 2024, that describe the incident, provide a time, and name the officers who used force to help place restraints on the class member and likely pat her down. *See* Incident Reports at 6-7. The LDI had enough information even without the subject interview to submit a video request.

In SATF-[redacted], the class member alleged that staff ignored his request for medical attention and an incontinence shower on November 14, 2024. The class member reported the misconduct on a 602 the same day and provided a timeframe for the incident.

See 602 at 1 (reporting "today at pill call I called for a 'mandown' and the tower [officer] [redacted] [sic] laughed at me and did not report the incident"). The LDI noted that video of the incident was not reviewed because the class member was "uncooperat[ive] during the interview," and therefore, "a time of the alleged allegation could not be determined." *See* Allegation Inquiry Report at 2. However, the class member had already provided a date and time in his grievance—November 14, 2024 at pill call. Moreover, the LDI incorrectly listed the date of the incident as November 11, 2024, and asked the claimant, staff, and witnesses about the wrong date. This mistake led the investigator to believe that the subject of the investigation was not working on the day of the incident, but the officer's schedule confirms he was actually working on November 14. *See* Exhibits at 8 (officer's work schedule showing RDO on November 11 but working second watch on the correct date, November 14).

In SATF-[redacted], the class member alleged that he was transported in a van that was not wheelchair accessible, which caused him to fall on October 28, 2024.[3] The class member reported the misconduct on a 602 dated December 24, 2024, and the case was assigned to an LDI for investigation on January 3, 2025 (67 days after the incident). *See* Allegation Inquiry Report at 1; Exhibits at 1. The investigator gathered documentation showing the date and time of the incident as well as the names of the transportation staff. *See* Exhibits at 8 (transportation schedule showing the class member was transported to an outside hospital by Officers [redacted], [redacted], and [redacted] on October 28, 2024, for an appointment at 1000 hours). However, the investigator failed to request any footage of the incident because "a time of incident could not be identified," despite having documentation that clearly provided the date, time, and officers involved in the incident. *See* Allegation Inquiry Report at 5.

In SATF-[redacted], the class member alleged that a sergeant and lieutenant used unnecessary and excessive force and called him a racial slur during an incident on July 11, 2023. The class member submitted his allegation on a 602 the same day. CST reviewed and approved the grievance for investigation by OIA on July 13, 2023, and it was assigned to the AIU on August 9, 2023. *See* Investigation Report at 1-2. However, OIA failed to assign an investigator until November 22, 2023—134 days after the incident—far later than the recommended three days. *See* AIU Investigative Workflow (rev. March 2024) at 1 ("Each investigation is assigned to an investigator through the AIU database after the triage process has been completed and generally, **within three days of receipt from the Centralized Screening Team (CST)**.") (emphasis added). By that time, the 90-day video retention period had passed and the investigator was unable to review any footage of the incident.

[3] The class member originally identified the date as October 26, 2024, however, the investigator was able to determine the date of incident was October 28, 2024, through transportation documentation and interviews with the claimant and staff.

D. Failures to Sustain Allegations and Impose Appropriate Discipline

In the following cases, Hiring Authorities either inappropriately failed to sustain allegations of misconduct or sustained an allegation but did not take appropriate action.

1. SATF-[redacted] – AIU, Sustained (L5; Reduced to No Penalty)

The Hiring Authority appropriately disciplined Officer [redacted] for punching a [redacted]-year-old class member in the face while he was on the ground. But it appears that CDCR and Officer [redacted] stipulated before the State Personnel Board (SPD) to remove the penalty entirely.

The facts here are undisputed. [redacted] ([redacted]), had his tablet on the yard, and officers told him to bring it back to his housing unit. The video footage begins while Mr. [redacted] and Officer [redacted] are engaging in a back-and-forth about the tablet as another officer, Officer [redacted] is conducting a clothed pat-down search of Mr. [redacted] *See* BWC at 4:21:21. Mr. [redacted] becomes increasingly frustrated with Officer [redacted] who is arguing about with him about whether Mr. [redacted] brought the tablet to the yard. After the pat-down search is complete, Officer [redacted] reaches for Mr. [redacted] arm to escort him back to his unit. *See* BWC at 4:21:42. Mr. [redacted] who uses a cane to ambulate, moves his arm so that the officer cannot grab him. *See* BWC at 4:21:43. Officer [redacted] says, "Woah woah woah, hey, let me escort you, dude." *See* BWC at 4:21:44. Mr. [redacted] turns and appears to be responding, and Officer [redacted] says, "Don't tense up on me." *See* BWC at 4:21:45. Officer [redacted] suddenly grabs Mr. [redacted] by the back of the neck and drops his body weight to the ground, pulling Mr. [redacted] to the ground with him. *See* BWC at 4:21:51. Officer [redacted] and four other officers immediately respond to the incident. The officers attempt to flip Mr. [redacted] onto his stomach, but he resists while on the ground. After several seconds of wrestling with Mr. [redacted] Officer [redacted] punches him in the face. *See* BWC at 4:22:05.

The Hiring Authority appropriately sustained misconduct against Officer [redacted] finding that his misconduct met four matrix categories: D1 (Discourtesy toward inmates, **1**23456); D2 (Negligently endangering self, fellow employees, inmates, 1**2**3); D26 (Failure to observe/perform within the scope, **1**2345); and L5 (Excessive use of force causing injury; 4**5**6789). *See* 402/403 at 1-3. The Hiring Authority found six aggravating factors and only one mitigating factor (that the misconduct was not premeditated), and imposed Level 5 discipline, a 5 percent reduction in salary for 25 pay periods. *Id*. The Skelly documents were not produced in the investigation file, so it is unclear whether this penalty was negotiated down to a lesser penalty.

The investigation file includes a stipulation approved by the SPB that states that, in exchange for dropping his appeal, Officer [redacted] received no discipline. *See* SPB

Stipulation at 2. As part of this stipulation, CDCR agreed to withdraw the Notice of Adverse Action (NOAA) and to pay Officer [redacted] back-pay "for the 5% salary reduction for 5 qualifying pay periods that was the result of the NOAA." *Id.* at 2. It appears that, after this SPB stipulation, Officer [redacted] received no penalty at all. Given the serious confirmed misconduct in this case—with an officer punching a [redacted]-year-old man with a disability in the face while he was on the ground, causing him injury—it is very concerning that CDCR decided not to hold Officer [redacted] accountable. **Plaintiffs' counsel requests an explanation for the decision to stipulate to drop or reduce the penalty in this case where clear video evidence confirms serious misconduct.**

2. LAC-[redacted] – AIU, Sustained (Training)

In this case, an officer allowed another incarcerated person into the cell of [redacted] ([redacted]), a class member who uses a wheelchair. The incarcerated person attacked Mr. [redacted] injuring him and leading to a use of force. Although the Hiring Authority sustained the allegation and issued training, the tower officer's conduct was very dangerous and merited adverse action.

As video shows, an incarcerated person waves to Officer [redacted] to open cell 119, which is not his cell. Mr. [redacted] is assigned to the cell, and he is inside. As soon as Officer [redacted] opens the door, the incarcerated person rushes in and begins attacking Mr. [redacted] punching at his head. The tower officer closes the cell door. *See* AVSS at 7:43:50. The two floor officers respond and pepper spray Mr. [redacted] and the other incarcerated person through the food port in multiple long bursts for almost 20 seconds. *See* BWC at 7:44:36. It takes Officer [redacted] almost 40 seconds from when the floor officers first arrive to open the cell door. *See* BWC (linked above) at 7:44:23; 7:44:59.

Mr. [redacted] filed a 602 alleging that Officer [redacted] improperly opened his cell door for the incarcerated person, which allowed them to enter and attack him, hitting his face and head area multiple times. *See* 602 at 8. Mr. [redacted] reported that, due to his disability, which includes spinal cord injuries, he was unable to defend himself, and the attack resulted in worsening disabilities, including further spinal cord injuries, headaches, and worsening mental health. *Id.* at 8-9.

The AIU investigator confirmed that Officer [redacted] opened Mr. [redacted] cell door without justification. Floor officers did not tell him to open the cell, nor were they standing near the cell. *See* BWC (linked above) at 7:44:00; AIU Report at 5-6. Instead, Officer [redacted] opened the cell because the incarcerated person asked him to, even though it was not his assigned cell. *See* AIU Report at 4-5.

The Hiring Authority sustained the allegation that Officer [redacted] opened Mr. [redacted] cell door and allowed an incarcerated person to assault him, yet concluded that only one disciplinary matrix category applied: D26 (Failure to observe/perform within the scope, **1**2345); *See* 402/403 at 1, 3. The Hiring Authority found three

mitigating factors and one aggravating factor—that serious consequences occurred or could have resulted from the misconduct, *see* 402/403 at 3—and only issued corrective action, requiring Officer [redacted] to attend a 30-minute training on "Expectations Regarding Procedures for Opening/Closing Cell Doors." *See* Closure Letter at 1; Training at 1.

This was not an appropriate penalty for Officer [redacted] failure, which could have had life threatening consequences, and actually led to Mr. [redacted] being brutally attacked, sustaining serious injuries, and ultimately being pepper sprayed by staff. Here, the Hiring Authority should have sustained a finding for negligent endangerment (D2, 123), which should have resulted in adverse action. Additionally, the AIU investigator pointed out that Officer [redacted] may have lied during the investigation, saying that he thought he heard floor staff call out for the cell door to be open, which is inconsistent with his written incident report. *See* AIU Report at 9. The Hiring Authority did not consider Officer [redacted] apparent dishonesty as an aggravating factor (and in fact included "the employee was forthright and truthful during the investigation" as a mitigating factor). *See* 402/403 at 3.

This kind of misconduct is especially concerning given that plaintiffs' counsel have raised multiple allegations of staff members—intentionally or unintentionally—similarly failing to closely monitor the coming and going of people in cells and housing units to which they are not assigned, that have resulted in multiple class member deaths. *See* July 24, 2025, email regarding death of [redacted], May 8, 2025, letter regarding the death of [redacted]

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

In this case, Sergeant [redacted] violated policy by ignoring safety concerns reported by [redacted] ([redacted]), and by using discourteous language during the interaction. The Hiring Authority failed to sustain the allegations against Sergeant [redacted] despite clear video evidence that he did not follow the required procedure when responding to Ms. [redacted] safety concerns.

On July 25, 2024, Ms. [redacted] was released from the [redacted] Ms. [redacted] reported that when she arrived at her new housing unit, another incarcerated person told her that there were two people living in the building that she cannot be housed with and who may cause her harm. *See* Investigation Report (IR) at 2-3. The BWC footage shows Ms. [redacted] approach the building officers and Sergeant [redacted] to report her safety concerns. *See* BWC at 6:12:23-6:14:55. Sergeant [redacted] tells Ms. [redacted] to "figure it out." *See* BWC at 6:12:54. Sergeant [redacted] continues, "Go into a cell for the night until you find someone is basically your only option. I can't send you back to [the [redacted] *See* BWC (linked above) at 6:13:31. The conversation concludes, and Ms. [redacted] is seen in the background walking around the dayroom trying to find a compatible cellmate. Several officers join Sergeant [redacted] at the podium. One of the building officers points at

Ms. [redacted] and explains that she does not want to house with anyone who is affiliated with an STG. *See* BWC (linked above) at 6:19:01. Sergeant [redacted] responds, "Well, every motherfucker in here is affiliated so he's [sic] going to have fucking figure it out." *See* BWC (linked above) at 6:19:08.

Sergeant [redacted] then walks outside the building to join another group of officers. Ms. [redacted] comes outside a few minutes later and requests to talk to the sergeant. *See* BWC at 6:23:48. Ms. [redacted] tries to explain her concerns again, but Sergeant [redacted] continues to dismiss her, saying, "There's nothing I can do. You've already been housed here." *See* BWC at 6:24:52. Ms. [redacted] walks back into the building, and shortly after that, Sergeant [redacted] tells the other officers, "How is it that these are fucking badasses that that commit all these crimes out in town, but they come here and they're a bunch of fucking bitches." *See* BWC at 6:25:43. After a few minutes, Sergeant [redacted] goes back inside the building, and Ms. [redacted] approaches him again. Sergeant [redacted] tells Ms. [redacted] that the concern she has raised "does not meet the criteria for safety concerns." *See* BWC at 6:28:58. In response, Ms. [redacted] says that she is suicidal, and officers handcuff her immediately and escort her out of the building. *See* BWC at 6:29:29. Because of custody's lack of response to her concerns about her safety, Ms. [redacted] was admitted to a mental health crisis bed. *See* Electronic Health Records System (EHRS), First Medical Responder – Text at 6:49 pm at 2 (July 25, 2024) ("I have a plan to hang myself because I feel like my life is in danger, I feel like I am going to get assaulted and the staff here does not care about my safety"); EHRS, Suicide Risk and Self-Harm Evaluation at 8:39 pm at 1 (July 25, 2024) ("At this time due to DTO and DTS, IP is being admitted to MHCB").

During his interview with the investigator, Sergeant [redacted] explained the appropriate process for responding to incarcerated people's reported safety concerns, which includes interviewing the incarcerated person in a confidential setting for specific information, placing the person in a holding cell, and corroborating the information received from the incarcerated person. *See* AIU Report at 8. Sergeant [redacted] took none of those steps here, apparently because he believed the information from Ms. [redacted] was not specific enough. *Id.* ("[Sergeant [redacted] was looking for [redacted] to tell him specific incarcerated persons, on the facility, [s]he had safety concerns against…. [redacted] stated if [redacted] were to have said something within that nature than [sic] he would have had escorted to the program office for a confidential interview to obtain more detailed information."). But that explanation makes little sense. CDCR's policy does not require an incarcerated person to reveal confidential information in a public setting *before* taking them to a confidential setting for an interview. Further, the policy does not require Ms. [redacted] to disclose a specific incarcerated person who is a threat in order to have a confidential interview about her safety concerns. It can be enough for her to disclose that she is transgender, that she is not affiliated with an STG, and that she received information from others stating that her life was in danger, all of which was known by Sergeant [redacted] at the time.

The investigation report in this case is clear. It describes the relevant policies and facts that are important for determining whether Sergeant [redacted] complied with those policies. For example, the report explains that the conversation between Sergeant [redacted] and Ms. [redacted] "took place inside the building while there were several incarcerated persons outside of their cells walking around the dayroom and exiting to the yard." *Id.* at 6. The investigation report also quoted each of the inappropriate and discourteous statements that Sergeant [redacted] made to Ms. [redacted] *Id.* at 5-6. However, despite the thorough investigation report, the Hiring Authority did not sustain Sergeant [redacted] misconduct. *See* 402/403/Closure Memo at 11.

Sergeant [redacted] should have offered Ms. [redacted] a confidential space to discuss her concerns and considered the information provided to determine if she could be safely housed in the building. Sergeant [redacted] comments about Ms. [redacted] and incarcerated people generally were also unprofessional and discourteous. The Hiring Authority should have sustained the allegations against Sergeant [redacted] for failing to follow policy, making discourteous comments, and potentially endangering Ms. [redacted] safety.

4. LAC-[redacted] – Local, Not Sustained; AIU, Sustained (ECR)

In this case, staff kept [redacted] ([redacted]) in a holding cage for over 11 hours under circumstances that violate the *Coleman* Program Guide and CDCR policies strictly limiting length of stays in holding cells. Staff also failed to document this use of a holding cage, also in violation of the Program Guide and CDCR policies. However, CDCR did not sustain misconduct. Further, despite staff expressly reporting that this happens routinely due to lack of space in the LAC [redacted] there is no indication that, as a result of the discovery of this problem, steps were taken to prevent these violations from occurring in the future

Mr. [redacted] was involved in a conflict with his cellmate and received a medical evaluation in a holding cell in the D Yard gym on July 26, 2024 at 2:25 PM.[4] *See* 7219 at 20; *See* Inquiry Report at 2, 7. Mr. [redacted] remained in that holding cell for more than 11 hours until staff moved him to the CTC to receive medical attention for facial injuries. *See* Inquiry Report at 4. An hour or so later, at 3:02 AM, staff finally moved Mr. [redacted] to overflow [redacted] housing on C Yard, 12 hours and 37 minutes after his placement. *See* Bed Assignments at 26; Inquiry Report at 3. Mr. [redacted] filed a 602 alleging he was kept in a holding tank for over 14 hours. *See* 602 at 3-4.

The case was assigned to an LDI. During the investigation, Officer [redacted] who was on duty during part of the time that Mr. [redacted] was in the cage, reported that when

[4] Lt. [redacted] confirmed during his interview that the 7219 medical evaluation indicates Mr. [redacted] was in a holding call for this time. *See* Inquiry Report at 3.

he arrived on duty for first watch, Mr. [redacted] told him that he had been in the holding cage all night. Officer [redacted] told the investigator he could not move Mr. [redacted] because there was insufficient bed space in the [redacted] *See* Inquiry Report at 4-5. Similarly, Lieutenant [redacted] and Officer [redacted] both said in their interviews that long stays in holding cells are a "normal occurrence" for the LAC [redacted] yard due to the lack of bed space in the [redacted] *See* Inquiry Report at 3, 6.

Regardless of the reasons, keeping Mr. [redacted] in the holding cell for almost 12 hours violates CDCR policies recognizing that these cells should be used rarely and only with significant protections in place. The *Coleman* Program Guide, for example, states that holding cells should be used as a "last option," and "these cells shall only be used to temporarily hold patients awaiting mental health emergent evaluation, transfer to alternative housing, or awaiting immediate transfer to the MHCB." *See* Program Guide at 1 (page 371 of Program Guide; Policy 12.05.301). Further, "[t]hese cells are NOT to be designated alternative housing, as placement is a last option and is intended to be used for as little time as possible, **not to exceed four hours** …" *See id.* The Department Operations Manual also states that a "holding cell shall not be used as a means of punishment, housing or long-term placement." CDCR DOM § 51020.4. Mr. [redacted] placement for almost 12 hours in the holding cell violates these policies. It is highly concerning that two staff members reported that this type of conduct is "normal" and that it does not appear that CDCR is taking steps to address this practice.

Mr. [redacted] was likely on suicide watch at the time, as a nursing note from when he went to the CTC states "on SW 1:1 CO watching I/P," and he was clinically referred to the [redacted] level of care on July 26 at 6:48 PM, about 4.5 hours after he was placed in the holding cage, and he remained in the holding cell for another approximately seven hours. *See* Nursing Note dated July 27, 2024; Patient Placement History at 2. Regardless, Mr. [redacted] further decompensated. As his medical records show, the following day, he announced that he had begun a hunger strike. *See* Progress Note dated July 28, 2024 at 1. Mr. [redacted] also reported that he was experiencing suicidal ideation and was again placed on suicide watch. *See* Suicide Risk and Self-Harm dated July 28, 2024 at 1. He was ultimately admitted to the [redacted], where he remained for around 11 days. *See* Patient Placement History at 2. Following Mr. [redacted] [redacted] stay, he discharged to the [redacted] level of care—a higher level of care than he had been at for the month prior to the incident. *See* Patient Placement History at 2.

Staff also failed to document the holding cell placement. The investigator could not locate the holding cell logs despite "every effort." *See* Inquiry Report at 6. The failure to document also violates policy, as the Program Guide states that "[u]se of these cells shall be documented on the custody log for holding cells." *See* Program Guide at 1 (page 371 of Program Guide). The lack of a formal record prevents both CDCR and Plaintiffs' counsel from being able to track these types of violations.

Indeed, the LAC production contained other evidence of similar misconduct. In [redacted] the investigator uncovered evidence that LAC staff held [redacted] ([redacted]) in a holding cell for 7.5 hours after he reported he was suicidal. The Hiring Authority sustained the allegation that Sergeant [redacted] failed to receive managerial approval to hold Mr. [redacted] in a holding cell for over four hours. *See* 402/403 at 1.[5] The Hiring Authority issued corrective action in the form of an employee counseling record. ECR at 1-2. The holding cell logs failed to document the release time, the total time in the holding cell, or a supervisor's signature authorizing Sergeant [redacted] to extend Mr. [redacted] confinement in the cage. *See* Holding Cell Logs at 31-32.

The problem of holding mental health patients in holding cells in ways that violate policy may be present at more institutions than just LAC. [redacted] **Please report on what LAC and CDCR more broadly is doing to address this problem.**

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

In this case, CDCR failed to hold an officer accountable for apparent retaliation against a class member, [redacted] ([redacted]), who had filed multiple grievances against the officer. Mr. [redacted] filed a 602 alleging that Officer [redacted] retaliated against him by speaking over the housing unit intercom—so that everyone else in the unit could hear—about previous grievances he had filed against Officer [redacted] *See* 602 at 3-4. BWC confirms the allegation and shows Officer [redacted] mocking Mr. [redacted] disability.

The video shows Officer [redacted] who is in the control booth, asking Mr. [redacted] to secure his door so that she can run showers. *See* BWC at 9:36:40. Mr. [redacted] approaches the control booth and tells Officer [redacted] to "go home." *See* BWC (linked above) at 9:39:29; AIU Report at 3. After some additional conversation, Officer [redacted] says, over the intercom, "I think you're the one that's aggravated, sir, you're holding some sort of vendetta from previous write-ups that you did, I don't know what your deal is, all I said was take it in, secure your door, wear your vest because you're mobility impaired …" *See* BWC at 9:39:44. The dayroom is mostly quiet other than the conversation between Officer [redacted] and Mr. [redacted] it easier for others to hear what Officer [redacted] says

[5] It appears that local operating procedure, OP 511 allows staff to hold incarcerated people in a cell for over four hours if the supervisor obtains a Captain's or AOD's signature. *See* ECR at 1. This LOP may violate the *Coleman* Program Guide.

over the intercom. Mr. [redacted] then says something that is difficult to make out, potentially objecting to Officer [redacted] referring to his grievances publicly, and Officer [redacted] says "No, I'm talking to you so you can hear me, I know you're hearing impaired, now you can hear me." *See* BWC at 9:40:07.

The AIU investigation report provides a clear summary of this video evidence.[6] The evidence shows Officer [redacted] discussing Mr. [redacted] grievances against her over the intercom, audible to other incarcerated people, which could affect Mr. [redacted] safety. Officers are admonished not to discuss the details of the investigations, and "all information and/or documents discussed during the related interview process are deemed confidential." *See*, for example, NOIA at 27. Here, Officer [redacted] actions were similar to publicly disclosing that Mr. [redacted] was a "snitch," placing his safety at risk. Despite clear evidence that she publicly announced that Mr. [redacted] had filed staff complaints against her, and despite Officer [redacted] justifying doing so by pointing to Mr. [redacted] hearing disability, the Hiring Authority failed to confirm any misconduct. In so doing, CDCR condones Officer [redacted] actions and send the message to officers that they can retaliate against class members who file complaints against them without consequence.

II. CONCLUSION

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

[6] However, the investigator should have asked Officer [redacted] if her statements were made out of retaliation for Mr. [redacted] filing grievances against her, as he alleged.