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August 8, 2025

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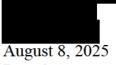
Re: Armstrong v. Newsom: Plaintiffs' August 2025 Review of CDCR's Accountability System at the Six Prisons Our File No. 0581-03

Dear :

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



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

Sincerely,

ROSEN BIEN GALVAN & GRUNFELD LLP





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

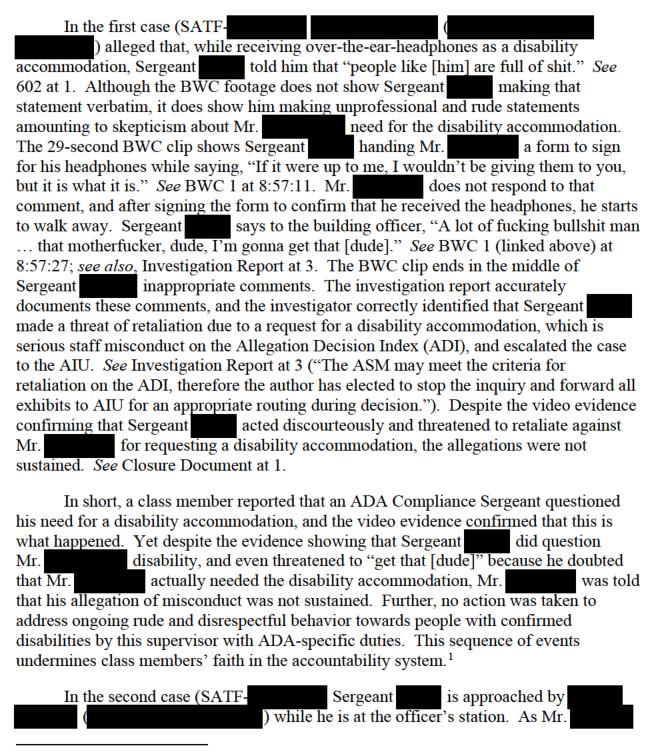
A. Failure of the Accountability System to Prevent Ongoing Harm Caused by ADA Sergeants at SATF

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.

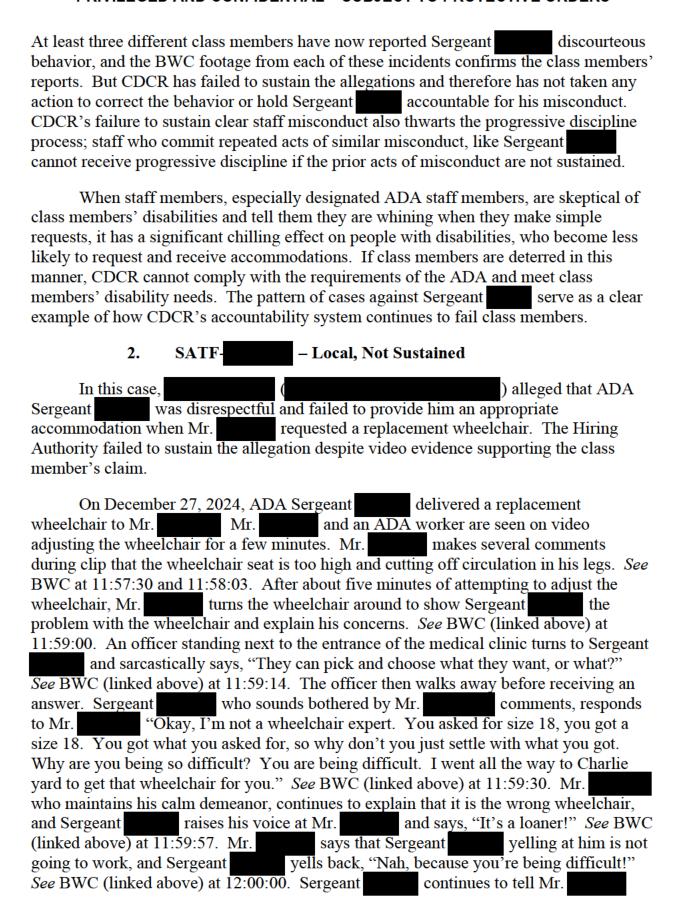
1. SATF- Local, Not Sustained

In our most recent report, we wrote about Sergeant, 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-, see BWC). The class member's allegation in that case was not sustained, even though video footage clearly demonstrated was discourteous. Therefore nothing was done—not even training that Sergeant 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 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 was not held accountable and nothing was done to put a stop to his ongoing harmful behavior to class members.



¹ Although the investigator appropriately routed the allegation of "retaliation" to the AIU, it is unlikely to lead to a sustained finding because Sergeant statement to another officer alone—without a further action against Mr. 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. 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 tells Mr. to go to the program office to see if they will help him. See BWC 2 (linked above) at 8:59:02. Mr. explains his reason for needing the phone and states that he is having a hard time coping, but Sergeant appears to be dismissive of Mr. 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 says if they give Mr. a phone call, then everyone has to get one. See BWC 2 (linked above) at 8:59:59. This comment upsets Mr. and he walks away from Sergeant above) at 8:59:59. This comment upsets Mr.
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. is not doing well coping with the anniversary of his daughter's death, Sergeant 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 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. not refrained from reacting. Sergeant then tells another incarcerated person to tell Mr. 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 discourteous comment that Mr. 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 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 pattern of unprofessional behavior deters class members from requesting disability accommodations. In light of this pattern, we request that CDCR remove Sergeant from the ADA Compliance Sergeant position.
These three cases involving Sergeant (one from the previous quarter and two from this quarter) underscore serious issues with Defendants' accountability system.



that he should settle for what he got: "I ain't looking at nothing. Whatever. I'm done. 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. saying, "you're getting a phone call from the Warden today," to which Sergeant 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. by making crying noises as he prepares to leave. *See* BWC (linked above) at 12:00:49.

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

Plaintiffs' counsel continue to identify, every quarter, multiple serious use-offorce 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.

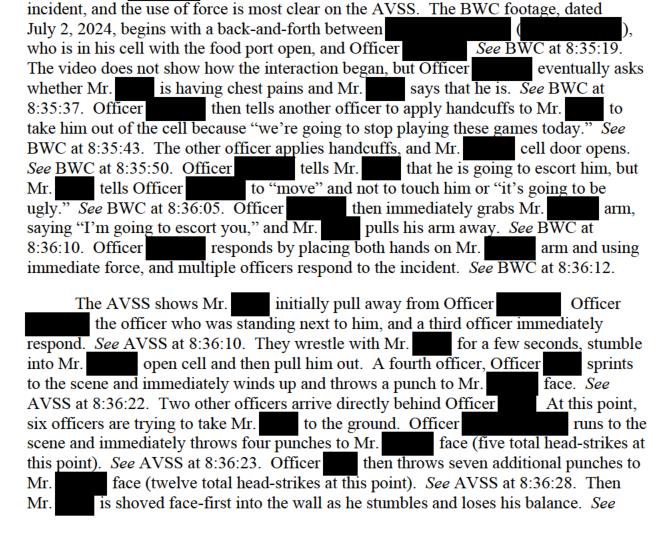
The Office of Inspector General (OIG)'s reporting on CDCR's investigations into use-of-force allegations continues to be consistent with Plaintiffs' findings. On July 31, 2025, the OIG published a report assessing CDCR's performance in 13 use-of-force cases closed between January 1 and June 30, 2025. *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- - 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.

body-worn camera footage shows the initial escalation of the

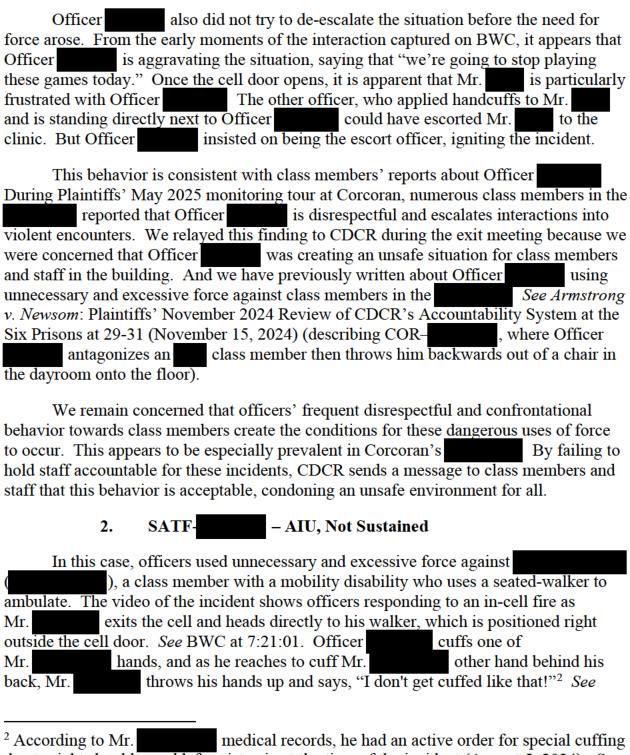


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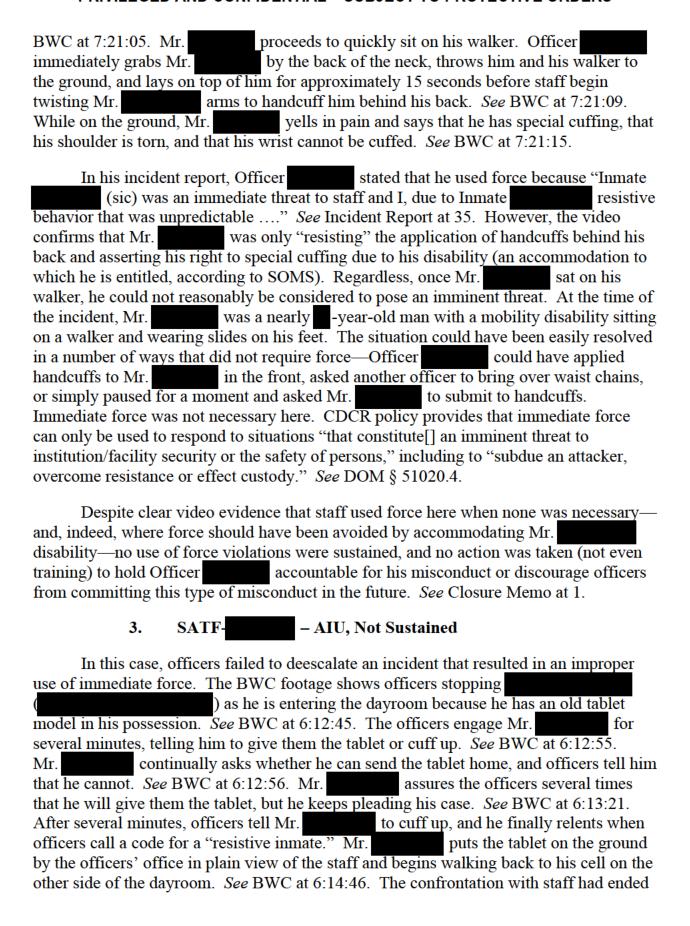
Officer

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. head into the bucket, and as his head slightly comes up for a moment, Officer 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. chest is on another bucket. See AVSS at 8:36:38. At that point, with Mr. head hovering in the air, Officer sits up straight to wind up, drops his weight, and throws an elbow to the back of 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 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 [sic] facial area multiple times to stop the threat and overcome resistance." See Investigation Report at 5. Officer claimed that he determined that "[e]ach strike did nothing to as he continued with his aggressive behavior." Id. However, even though his numerous strikes to Mr. face were admittedly not having the intended effect, Officer continued striking him. He wrote that, "[h]aving negative results in my physical use of force as a continued aggressively resisting, I would strike with an additional forward strike to the facial area." Id. Again, Officer wrote that "my strikes had no effect on Id. Once Mr. fell down, Officer reports that "my strikes had no effect on Id. Once then wrote that, "Id. appeared to try and turn his face towards me. Fearing would spit me (sic), I utilized physical force by utilizing my right elbow in a forward strike motion contacting facial area to stop the threat." Id. Officer report that Mr. fried turning his face towards Officer does not appear to be consistent with the video evidence. Officer who threw four punches in quick succession to Mr. 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 and when they began throwing punches at his face. Id. at 10, 11.
Allegations of excessive use-of-force should have been sustained against Officer and Officer 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. was handcuffed (if true) does not make the level of force objectively reasonable. All movement in a second is done while people are handcuffed, so the officers should have known that Mr. was handcuffed. Additionally, seven officers were surrounding Mr. 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. 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.



due to right shoulder and left wrist pain at the time of the incident (August 5, 2024). See 7410 (May 1, 2024).

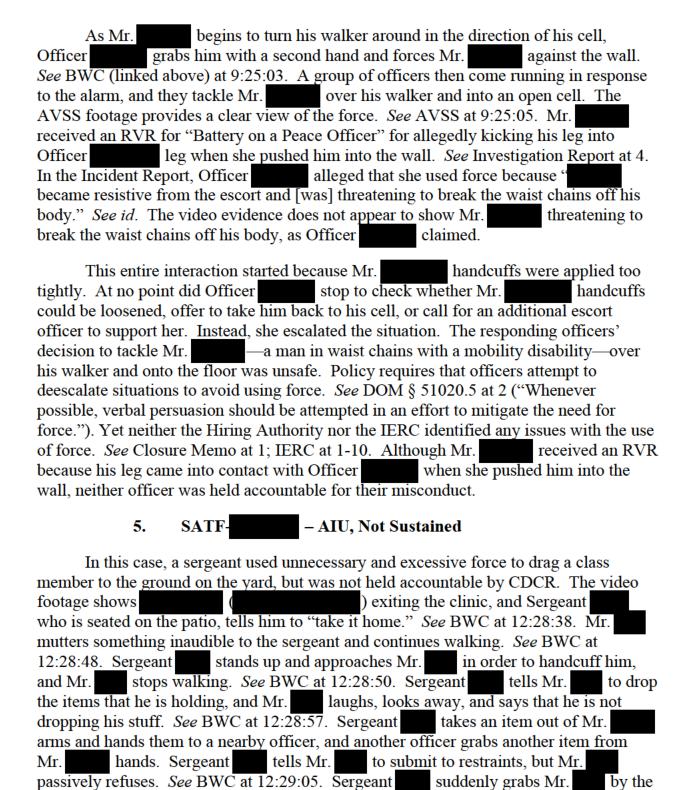


at that point, and no imminent threat was present. The officers succeeded in their objective of getting the tablet back. If they wished to penalize Mr. for taking the dispute that far or for disobeying the order to cuff up, they could have easily issued him an RVR.

Instead, the officers follow Mr. back towards his cell to place him in restraints. See BWC at 6:14:46. Additional officers arrive to the dayroom, and they to cuff up behind his back, and in the process of doing so, fail to mobility disability, which had been exacerbated by a accommodate Mr. recent surgery. See BWC at 6:15:38. The officers handcuff Mr. 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. because " 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. 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- - AIU, Not Sustained

In this case, officers once again escalate a situation into a dangerous use of force -year-old class member in on), a 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 BWC. Officer through the food port of his cell and opens his cell applies waist chains on Mr. door to begin escorting him. See BWC (linked above) at 9:23:23. As Mr. exiting his cell, he tells Officer that the waist chains are "too tight on me again." See BWC (linked above) at $9:2\overline{4:26}$. Nevertheless, he exits the cell and starts walking During the approximately 30-second escort, he says a down the hallway of the number of times that the waist chains are too tight. Mr. 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. takes a few more steps forward to continue the escort. When he stops again to adjust the waist chains, Officer activates her alarm in response. See BWC at 9:24:53. Officer then squeezes Mr. See BWC at 9:24:57. As she is arm more tightly, which further aggravates Mr. says, "Listen, you're going to let go, squeezing Mr. arm, Officer you're not gonna ... you're gonna hold your thing," referring to his walker. See BWC (linked above) at 9:24:59. Mr. interrupts her and says, "I'm not gonna hold a goddamn thing! Take me back to my goddamn cell."



arm and throws him to the ground with his entire body weight. See BWC at 12:29:08. At

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

is not presenting an imminent threat, so the decision

[4742130.1]

the moment force is used, Mr.

received an RVR for this incident for

circumstances. See DOM 51020.4. Mr.

"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. 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 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. to submit to restraints, " stopped, [and] informed he wasn't going to talk to a demanded to speak with a Sergeant. had already spoke to multiple Sergeants regarding a Sergeant as they were aware bed move." See Investigation Report at 2. That conversation did not happen in the video. Second, Sergeant claimed that he used force "due to resistive action of tensing up his arm and refusing to let go of his items," causing Sergeant was possibly hiding a weapon," but nothing in the video supports Sergeant speculation of the existence of a weapon. Mr. 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. was not found to be in a possession of a weapon after the incident. Third, Sergeant wrote in his incident report that had been refusing orders throughout to day to return to their assigned cell," which makes Sergeant quick decision to use force appear like it may have been in response to Mr. disobedience earlier in the day, as opposed to any imminent threat in that moment. In fact, Sergeant and Mr. had a disagreement earlier in the 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 had reportedly ordered him to return to his assigned building, and Mr. *Id.* In response, Sergeant reportedly said that no one wants to house with Mr. because he uses drugs. *Id*. Mr. 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 was attempting to effect custody of he began to physically resist" See Incident Report at 28. But the video of the incident does not show Mr. being physically resistive before Sergeant throws him to the ground. Second, Officer who was nearby when force was used, wrote in his report that Sergeant a direct order to turn around and submit to handcuffs and observed away." See Investigation Report at 3. But the video footage does not show Mr. pulling away; he only refused to submit to handcuffs. None of the inconsistencies in Sergeant Officer or Officer 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.

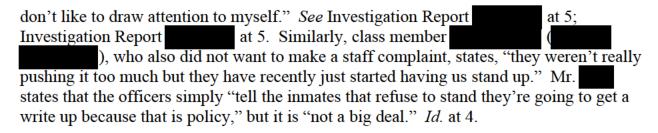
The first two cases below involve serious allegations of disability-related staff misconduct that Defendants' accountability system failed to address. Both cases involved inadequate local investigations (or "inquiries") into the alleged misconduct. These cases are especially concerning given that these 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 – Local, Not Sustained

Multiple class members filed complaints this quarter reporting that Sergeant is threatening to issue RVRs to class members with mobility disabilities if they fail to stand during count. *See* 1824 at 5; 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 class member as identified by a "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 class members are in fact threatened with RVRs if they fail to stand. One class member witness who was interviewed for the investigations, ([F]]) 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



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 at 7; Investigation Report

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 at 1; *see also* Closure Memo 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 – Local, Not Sustained

), a class member with disabilityrelated incontinence, alleged that he was turned away for arriving late for his class by even though he was late because he had to clean himself before attending class due to an incontinence accident. Mr. 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. denied Mr. The investigation confirmed that Counselor 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. claim that he was late to class due to his incontinence or other disability-related issues. Had the investigation determined that Mr. 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. 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- , 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- , 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.

, the class member alleged that officers injured his arm and In SATFharassed 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."

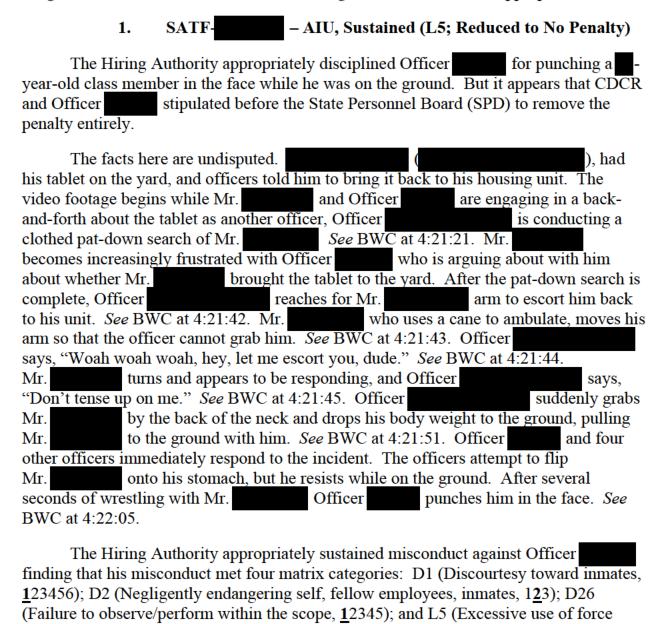
In SATF-water, the class member alleged that staff ignored his request for medical attention and an incontinence shower on November 14, 2024. The class member reported the misconduct on a 602 the same day and provided a timeframe for the incident.

[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).

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.

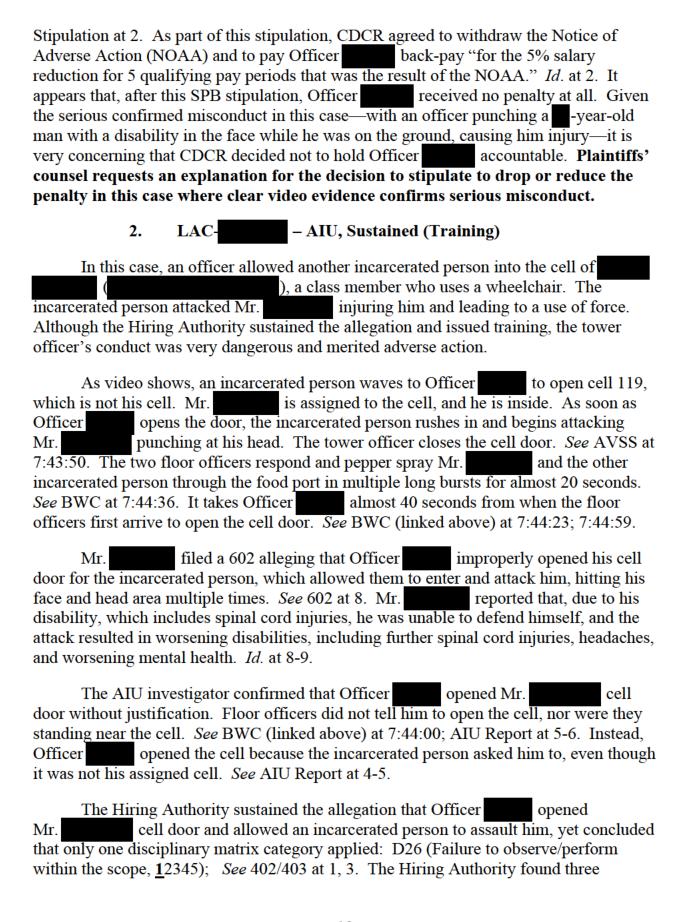


The investigation file includes a stipulation approved by the SPB that states that, in exchange for dropping his appeal, Officer received no discipline. See SPB

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

causing injury; 4<u>5</u>6789). See 402/403 at 1-3. The Hiring Authority found six aggravating factors and only one mitigating factor (that the misconduct was not

unclear whether this penalty was negotiated down to a lesser penalty.



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 to attend a 30-minute training on "Expectations Regarding Procedures for Opening/Closing Cell Doors." See Closure Letter at 1; Training at 1.

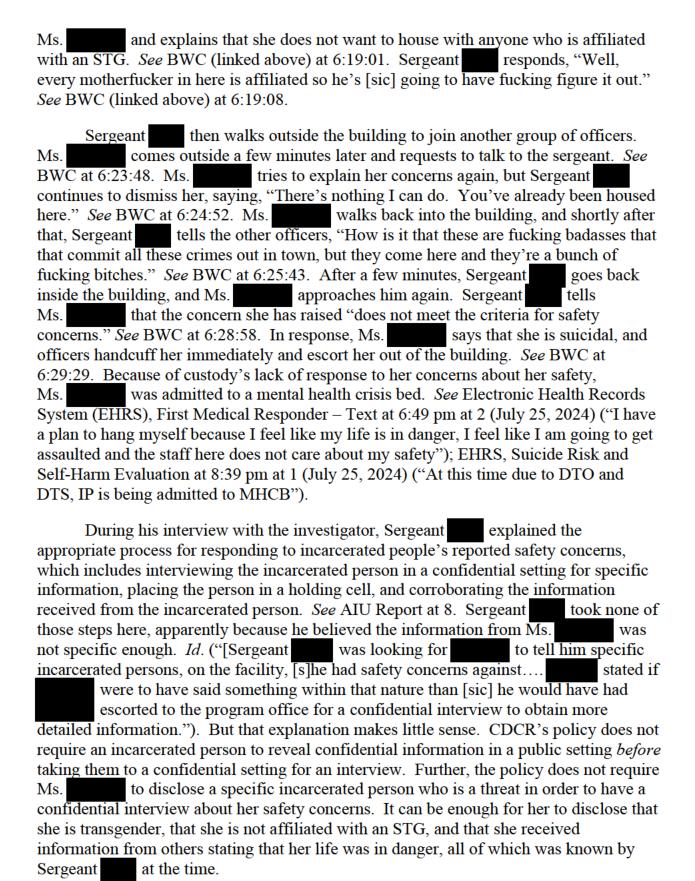
This was not an appropriate penalty for Officer failure, which could have had life threatening consequences, and actually led to Mr. being brutally attacked, sustaining serious injuries, and ultimately being pepper sprayed by staff. Here, the Hiring Authority should have sustained a finding for negligent endangerment (D2, 123), which should have resulted in adverse action. Additionally, the AIU investigator pointed out that Officer 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 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.

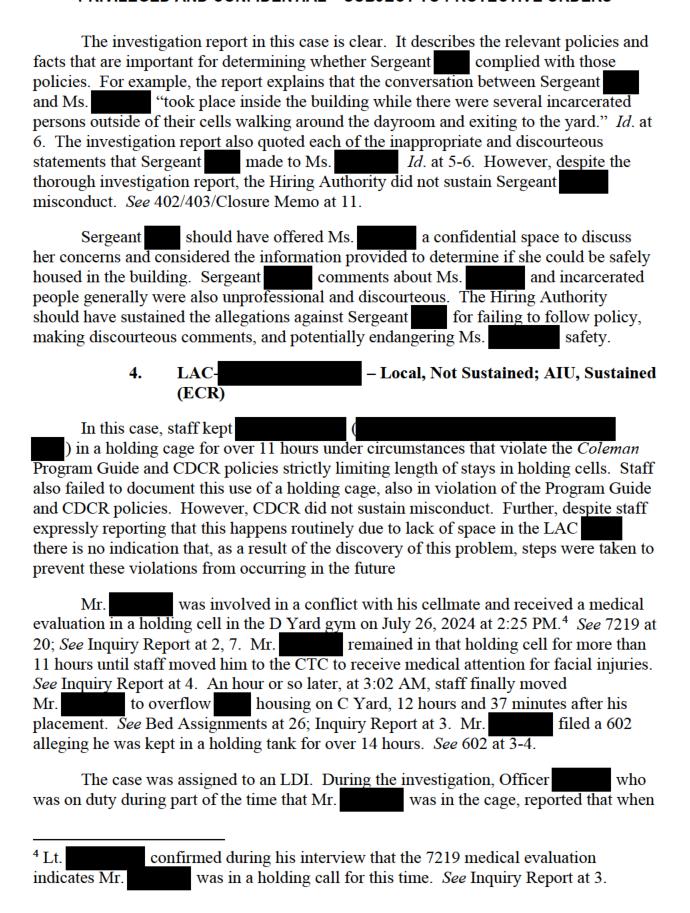
This kind of misconduct is especially concerning given that plaintiffs' counsel have raised multiple allegations of staff members—intentionally or unintentionally—similarly failing to closely monitor the coming and going of people in cells and housing units to which they are not assigned, that have resulted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

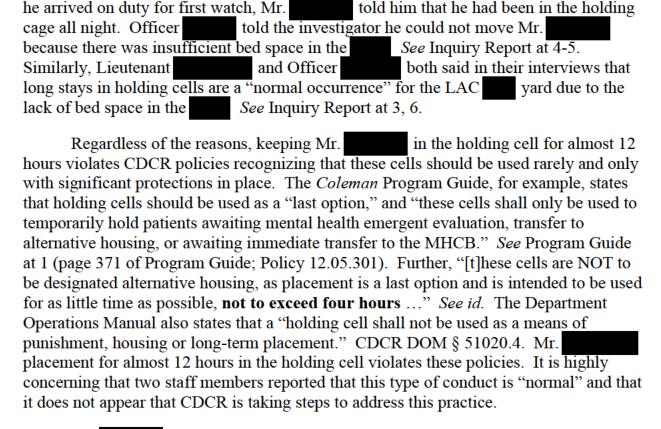
3. COR- - AIU, Not Sustained

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

was released from the On July 25, 2024, Ms. Ms. 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 approach the building officers and Sergeant Ms. to report her safety concerns. See BWC at 6:12:23-6:14:55. Sergeant tells Ms. out." See BWC at 6:12:54. Sergeant 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 See BWC (linked above) at 6:13:31. The conversation concludes, and Ms. seen in the background walking around the dayroom trying to find a compatible cellmate. Several officers join Sergeant at the podium. One of the building officers points at

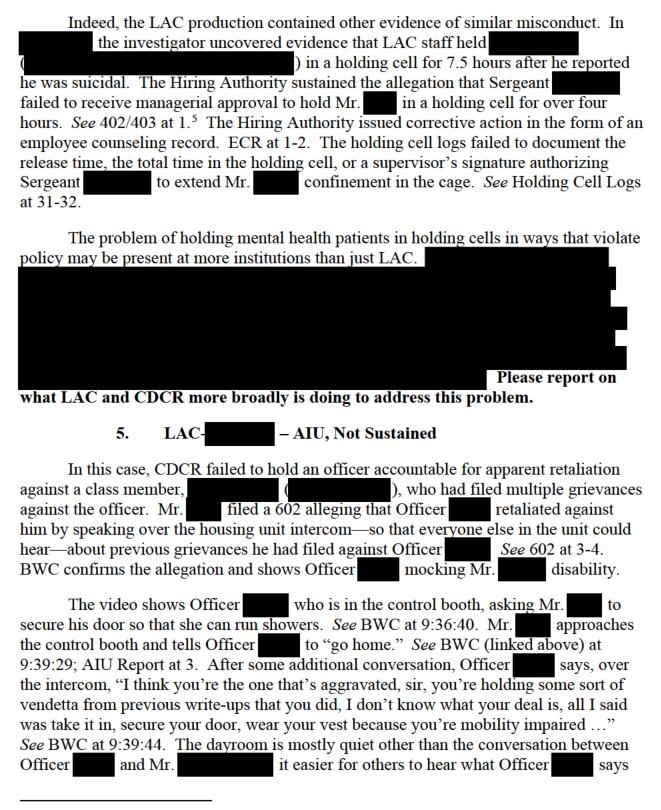






was likely on suicide watch at the time, as a nursing note from when Mr. he went to the CTC states "on SW 1:1 CO watching I/P," and he was clinically referred level of care on July 26 at 6:48 PM, about 4.5 hours after he was placed in the holding cage, and he remained in the holding cell for another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



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. then says something that is difficult to make out, potentially objecting to Officer referring to his grievances publicly, and Officer says "No, I'm talking to you so you can hear me, I know you're hearing impaired, now you can hear me." <i>See</i> BWC at 9:40:07.
The AIU investigation report provides a clear summary of this video evidence. The evidence shows Officer discussing Mr. grievances against her over the intercom, audible to other incarcerated people, which could affect Mr. 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 actions were similar to publicly disclosing that Mr. was a "snitch," placing his safety at risk. Despite clear evidence that she publicly announced that Mr. had filed staff complaints against her, and despite Officer justifying doing so by pointing to Mr. hearing disability, the Hiring Authority failed to confirm any misconduct. In so doing, CDCR condones Officer 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 if her statements were made out of retaliation for Mr. filing grievances against her, as he alleged.