ROSEN BIEN
GALVAN & GRUNFELD LLP

101 Mission Street, Sixth Floor
San Francisco, California 94105-1738
T: (415) 433-6830 ▪ F: (415) 433-7104
www.rbgg.com

[redacted]
Email: [redacted]

February 6, 2026

PRIVILEGED AND CONFIDENTIAL

SUBJECT TO PROTECTIVE ORDERS

VIA ELECTRONIC MAIL ONLY

[redacted]

[redacted]

Re: *Armstrong v. Newsom*: Plaintiffs' February 2026 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 March 2026. 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]

cc: [redacted]

TABLE OF CONTENTS

Page

I. DEFENDANTS FAILED TO HOLD OFFICERS ACCOUNTABLE FOR USING EXCESSIVE FORCE

In the following cases, officers used excessive and often unnecessary force against class members. The Hiring Authorities, however, failed to sustain any use-of-force violations.

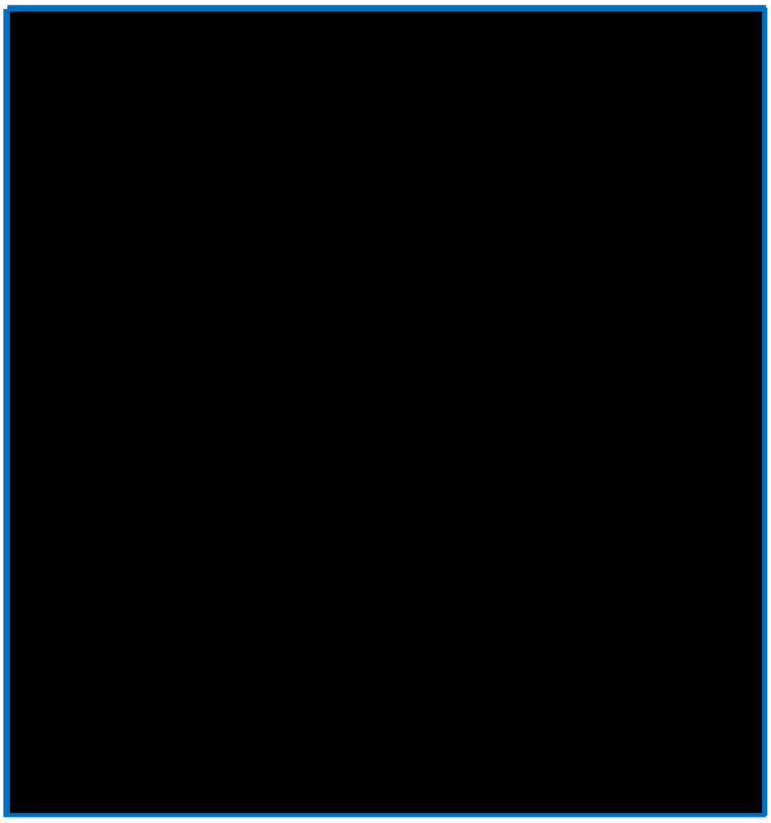
The first three cases involve officers throwing incarcerated people to the ground in extremely dangerous ways. In all three of these cases, officers failed to attempt to deescalate the situations and significantly overreacted to the minor issues presented by the incarcerated people. In the first case, an officer at SATF grabbed a [redacted] class member around the waist and threw him head-first into the ground because the class member did not follow an order to stand on a line of a particular color, even though the class member told the officers he could not see colors due to his vision disability. In the second case, an officer at RJD slammed the class member, who was restrained in handcuffs behind his back, to the ground when he momentarily paused an escort. And in the third case, after an officer at SATF became upset at a class member for requesting the officer's name, the officer unnecessarily grabbed the class member and, when the class member attempted to pull away, picked him off his feet and slammed him to the ground.

The next three cases involve officers striking incarcerated people during cell extractions. In the first two cases from COR, which address separate incidents involving the same class member, officers punched the class member in the head dozens of times when attempting to apply restraints. The KVSP case involves an officer repeatedly striking the class member, who is in a mental health crisis and is curled in a defensive position, with a baton. Though both incarcerated people resisted the application of restraints, neither were attempting to harm staff. Accordingly, the gratuitous punches and strikes to the class members were all excessive, as they served no legitimate purpose for getting the class members into restraints. In all three cases, the officers had the incarcerated person surrounded, had time on their side, and could have used strength and holds to ultimately effect custody of the class members. Instead, the officers appear to have intended to inflict pain and suffering on the class members by striking them repeatedly. The cases suggest that officers believe that a class member's refusal to submit to restraints gives them license to use whatever type of force they want.

1. SATF-[redacted] – AIU, Sustained (Corrective Action)

In this case, an officer used unnecessary and excessive force on a class member with a vision disability, in part because the class member could not see well enough to follow officers' orders. The use of force caused a significant head injury. The CARU, however, only sustained an allegation that the officers failed to de-escalate the situation and issued corrective action.

The entire incident occurred in less than 30 seconds. [redacted] ([redacted]) is walking on the track with a group of other incarcerated people. The track has two lines painted on it: an inner white line and an outer yellow line. Mr. [redacted], who is legally blind and wearing a yellow disability vest, is walking on the yellow line instead of the white line that he was apparently supposed to be walking along. *See* BWC 1 at 10:32:46. Officer [redacted], who is about 100 feet away from Mr. [redacted], shouts to Mr. [redacted] to "get on the white line," and Mr. [redacted] responds, "I'm sorry? I don't see color." *Id.* Officer [redacted] and several other officers then tell him to step to his right. Mr. [redacted] keeps walking straight. Five officers then approach Mr. [redacted], and Mr. [redacted] stops walking about eight feet short of the officers. *See* AVSS at 10:33:00-20. The officers yell "get down" to Mr. [redacted] several times, and he remains standing, repeating, "Do it." *See* BWC 1 (linked above) at 10:33:07. As the officers are yelling at Mr. [redacted] to get down, one officer, Officer [redacted] extends his baton, walks behind Mr. [redacted] and places one of his hands on Mr. [redacted] back. *Id.* at 10:33:13. Neither Officer [redacted] nor any other officer orders Mr. [redacted] to submit to handcuffs. Instead, without warning, Officer [redacted] quickly grabs Mr. [redacted] around the waist, picks him up several feet off the ground, and slams him head-first into the asphalt. *Id.* at 10:33:17. Mr. [redacted] face and the ground are covered in blood. *See* BWC 2 at 10:33:42.



Mr. [redacted] suffered a serious laceration on his head that had to be glued shut. *See* Outpatient Progress Note at 1 dated July 7, 2024. CDCR found Mr. [redacted] guilty of an RVR for Resisting Staff.[1] *See* Investigation Report at 8-9; RVR Paperwork at 85-87.

The CARU did not sustain allegations of unnecessary or excessive force against Officer [redacted] but it did sustain allegations against all five officers (including Officer [redacted]) who were present for discourtesy (D1, **1**23456), negligent endangerment (D2, 1**2**3), and failure to observe and perform (D26, **1**2345). *See* 402/403 at 3, 7, 10, 13, 16. According to the 402, the CARU determined that each officer failed to use appropriate de-escalation techniques prior to using force. *Id.* at 2, 5, 8, 11, 14. The CARU imposed corrective action on all five officers.

The CARU should have sustained allegations for unnecessary and excessive force against Officer [redacted]. Officer [redacted] did not even verbally order Mr. [redacted] to submit to handcuffs. Instead, he immediately bear-hugged him from behind and slammed him to the ground. Although Mr. [redacted] was not compliant with officers' orders being yelled in his face, he did not present an imminent threat by merely standing on the track,

[1] Although Mr. [redacted] was blind and being ordered to comply with visual cues, which led to this incident, the questions on the RVR form about whether the incarcerated person's disability contributed to incident are marked "N/A" or "No." *See* RVR Paperwork at 85.

surrounded by five officers. Even more glaring, the force was clearly excessive. Grabbing and picking up an elderly blind man (who had announced that he had a vision disability and was wearing a vision disability vest) and slamming his head into the concrete because he was a few steps out-of-bounds was objectively more force than was necessary. Had the CARU applied correct disciplinary matrix categories, Officer [redacted] would—and should—have been issued a more significant penalty (L2, Unnecessary use of force causing injury, 4**5**6789; L5, Excessive use of force causing injury, 4**5**6789). *See* Employee Disciplinary Matrix.

Putting aside the failure to sustain a use-of-force violation, the penalty for Officer [redacted] was inappropriate. While the CARU correctly identified and held accountable the four other officers who failed to use de-escalation techniques, Officer [redacted] should not have received the same consequences (corrective action) as those officers. Officer [redacted] actions were dangerous and resulted in injury, and his discipline should have reflected the seriousness of his misconduct.

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

In this case, the CARU failed to sustain any policy violations even though a sergeant failed to deescalate a conflict with a class member about housing safety concerns and then used unnecessary and excessive force to slam the class member to the ground while he was handcuffed.

According to [redacted] ([redacted]) 602, he did not feel safe accepting housing with a new assigned cellmate who refused to accept him. He requested that staff place him in administrative segregation. *See* 602 at 4-5. Video shows Sergeant [redacted] approaching the housing unit. The control booth officer, who is speaking through the window from the control booth to outside of the housing unit, tells Sergeant [redacted] that Mr. [redacted] is ready to go to administrative segregation. Sergeant [redacted] says "I don't give a fuck" and enters the building. *See* BWC 1 at 21:06:27; BWC 2 at 21:06:27. Before even reaching Mr. [redacted] Sergeant [redacted] has a set of handcuffs in his hands. Sergeant [redacted] walks aggressively toward Mr. [redacted] and angrily orders him three times in quick succession to "turn around." Without saying anything to Sergeant [redacted] Mr. [redacted] complies. Sergeant [redacted] applies the handcuffs. Sergeant [redacted] asks another officer where Mr. [redacted] cell is and then, once he knows the location (cell 224), begins escorting Mr. [redacted] towards the stairway. When they reach the stairway, Mr. [redacted] uses his leg to halt the escort by pushing against the bottom step. Sergeant [redacted] then immediately slams Mr. [redacted] to the ground, sending Mr. [redacted] glasses flying and causing abrasions and redness on his face. *See* BWC 3 at 21:07:04; AVSS at 21:07:04. Mr. [redacted] later complained of a head injury as well. *See* Primary and Secondary Assessment at 1-2 dated December 9, 2023; First Medical Responder Note at 1 dated December 9, 2023.

Sergent [redacted] conduct before the use of force and the use of force itself violated policy. The CARU, however, did not sustain any policy violations. *See* Closure Memo at 1.

Before the force, Sergeant [redacted] knew that Mr. [redacted] was unwilling to accept his current housing assignment because of safety concerns regarding his cellmate. Sergeant [redacted] could have attempted to discuss the issue with Mr. [redacted] before deciding to escort him toward his cell; could have placed him in administrative segregation, as Mr. [redacted] requested; or could have threatened an RVR for refusing housing. Instead, Sergeant [redacted] chose the most confrontational approach, which involved aggressively cuffing Mr. [redacted] without any discussion and then immediately escorting him toward the cell he felt unsafe entering. *See* DOM § 51020.5 ("Wherever possible, verbal persuasion should be attempted in an effort to mitigate the need for force."); Investigation Report at 8 (Sergeant [redacted] acknowledging that CDCR policy requires de-escalation and that officers should have a "minimum reliance on force" and use "verbal persuasion and 'verbal judo' over physical intervention").

The use of force itself was excessive. An officer uses excessive force if they use "more force than is objectively reasonable to accomplish a lawful purpose." *See* DOM § 51020.4. Here, the amount of force that Sergeant [redacted] used was unreasonable for accomplishing any lawful purpose. When Mr. [redacted] used his foot to halt the escort, Sergeant [redacted] could have paused the escort and given Mr. [redacted] instructions to continue up the stairs. He could have requested that the two officers who were trailing him provide assistance with the escort. But he did none of those things and instead dangerously slammed Mr. [redacted] who was cuffed, to the ground.

The use of force was potentially also unnecessary. In Sergeant [redacted] incident report, he claimed that he used force because he did not "know[] [Mr. [redacted]] intention and fear[ed] [redacted] would batter" him. *See* Incident Report at 33. Sergeant [redacted] explanation does not hold up under scrutiny, as it would give him license to body slam any incarcerated person who is handcuffed and who stops an escort. Mr. [redacted] did not push back off of the stairs into Sergeant [redacted] body. He simply stopped the forward progress of the escort. As a result, this case is no different than the many others Plaintiffs have discussed in which officers use small movements by incarcerated people during escorts as inadequate justification for serious uses of force.[2]

[2] The IERC completed its review of the use of force prior to Mr. [redacted] filing a staff complaint. The IERC found that this use-of-force did not violate policy. *See* IERC at 2, 3, 4, 6, 7.

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

In this case, the CARU failed to sustain an allegation of unnecessary and excessive force even though video shows an officer rapidly escalating a verbal dispute into a violent physical takedown. [redacted] ([redacted]) approaches the officer podium during medication pass and requests Officer [redacted] name. *See* BWC 1 at 20:32:27; BWC 2 at 20:32:27. Officer [redacted] refuses to give his name to Mr. [redacted] and instead orders him to return to his section of the housing unit. *Id*. When Mr. [redacted] continues to ask for Officer [redacted]'s name, Officer [redacted] approaches Mr. [redacted] and grabs his arm to "escort" him away while warning him not to resist. *Id*. at 8:32:41. As Officer [redacted] grabs Mr. [redacted] arm, Mr. [redacted] tells Officer [redacted], "I'm not a threat to you, bro." Mr. [redacted] stops walking and tells Officer [redacted] several times to get his hands off of him. Officer [redacted] then lifts Mr. [redacted]'s body and slams him to the ground. *Id*. at 20:32:54; *see also* AVSS from 20:32:30 to 20:32:58. The entire incident—from the first request for the officer's name to the body slam—takes place over about 30 seconds. Mr. [redacted] was found guilty of an RVR for willfully resisting a Peace Officer in the performance of duties, and lost, *inter alia*, 90 days of credits.

The force in this case was both unnecessary and excessive. Initially, Officer [redacted] failed to use required verbal de-escalation techniques before initiating force. *See* 15 C.C.R § 3268(b)(1); DOM § 51020.5. If Officer [redacted] had simply told Mr. [redacted] his name, the entire situation could have been avoided. After refusing to provide his name, Officer [redacted] was not justified in using force because Mr. [redacted] did not pose an imminent threat. *See* 15 C.C.R. § 3268(4); DOM § 51020.4. Mr. [redacted] was not being aggressive, he was generally moving in the direction that he was being ordered to move in, and a second officer had arrived to help Officer [redacted] continue the escort.

Officer [redacted] also used "more force than is objectively reasonable to accomplish a lawful purpose." *See* 15 C.C.R § 3268(a)(3); DOM § 51020.4. Mr. [redacted] is a relatively small person, and Officer [redacted] picked him up by the waist, hoisted both of his feet off the ground, and slammed him into the concrete. The force was dangerous and unsafe. Nevertheless, the Hiring Authority did not sustain any allegations related to this incident. *See* 402/403 at 1.

CDCR should immediately rescind and/or dismiss the RVR issued to Mr. [redacted] for this incident and remove all related consequences from his custodial records, including the loss of credits.

The AIU also wasted resources by partially investigating this incident twice. Initially, Mr. [redacted] filed a 602 which resulted in opening AASTS investigation [redacted] (the number for the instant case). He later made an oral report of misconduct

to a lieutenant, which the lieutenant forward to the CST. That report resulted in opening a separate investigation with AASTS number [redacted]. The second investigation was assigned to a different investigator, who proceeded to gather and review documents and to write a partial investigation report before realizing the existence of duplicative investigations and ending the second one. *See* AIU Report Exhibit at 91-93. Had the AIU recognized the second case as a duplicate, the second investigator would not have wasted time investigating this case.

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

In these two cases, officers used extraordinary amounts of excessive force—including repeated, gratuitous head strikes—against [redacted] ([redacted]) during two different cell extractions that occurred about two weeks apart. The force used was far more than a reasonable officer would have used to accomplish the lawful objective of restraining and removing Mr. [redacted] from the cell. Nevertheless, the Hiring Authority did not sustain any allegations of excessive use of force. That CDCR failed to hold any officers accountable for excessive beatings they applied to Mr. [redacted] is a serious failure and reflects cultural use-of-force problems.

In COR-[redacted], officers conducted a cell extraction of Mr. [redacted] related to Mr. [redacted] lighting a fire in his cell. When officers open the door, Mr. [redacted] charges at them. Many officers then force him back on the bed in the cell and surround him. Officer [redacted] then proceeds to strike Mr. [redacted] in the head many times. *See* BWC 1 at 18:59:25-19:00:25; BWC 2 at 18:59:25-19:00:25; BWC 3 at 18:59:25-19:00:25. Mr. [redacted] does not appear to try to harm any of the officers. The officers eventually restrain him and remove him from the cell. Medical records show that Mr. [redacted] had suffered serious, visible head injuries, though he refused treatment. *See* Progress Note, Aug. 25, 2024; Refusal of Examination, Aug. 25, 2024; Primary and Secondary Evaluation, Aug. 25, 2024.

In COR-[redacted], a large group of officers conducted an emergency cell extraction because Mr. [redacted] had covered the windows of his cell. When officers open the cell door, Mr. [redacted] charges at them. *See* AVSS at 00:31 (on the video player). Many officers take him to the ground and pile on top of him. Mr. [redacted] does resist the placing of restraints on his wrists, but does not appear to take any offensive action toward the officers. Multiple officers proceed to punch Mr. [redacted] repeatedly in the head over the course of more than a minute, while Mr. [redacted] yells, "Keep hitting me!" *See* BWC 1 at 20:17:23-20:20:00; BWC 2 at 20:17:27-20:18:40. After a lengthy struggle, officers ultimately restrain Mr. [redacted] with handcuffs and leg restraints and strap him to a gurney.

The head strikes and punches to other areas of Mr. [redacted] body in these cases were all excessive. In both incidents, officers were authorized to use some force to get Mr. [redacted] out of the cell and into restraints. But in both cases, after Mr. [redacted]

original charge toward the officers, the officers had Mr. [redacted] surrounded and partially controlled. At that point, Mr. [redacted] was not threatening the officers. Officers had time on their side and could wear Mr. [redacted] down with pressure, strength, and holds. Striking him with punches, especially punches to the head, endangered Mr. [redacted] without furthering their goal of restraining Mr. [redacted] The punches were therefore gratuitous and appear intended to hurt Mr. [redacted] These types of incidents—with multiple officers using force, including head strikes, to try to restrain an incarcerated person—can be incredibly dangerous.

The failure to hold any staff accountable in these cases suggests that CDCR approves of this gratuitous, dangerous violence against incarcerated people. And it sends a signal to officers that, when restraining an incarcerated person, they can strike the person in the head with impunity.[3] CDCR must take steps to address this entrenched cultural problem regarding use of force.

As Plaintiffs have previously written, CDCR should, update its policies and trainings to allow head strikes only when an officer has a reasonable fear that the force is necessary to prevent serious bodily injury or death, as the New York City Jail system has done. *See* Directive 5006R-D, Use of Force, at 2 ("The Department strictly prohibits the use of high impact force, including: (1) Strikes or blows to the head, face, groin, neck, kidneys, and spinal column," with exception for situations "where a Staff Member or other person is in imminent danger of serious bodily injury or death, and where lesser means are impractical or ineffective …").

In addition, the concentration of these incidents in one unit at COR reflects a dangerous culture about which our clients have frequently reported. Plaintiffs' counsel have heard additional reports from [redacted] regarding retaliatory uses of force in the unit, including uses of force where officers use head strikes.

[3] Plaintiffs reviewed an additional case from this quarter, COR-[redacted], in which officers in the same housing unit [redacted] (an [redacted]) struck an incarcerated person in the head during two separate uses of force. In the first incident, six officers are escorting [redacted] ([redacted]), who is handcuffed behind his back. Mr. [redacted] attempts to kick an officer. A different officer then strikes Mr. [redacted] in the chin or neck with significant force as officers are taking Mr. [redacted] to the ground. *See* BWC at 13:35:10. A group of officers then escort Mr. [redacted] to another part of the building for a medical evaluation. Mr. [redacted] who is seated in a chair and is now also in leg restraints, lunges toward an officer. As a different officer pulls Mr. [redacted] away and brings him to the ground, that officer appears to strike or attempt to strike Mr. [redacted] in the head or neck. *See* AVSS at :14 (time stamp of video player).

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

In this case, officers used unnecessary and excessive force when they failed to comply with a class member's cuffing accommodation when extracting him from a cell. The CARU did not, however, hold the officers accountable for their misconduct.

On August 19, 2024, mental health staff determined the need for an immediate cell entry in order to transfer [redacted] ([redacted]) to a [redacted] based on their assessment he posed a danger to himself. Mental health staff noted he suffered from a psychotic break "that significantly affects his ability to under [sic] request/commands and to follow directions" and an "inability to communicate effectively." *See* Mental Health Form 195-196.

Video shows four officers in protective gear approaching Mr. [redacted] cell. Officer [redacted] who is closest to the door and is holding a shield, tells Mr. [redacted] to "Go ahead and hit the wall and then turn around and put your hands behind your back. We'll get you out." *See* BWC 1 at 15:15:30. Mr. [redacted] can be seen through the window standing calmly, facing the officers with his hands held out in front of him as if submitting his hands for cuffing. Mr. [redacted] appears to say something to Officer [redacted] that cannot be heard on the video. He can also be seen through the window showing his wrists to the officers. *See* BWC 1 (linked above) at 15:15:45. In his September 14, 2024 use-of-force interview, Mr. [redacted] stated, "All I wanted to do was to get cuffed, shackled, but they didn't respect the chrono so they came in and assaulted me ... with a baton." *See* [redacted] UOF Interview at 1:49. At the time of the incident, Mr. [redacted] had a chrono which required that staff cuff him in front of his body using waist restraints, rather than behind his back, due to prior left wrist surgery. *See* August 2024 SOMS roster ("Cuffing accommodation in front with waist chains because of Left Wrist prior surgery with metal hardware").

Officer [redacted] still outside the cell, then tells Mr. [redacted] "Go ahead and go behind. Go ahead and step back then." *See* BWC 1 (linked above) at 15:15:42. Officer [redacted] statement appears to be in response to something that Mr. [redacted] said that cannot be heard on the video or to Mr. [redacted] gestures through the window. Mr. [redacted] continues to stand quietly and calmly in the same position with his hands together in front of him as if submitting to handcuffs in front of his body.

The extraction team proceeds to open the cell door. Mr. [redacted] still has his hands together in front of him. The officers rush into the cell, leading with the shield and with batons drawn. Mr. [redacted] crouches to the ground in a defensive position, covering his head with his hands. Officer scream at him to "stop resisting." Officer [redacted] then strikes Mr. [redacted] several times with the baton. *See* BWC 1 (linked above), for example, at 15:16:11, 15:16:12; BWC 2 at 15:16:01; 15:17:28. Officers placed leg restraints on Mr. [redacted] and place the two handcuffs of the waist restraint on Mr. [redacted] Mr. [redacted] resists, to some extent, the officer's attempts to secure the

waist chains by bringing his arms in close to his chest. Officer [redacted] strikes Mr. [redacted] additional times with the baton. Ultimately, officers secure the waist chains, remove him from the cell, and place him on a gurney. The IERC noted a total of 11 baton strikes. *See* 3035 at 1. Mr. [redacted] had an abrasion on his shin following the incident. *See* 7219 at 141.

This use of force was unnecessary and excessive. Although a cell extraction had been authorized, it appears from the video that there was an opportunity to avoid force if the officers had accommodated Mr. [redacted] disability by cuffing him in front of his body, rather than by insisting he turn around to submit to cuffs behind his back. Given Mr. [redacted] gestures prior to opening the cell door, it appears that he was calm and was attempting to submit to handcuffs, albeit in the front of his body. It does not appear that officers ever asked Mr. [redacted] to submit his hands in front of his body through the tray slot. None of the officers acknowledge Mr. [redacted] apparent gesture and possible verbal request for and entitlement to the accommodation of front cuffing. Officer [redacted] repeatedly ordered Mr. [redacted] to submit to cuffing behind his back. The failure to address Mr. [redacted] documented disability accommodation requirements was therefore a cause of this potentially unnecessary use of force.

Officer [redacted] eleven baton strikes were also excessive, as they were more force than is objectively reasonable to accomplish the lawful objective of placing Mr. [redacted] in restraints. Once the officers entered the cell, Mr. [redacted] was not trying to harm the officers or himself. He was, at times, curled up in a ball or holding his arms close to his body in an effort to protect himself and, it appears, because he was scared. As a result, officers had time on their side and could have used much less dangerous forms of force—namely physical strength and holds—to put pressure on Mr. [redacted] until they could apply the waist restraints. There was no need to endanger Mr. [redacted] by using a baton, which is a more dangerous form of force than physical holds and strength. This is especially true considering that the entire purpose of removing Mr. [redacted] from the cell was because he was suffering in mental health crisis and needed additional care to help him. In addition, the fact that Officer [redacted] struck Mr. [redacted] 11 times suggests that it was an ineffective form of force.

Statements in Officer [redacted] incident report and his AIU interview reflect a dangerous misunderstanding that CDCR's use-of-force policies permit baton strikes in circumstances like this case. In his incident report submitted on the date of the incident, Officers [redacted] claimed that he used force because Mr. [redacted] was "violently kicking his legs." *See* Incident Report at 124. However, Officer [redacted] authored a supplemental report after watching his body-worn camera footage and removed statements regarding Mr. [redacted] kicking his legs at staff. *See* Incident Report at 126. Instead, he noted that Mr. [redacted] was resisting staff by "enter[ing] a defensive position on the ground by crouching his body and lifting his hands by his head and facial areas." *Id.* Officer [redacted] claimed he utilized his baton "to gain compliance with a lawful order, effect custody, and

fearing that [redacted] was going to strike Officer [redacted] with his right fist or right foot …" *Id.* But offensive baton strikes, when Mr. [redacted] was not threatening officers or himself, are not reasonable and therefore are excessive.

Even more troublingly, in Officer [redacted] August 14, 2025 investigation interview (nearly one year after the August 19, 2024 incident), he stated he "utilized the baton because he was assigned to [sic] baton and that was the use of force he had ready to use. At the time of incident, [redacted] did not think about utilizing any other force options." *See* Investigation Report at 11. This is a shocking statement for an officer to make to an investigator, and shows a profound lack of understanding of CDCR's use-of-force policies. It suggests that Officer [redacted] believes he can use a baton any time that force is authorized so long as he has been assigned the baton or has a baton in his hand. But this statement does not reflect policy or the law. CDCR policy only permits him to use a baton if so doing would be reasonable to accomplish a lawful objective.[4]

Lastly, CDCR improperly issued Mr. [redacted] an RVR for Willfully Resisting a Peace Officer in the Performance of Duties. *See* Incident Report at 118. The RVR Mental Health Assessment (MHA), which found that "mental health factors substantively and negatively impacted IP's judgment and behavior," also notes that "this incident on 8/19/24 occurred in connection with a cell extraction for transfer of the patient to a mental health inpatient unit, specifically to mental health crisis bed (MHCB)." *See* 08-26-2024 RVR MHA at 2. CDCR policy prohibits the issuance of RVRs for behavior that "occurred in connection with a cell extraction for transfer of the inmate to a mental health inpatient unit or between mental health inpatient units." *See* 2021 Program Guide, ECF 7333-1, at 4. **CDCR should immediately rescind and/or dismiss the RVR issued to Mr. [redacted] for this incident and remove all related consequences from his custodial records.**

II. INVESTIGATORS FAILED 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

[4] There are serious questions regarding why CDCR officers use batons at all for cell extractions. Plaintiffs' use-of-force expert has indicated that batons are generally for use in larger areas to extend an officer's reach (*e.g.*, on a yard). He further indicated that in the jurisdiction where he worked and helped to develop use-of-force policies, it was practice not to even bring weapons into cell extractions because they were, almost by definition, excessive for that purpose.

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.

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

In this case, two officers threw an *Armstrong* class member to the ground during an escort when he did not present any threat. The officers then submitted incident reports with false claims about the class member's conduct. The Hiring Authority, however, did not sustain any allegations related to the use of force and did not consider any allegations related to the false incident reports. In addition, the investigator failed to conduct a comprehensive investigation into the allegation that the use of force was retaliatory, even though the suspicious circumstances of the use of force and other evidence supported that claim.

[redacted] ([redacted]) alleged that on June 28, 2024, Officers [redacted] and [redacted] assaulted him in retaliation for "an incident that had taken place a prior day w[h]ere I was involve[d] in a scuffle with" a third, unnamed officer. *See* Attachments at 6. There is no video or any other information about this previous incident in the investigation file.

Prior to the use of force at issue, Mr. [redacted] is in a room in the [redacted]. *See* AIU Report at 21. Officer [redacted] is with Mr. [redacted] Meanwhile, Officers [redacted] and [redacted] are at the officer station in [redacted]. *See* BWC 1 at 12:16:12. Officer [redacted] says to Captain [redacted] "Want us to get him back?" Captain [redacted] asks, "Is he ready?" Officer [redacted] then says, "If he's ready, we'll bring him back."

Officers [redacted] and [redacted] then walk from [redacted] to the [redacted] and stand outside the room where Mr. [redacted] and Officer [redacted] are located. *See* BWC 1 (linked above) at 12:17:15. Right as Mr. [redacted] and Officer [redacted] are leaving the room, Officer [redacted] says to Officer [redacted], at a very quiet volume, "Ready?" *See* BWC 2 at 12:17:40. The two officers then catch up to Officer [redacted] and Mr. [redacted], who are a few steps ahead of them. Officer [redacted] indicates that he and Officer [redacted] were sent to "relieve" Officer [redacted]. *See* BWC 1 (linked above) at 12:18:00. Officer [redacted] and Officer [redacted] take over the escort and walk with Mr. [redacted] from the [redacted] to [redacted].

Once Mr. [redacted] Officer [redacted], and Officer [redacted] are inside [redacted], Officer Giroud tells Mr. [redacted] that he is being moved to cell 250, instead of cell 247 where he was previously housed. *See* AIU Report at 23. In response, Mr. [redacted] states "no, I'm not going there." *See* BWC 1 (linked above) at 12:18:55.

A few seconds later, Officers [redacted] and [redacted] violently force Mr. [redacted] forward to the ground, slamming his head into the floor in the process. *See* AVSS at

12:18:57. In the split second before the use of force, Mr. [redacted] shoulders move upward slightly, though it is unclear whether he initiated that movement or the officers did so by pulling on his arms. Mr. [redacted] does not appear to make any other movements with his body. The officers fall on top of Mr. [redacted] sound a code, and then place leg restraints on Mr. [redacted] with the assistance of other officers. After the incident, Mr. [redacted] reported that staff returned him to his original cell, 247, rather than to cell 250 (as they had previously indicated they were going to do). *See* AIU Report at 18.

After an AIU investigation, the Hiring Authority (the acting warden at RJD) did not sustain any allegations. *See* Closure Documents at 1.

The Hiring Authority should have sustained the use-of-force allegations. The AVSS and BWC footage does not show that Mr. [redacted] presented any threat, let alone an imminent threat that would justify an immediate use of force. *See* DOM § 51020.4. Mr. [redacted] is walking with the escort when the officers, without any warning, throw him to the ground. Even if he did shrug his shoulders, that movement did not represent an imminent threat authorizing the officers to use force. Because there was no imminent threat, the use-of-force violated policy.[5]

In addition, the Hiring Authority should have, but did not, consider allegations that the officers submitted false incident reports. Officer [redacted] wrote in his incident report that Mr. [redacted] "attempted to resist the escort by planting his foot and turning toward Officer [redacted]." *See* Incident Report at 29. Officer [redacted] claimed in his incident report that Mr. [redacted] "dropped his weight, planted his foot, and turned towards me while raising his right arm." *See* Incident Report at 30. The footage, however, does not show any of those actions occurring.

Lastly, the investigation into Mr. [redacted] allegation that the force was retaliatory was incomplete in ways that potentially shielded the officers from accountability. As explained below, there was substantial evidence supporting Mr. [redacted] retaliation allegation. Given that evidence, it was incumbent on the investigator to turn over every stone. Instead, the investigator conducted a perfunctory investigation in which he failed to attempt to gather all of the available evidence that could have shed light on whether the misconduct was retaliatory.

The most damning evidence of retaliation is the video itself, which does not show any behavior by Mr. [redacted] that could justify the force. The video therefore suggests that the officers used force against Mr. [redacted] for some other reason, such as retaliation. The investigator should have used the video in the interview to force the

[5] The IERC, which completed its review before the AIU investigation, also failed to find any policy violations. *See* IERC at 3, 4, 5, 11, 12.

officers to explain, on a second-by-second basis, why they used force and to question the officers about the inconsistencies between the video and the incident reports. During the interviews with the officers, however, the investigator did not show the officers the video and did not push back on their false narratives regarding what occurred.

The investigator also failed to adequately explore why the officers relieved Officer [redacted] from escorting Mr. [redacted]. In their interviews, the two officers and Captain [redacted] all stated that Captain [redacted] ordered the officers to escort Mr. [redacted] because he required a two-person escort. *See* AIU Report at 19-20, 21, 23. That explanation does not make sense. On the BWC, the officers state to Officer [redacted] that they were ordered to "relieve" him. But if the goal was to have two officers escort Mr. [redacted] why did Captain [redacted] order both Officer [redacted] and Officer [redacted] to escort Mr. [redacted] rather than simply order one of them to escort Mr. [redacted] with Officer [redacted] who was already with Mr. [redacted]. In addition, Mr. [redacted] must have been escorted to the medical building before this incident occurred. The investigator could have obtained video of that escort (or other prior escorts) or interviewed Officer [redacted] to determine if, in fact, there was any evidence that Mr. [redacted] had previously been escorted by two officers or whether the double escort in this instance was potentially a pretext. Instead, the investigator did not probe this issue at all and accepted at face value the officers' unsatisfying explanation for why they relieved Officer [redacted]

Relatedly, the investigator did not ask the officers any questions about when Officer [redacted] asked Officer [redacted] if he was "ready" right before taking over the escort. That statement, especially the way Officer [redacted] whispered it, was suspicious. Perhaps Officer [redacted] was asking only whether Officer [redacted] was ready for the escort, but perhaps he was asking whether he was ready to follow through with their plan to retaliate against Mr. [redacted]. Since the investigator did not ask any questions about it, the case file is devoid of any explanation or clarification about that important moment.

The issue of Mr. [redacted] cell assignment was also suspicious and insufficiently explored. Mr. [redacted] claimed that, once the incident was over, he was taken to cell 247 (his original cell), rather than cell 250 (the cell the officers stated they were going to take him to in the seconds prior to the use of force). If that was true, it would support Mr. [redacted] contention that the officers threatened a false cell move (from 247 to 250) to potentially upset Mr. [redacted] and to provide cover for a use of force. In fact, both officers' incident reports tie the use of force to Mr. [redacted] getting upset over the cell move.[6] And the use of force occurs a few seconds after officers mention the cell

[6] Officer [redacted] "Officer [redacted] informed him that he would be relocated to cell 250. In response, Inmate [redacted] immediately stated, 'I'm not going to cell 250,' and without provocation, attempted to resist the escort by planting his foot and turning towards Officer [redacted] *See* Incident Report at 29.

move. If, instead, housing unit staff had actually initiated the cell move (as claimed by Officers [redacted] and [redacted] but not supported by any video), that would serve as exculpatory evidence. The investigator, however, did nothing to investigate this question, such as interviewing housing unit staff or obtaining their BWC footage.

The investigator also did nothing to establish what, if any, prior incident was the source of the alleged retaliation. Mr. [redacted] claimed that he got into a "scuffle" with an officer in the days prior to the use of force. Officer [redacted] indicated in his interview that the purported need for a double escort was because of an incident that had occurred the prior day. *See* [redacted] AIU Interview at 19:15. If such an incident had occurred, there would be an incident report. Yet the file is devoid of any information about a prior incident or any efforts by the investigator to find that information.

Each of these unexplored investigatory avenues would have provided useful information regarding whether Mr. [redacted] retaliation allegation was true. Of course, it is possible that, even if the investigator had pursued these leads, the evidence would either have exonerated the officers or have been inadequate to support sustaining the allegation. By not even attempting to discover this relevant information, the investigator ensured that the truth would not be uncovered and that if the officers did retaliate against Mr. [redacted] they would not be held accountable, including through potential criminal prosecution.

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

In this case, LAC staff housed two incarcerated people with lower bunk chronos in the same cell, including a class member with mobility disabilities, [redacted] ([redacted]). Mr. [redacted] advised an officer about the issue and asked to be moved. Six days later, while still housed in the same cell, he fell from the top bunk and injured his head. The investigator failed to adequately investigate the allegation by leaving unchallenged the officer's claims that he attempted to find the class member a new accessible bed before the fall. Despite those failures, the CARU did not send the case back for further investigation.

LAC issued Mr. [redacted] a lower bunk, lower tier chrono on December 26, 2024. *See* DPP Accommodation Chrono at 11. On January 24, 2025, LAC moved Mr. [redacted] to cell 145 and assigned him to the bottom bunk. *See* Facility [redacted] Bed History at 13. As of that date, [redacted] ([redacted]) was assigned to the upper bunk in that cell. *Id.* However, LAC had issued Mr. [redacted] a disability accommodation of a lower bunk on

---

Officer [redacted] "As we informed inmate [redacted] of his relocation to cell 250, he unexpectedly refused to comply, stating, 'I'm not going to cell 250.' In an attempt to resist the escort, he dropped his weight, planted his foot, and turned towards me while raising his right arm." *See* Incident Report at 30.

December 24, 2024, though it had never reassigned him to a lower bunk. *See* Facility [redacted] Bed History at 15. As a result, two people with lower bunk accommodations were housed in the same cell beginning on January 24, 2025, when Mr. [redacted] moved in. According to Mr. [redacted] 602 and interview, he took the upper bunk because he does not like confrontation and Mr. [redacted] was older and had a hernia. *See* 602 at 6; AIU Report at 8.

On February 17, 2025, Mr. [redacted] approached Officer [redacted] in his housing unit to advise that he and his cellmate both had lower bunk, lower tier chronos. *See* BWC 1 at 8:39:10. Officer [redacted] indicated that he would take care of the situation that day.[7] In the remainder of the video produced to Plaintiffs, Officer [redacted] does nothing to address the problem of having two people with lower bunk chronos in the same cell.

Mr. [redacted] and Mr. [redacted] remained in the cell. Six days later, Mr. [redacted] sustained a serious head injury that he claims occurred when he fell from or was getting down from the top bunk. Video shows Mr. [redacted] holding a blood-stained t-shirt, telling Officer [redacted] that he split his head open while coming down from the top bunk. *See* BWC 2 at 16:09; AIU Report at 4-5, 7. Mr. [redacted] received six staples in his head following the incident and was diagnosed with a concussion. *See* Medical Record at 115, 118. LAC moved Mr. [redacted] to a new cell shortly after the fall. *See* Facility [redacted] Bed History at 13.

The investigation into this serious allegation of a failure to accommodate a disability was not comprehensive. The available evidence indicates that, even though Mr. [redacted] put Officer [redacted] on notice of the failure to accommodate his housing needs, Mr. [redacted] remained in the unsafe assignment until he sustained a serious head injury from being housed inappropriately. That evidence strongly suggests that Officer [redacted] violated policy requiring that staff accommodate people with disabilities. In order to complete the investigation, however, the investigator needed to address Officer [redacted] claim that he attempted to rehouse Mr. [redacted] and Mr. [redacted] between February 17 and February 23. Specifically, Officer [redacted] claimed that he offered Mr. [redacted] numerous

[7] The investigator buried the description of this interaction in the investigation report. The report first states that the investigator first reviewed Officer [redacted] BWC from 7:15-8:45 a.m. on February 17, 2025 and concluded there was no interaction between Mr. [redacted] and Officer [redacted] *See* Investigation Report. at 9. However, after Officer [redacted] insisted that he spoke with Mr. [redacted] about his bed assignment, the investigator re-reviewed the video and discovered the interaction that occurred at around 8:39 a.m. The investigator discussed this crucial piece of evidence in a short "investigator's note" sandwiched between two subject interviews, two pages after the investigator first concluded that the video showed no interaction between Officer [redacted] and Mr. [redacted] *Id.* at 11. The investigator should have simply identified the relevant footage for the CARU, rather than including two contradictory statements about the same footage.

different lower bunk housing assignments, but that Mr. [redacted] rejected them. *See* AIU Report at 10-11. The investigator failed to take any action to prove or disprove this crucial fact. The investigator did not interview Officer [redacted] until June 9, 2025, outside of the 90-day retention period, despite being assigned to the case on March 17, 2025. *See* AIU Report at 9. The delay made it impossible to request additional footage to verify Officer [redacted] claims that he offered Mr. [redacted] accessible housing. The investigator also did not ask Mr. [redacted] (or his cellmate) about Officer [redacted] claims, as the investigator completed the interview with Mr. [redacted] prior to interviewing Officer [redacted] and did not reinterview them once he gathered information from Officer [redacted] Officer [redacted] also claimed that he advised the second watch sergeant on February 17 about his attempts to find a new cell for either Mr. [redacted] or Mr. [redacted] *See* AIU Report at 11. The investigator did not take any steps to identify (beyond asking Officer [redacted] if he remembered the sergeant's name four months later) or interview the sergeant to confirm Officer [redacted] claims and, as discussed above, waited too long to obtain video of the alleged interaction.

Given the incomplete investigation, the CARU incorrectly found that the investigation was adequate. *See* Closure Memo at 1. Before resolving the case, the CARU should have sent the investigation back to AIU for the additional investigation necessary to confirm or disprove Officer [redacted] claims.

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

This case involved a flawed investigation into a serious allegation. Class member [redacted] ([redacted]) alleged that on August 23, 2024, Sergeant [redacted] organized a fight between two incarcerated people. *See* 602 at 3. The AIU investigator was assigned to the case on September 6, 2024, 14 days after the incident. The investigator interviewed Mr. [redacted] on October 2, 2024, 40 days after the incident. During the interview, Mr. [redacted] reported that at around 7:00 a.m. on August 23, 2024 (the same date reported in the 602), Sergeant [redacted] said "if you guys are going to fight, then take it outside" to two incarcerated people who were fighting, rather than attempting to stop the fight. *See* AIU Report at 4.

Despite obtaining this information about the incident date and time from both the 602 and the interview, the investigator did not request any video. Instead, the investigator claimed in their investigation report that BWC and AVSS "were not available for review due to incarcerated Person [redacted] not being able to identify a specific time or date of said allegation." *See* AIU Report at 2. That statement is contradicted by the 602 and the interview summary in the report.

In addition, the investigator failed to obtain potentially relevant footage from the unit despite being on notice of it. Specifically, the investigator found an incident report from August 23, 2024, in Mr. [redacted] housing unit stating that two incarcerated people fought at around 12:21 p.m. *See* AIU Report at 2; Incident Report at 7. Given the

similarities to the allegations in Mr. [redacted] 602, the investigator should have at least reviewed that video and asked Mr. [redacted] about whether the fight in fact occurred around 12:00 p.m. rather than around 7:00 a.m. The investigator appeared to justify failing to review the incident video because Sergeant [redacted] was "not involved" in the incident, but whether Sergeant [redacted] responded to the incident is a different question than whether she encouraged or condoned the fight.

The investigator's inexcusable failure to obtain video made it impossible to confirm whether misconduct occurred.

The investigator also made other serious investigative errors. Despite interviewing Mr. [redacted] in October 2024, the investigator did not interview Sergeant [redacted] until August 17, 2025, almost a full year after the incident. The investigator also interviewed two incarcerated people—not identified as witnesses by the claimant—in August 2025. The investigator offered no explanation for these lengthy delays, during which memories likely faded.

Despite the investigator's failure to obtain video and provably false justification for doing so, the CARU closed the case without requesting additional investigation from the AIU. *See* Closure Memo at 1.

4. 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 are now piloting a Central Intake Triage Team within the AIU that is responsible for requesting and collecting video footage within five days. Plaintiff's counsel acknowledge this positive development. Plaintiffs will continue to monitor this issue.

(a) RJD-[redacted]

A class member alleged that, on August 26, 2024, at around dinner time, two officers identified by name harassed him in retaliation for previously filing a grievance against one of the officers. The class member filed a grievance about the retaliation on that same day. *See* 602 at 3-4. The investigation was assigned to the AIU on August 31, 2024, but was not assigned by the AIU Southern Region to an investigator until January 17, 2025. As a result of the delay in assignment, the BWC footage of the interaction between the class member and the officers was destroyed before the investigator could request it. *See* Investigation Report at 2.

(b) RJD-[redacted]

A class member, in a grievance filed on February 3, 2024, made a very serious allegation that on that same day an officer endangered the class member by disclosing the class member's disfavored commitment offense to other incarcerated people. *See* 602 at 5. For reasons not clear in the case file, this allegation that falls on the ADI (endangerment) was neither routed to the AIU for an investigation nor routed to an LDI for an inquiry, but was instead addressed with a routine grievance response. The routine reviewer did not gather any video evidence, even though the class member identified the officer and date of the retaliation, and denied the grievance. The Office of Appeals then granted the class member's appeal, because of the routine reviewer's failure to upload interview information into the Offender Grievance Tracking system. As a remedy, it reopened the claim, instructing that the new reviewer "review ... any relevant videotape footage." *See* AIU Report at 3. Of course, by that time the video had been destroyed.

(c) RJD-[redacted]

A class member, in a grievance filed on December 23, 2024, made a serious allegation that, on November 11, 2024, during the afternoon yard release, he told a sergeant and an officer that he needed to be separated from his cellmate for safety reasons, but that staff refused his request. He further alleged that his cellmate attacked him on November 15, 2024, causing a concussion, broken teeth, and other injuries. *See* 602 at 4-5. The officer involved, during his interview, admitted that the class member approached him because he was not getting along with his cellmate. *See* AIU Report at 11. Nevertheless, the investigator failed to obtain video of that or any other relevant interactions. The investigator determined that the relevant interaction between the class member and staff occurred on November 14, 2024, not on November 11, 2024, as alleged by the class member in his 602, because that was the only day during the relevant time period that the two subjects worked on the same day. The investigator then requested BWC for the officer (from 11:30-12:30) and sergeant (11:55-12:30). *See* AIU Report at 4, 6. But the time period requested by the investigator was likely wrong. The subject officer noted that the afternoon yard release occurs at 1:00. *See* AIU Report at 11. Unsurprisingly, neither video showed any interactions between the staff and the class member. Thereafter, the investigator did nothing to attempt to obtain video that captured the relevant interactions. He did not request additional footage from November 14, 2024, nor did he request footage from other days. As a result, the investigator did not obtain any video of the interaction between the class member and staff that was at the core of the allegation and that staff acknowledged occurred.

(d) LAC-[redacted]

A class member reported that staff used unnecessary and excessive force when they cut off her clothes with scissors and forcibly transported her to SATF, resulting in injury. The class member filed a grievance on June 3, 2024, three days after the incident,

and included the date and time of the incident. *See* 602 at 6-8. AIU did not assign an investigator until December 11, 2024, 191 days after the 602 and well outside the 90-day video retention period. *See* AIU Report at 1. CDCR thus failed to retain any video from the incident. The investigator reported that "AVSS and BWC files were not available for review as the video retention period was exceeded." *See* AIU Report at 6.

(e) LAC-[redacted]

A class member reported that officers used unnecessary and excessive force by handcuffing him too tightly. The class member filed the grievance on July 22, 2024. CDCR assigned an investigator on August 26, 2024, but that investigator did not take any apparent action until the case was reassigned to a different investigator on March 18, 2025—239 days after the 602 was filed. *See* AIU Report at 1. Although the 602 did not contain a date or time of the incident, the class member reported in an interview that the incident likely occurred on July 22, 2024—the same date as the 602—between around 1-3 p.m. *See* AIU Report at 2. The investigator also discovered a 7219 from that same date that seemed consistent with the class member's allegation. *See* AIU Report at 3. The investigator did a capable job of identifying the date of the incident despite the lack of specificity on the 602. However, the investigator's work was for naught because it occurred well after the 90-day retention period expired. Even if video was retained and showed misconduct, the Hiring Authority would not have been able to impose adverse action because AIU did not return the case to the Hiring Authority until the statute of limitations expired. *See* 403 at 2.

(f) COR-[redacted]

The class member, in a 602 received by CDCR on November 5, 2024, raised multiple allegations, including allegations of sexual assault, sexual harassment, and endangerment occurring on specific dates in September and October 2024. *See* 602 at 1. The AIU received the case on November 14, 2024. The AIU forwarded the case to the Central Intake Triage Team on July 3, 2025, and it was assigned to an investigator on July 7, 2025—nearly eight months after the AIU received the 602. At that point, of course, footage was no longer available. *See* AIU Report at 1.

(g) SATF-[redacted]

The class member, in a 602 received by CDCR on July 15, 2024, alleged that, on May 30 and 31, 2024, staff refused to dim the day room lights in retaliation for filing a 602. *See* 602 at 4-5. The CST routed the case to the AIU on July 18, 2024. An investigator was initially assigned to the case on July 30, 2024, which was still within the 90-day retention window to request footage, but the case was reassigned to another investigator on October 4, 2024, and by that time footage was no longer available. *See* AIU Report at 1. It is not clear why the initial investigator failed to request footage.

(h) SATF-[redacted]

The class member alleged that staff retaliated against him for filing a grievance and provided the date and approximate time (August 17, 2024, at 8:30 am) in the 602 received by CDCR on August 19, 2024. *See* 602 at 4-5. CST routed the case to the AIU on August 22, 2024, and the AIU assigned an investigator on October 10, 2024—still within the 90-day retention deadline. *See* AIU Report at 1. However, the investigator failed to request AVSS/BWC footage before the 90-day retention period expired.

(i) SATF-[redacted]

In a 602 received by CDCR on September 13, 2024, the class member alleged that on September 12, 2024, staff members retaliated against him in response to staff previously assaulting the class member by putting him up for transfer, among other allegations. *See* 602 at 3. The case was assigned to the AIU on September 16, 2024, and the AIU assigned the case to an investigator on September 25, 2024. The investigator failed to request video footage. The AIU then reassigned the case to a second investigator on June 2, 2025. That investigator requested video, but no video was available because the retention period had expired by the time he received the case. *See* AIU Report at 1-2, 4.

(j) SATF-[redacted]

The class member, in 602s received by CDCR on July 31, 2024 and August 14, 2024, alleged, *inter alia*, that several officers assaulted him on July 12, 2024. *See* 602 at 3. CDCR closed the second 602 as a duplicate of the first. *See* Investigation Report at 2-3. According to the investigative report for SATF-[redacted] the AIU received the case on August 13, 2024, but did not assign the case to an investigator until January 2, 2025, several months after 90-day retention period had expired. *See* AIU Report [redacted] at 15.

(k) KVSP-[redacted]

In this case, a class member alleged that staff violated policy by placing him in a holding cell for longer than four hours without obtaining necessary approvals. *See* 602 at 2. The institution indicated that the holding cell logs for the class member could not be located. Nevertheless, the investigator should have been able to determine how long staff held the class member in the holding cage by using AVSS or BWC footage. Even though the AIU assigned the case to the investigator within 45 days of the incident, the investigator failed to request any video before the expiration of the 90-day retention period. *See* AIU Report at 1-2. As a result, the investigator failed to gather any evidence to answer the basic and easily answerable question of whether staff held the class member in the holding cell for longer than four hours.

(l) KVSP-[redacted]

In this case, a class member alleged that officers used excessive force by forcing him to cuff behind his back, instead of waist chains, and squeezing the handcuffs too tight. *See* 602 at 1-2. At the time of the incident, the class member had a permanent cane and also appears to have had a special cuffing chrono. *See* 7536 DME/Supply Receipt at 1 dated July 16, 2024; 1845/7410 at 1 dated March 28, 2023. Some BWC footage was retained in connection with the corresponding RVR, but the footage ended prior to placement of the handcuffs. The investigator stated in his report that "additional AVSS/BWC was not requested" due to the class member providing inaccurate details and refusing to participate in a clarifying interview, and due to the class member's interview "being conducted beyond the 90-day retention policy." *See* AIU Report at 5. These reasons were irrelevant, as the RVR matched the description of the incident and the investigator could easily have retained additional video for that date and time. *See* AIU Report at 4. However, the investigator did not request the video until more than four months after his assignment, when he requested all video relating to the RVR and found that only footage ending before the alleged misconduct had been retained. *See* AIU Report at 1, 5; Video Request at 1.

(m) KVSP-[redacted]

In this case, a class member alleged sexual misconduct, unnecessary force, and denial of medical attention in connection with a body search, handcuffing, and placement in a holding cell. *See* 602 at 5-6. Although the investigator was assigned less than one month after the date of the allegations, he did not make any request for AVSS/BWC, so only limited AVSS footage was available. The investigator noted in his report, "[b]y the time this case was opened, and [the class member] was interviewed for additional information, the ninety-day window of evidence preservation was expired, therefore no additional AVSS or BWC footage was requested or reviewed." *See* Investigation Report at 6. The BWC was necessary to hear whether the officer sexually harassed the claimant and whether the claimant complained to the officer about whether the handcuffs were too tight. And additional AVSS was necessary to determine whether the claimant was left unattended in a holding cell. Had the investigator requested the already retained footage in a timely manner, he would still have had enough time to request relevant missing BWC footage.

III. HIRING AUTHORITIES—INCLUDING THE CARU AND WARDENS—FAILED TO SUSTAIN ALLEGATIONS AND IMPOSE APPROPRIATE DISCIPLINE

In the cases in this section, Hiring Authorities—both from the CARU and from the institutions—failed to sustain allegations supported by evidence and/or to impose appropriate discipline after sustaining an allegation. These cases are in addition to the cases discussed in the section regarding excessive force (*see supra*, Section I), in which

the hiring authorities should have, but did not, sustain allegations that officers violated CDCR's policy prohibiting excessive force. The cases involved the following issues:

1. LAC-[redacted] – OIA, Sustained (L9; Reduced to L7)

This case involves a class member who committed suicide by hanging in [redacted], LAC's [redacted]. Officer [redacted] failed to perform adequate safety checks in the hours before the class member was found hanging. Officer [redacted] then lied during the investigation, claiming that he had confirmed during his safety checks that the class member was living and breathing when he had not done so. The LAC warden initially terminated Officer [redacted] Following a *Skelly* hearing, however, the warden improperly agreed to reduce the penalty to a 90-day suspension. CDCR's capitulation in this case signals to staff that they can retain their jobs after misconduct—lying to an investigator in a case that involved the death of an incarcerated person—that fundamentally undermines the accountability system.

[redacted], [redacted] ([redacted]) committed suicide at LAC on June 5, 2024. Officer [redacted] was responsible for conducting welfare and security checks in [redacted] that day. Under LAC local operating procedure, officers must conduct the welfare and security checks in that unit twice an hour at intervals no longer than 35 minutes. *See* [redacted] Security/Welfare Check Procedure at 18. The check requires "a visual/physical observation of a living, breathing inmate, free from obvious injury ensuring there is a clear and unobstructed view into the cell or ... self-injurious behavior." *Id.* After beginning his shift, Officer [redacted] conducted four checks before staff found Mr. [redacted] death, passing cell 241 at 2:24, 2:54, 3:17, and 3:54. *See* OIA Report at 12; *see also* BWC 1 at 2:24:23, BWC 2 at 2:54:27, BWC 3 at 3:17:31, BWC 4 at 3:54:26.[8] As the warden documented in the NOAA, Officer [redacted] spent only one second at the front of cell 241 for each of the first three checks and spent three seconds for the last check; he spent more time on the final check because he needed to re-tap the Guard One sensor. *See* NOAA at 16-17. Even though the cell was dark because the lights were off and Mr. [redacted] had affixed a privacy curtain covering much of the door, Officer [redacted] never moved his face close to the cell window to see past the privacy curtain or shined his light into the cell during any of the checks. *See* NOAA at 16-17.

At about 4:12 (18 minutes after Officer [redacted] final safety check), Officers [redacted] and [redacted] were performing count when they looked into Mr. [redacted] cell. *See* BWC 5 at 4:12:15. Officer [redacted] looked around the privacy curtain, used his flashlight, and stated he believed that Mr. [redacted] was hanging. *See* OIA Report at 4, 7; *see* BWC 5 (linked above) at 4:12:40. As Officer [redacted] began to activate his alarm, Officer [redacted] looked a second time and confirmed that Mr. [redacted] was hanging. *Id.*

[8] For reasons that are unclear, the investigator did not attempt to review any AVSS footage of the safety checks.

at 7. About a minute and a half later, Officer [redacted] Officer [redacted] and other officers entered the cell to cut Mr. [redacted] down. A responding health care staff member states, "oh, he's cold" after touching Mr. [redacted] arm. *See* BWC 5 (linked above) at 4:15:45; *see* NOAA at 17. When paramedics from the Los Angeles County Fire Department arrived on scene, one commented that Mr. [redacted] was in "rigor," and Mr. [redacted] was declared deceased shortly thereafter at 4:33 p.m. *See* NOAA at 18. According to internet sources, rigor mortis typically sets in within 2-6 hours after death.[9]

The investigator reviewed video of Officer [redacted] speaking partly in Spanish to another officer, Officer [redacted] after the incident.[10] According to OIA's translation of the conversation, Officer [redacted] said, in part, "I didn't get to see him" in reference to Mr. [redacted] *See* OIA Report at 14; *see also* Translation at 57.

The investigator asked Officer [redacted] about his safety checks, including the checks at 3:17 and 3:54. According to Officer [redacted] at the 3:17 and 3:54 checks, he saw Mr. [redacted] "alive and breathing," although he did not remember how he was positioned. *See* OIA Report at 12. Officer [redacted] told the investigator that he could see into the cell and that Mr. [redacted] was not harming himself. *Id.* at 13.

On June 6, 2025, the Hiring Authority (the now-former LAC warden) sustained violations for failure to observe and perform within the scope of training for failing to properly conduct health and safety checks, as well as a violation for intentional dishonesty during the OIA interview when he said that he saw Mr. [redacted] alive during each security check. *See* 402/403 at 1-2. Intentional dishonesty during an OIA investigation (E6) carries a baseline penalty of termination (Level 9). After listing a single mitigating factor (that the misconduct was not premeditated) and a litany of aggravating factors, the Hiring Authority imposed termination. *See* 402/403 at 3-4.

On June 17, 2025, the Hiring Authority served the NOAA on Officer [redacted] The NOAA indicated that Officer [redacted] failed to conduct proper security checks of Mr. [redacted] cell, that he failed to ensure Mr. [redacted] removed the privacy curtain from his cell window during any check, and that he lied during the OIA interview. *See* NOAA at 16, 18.

On June 23, 2025, the Hiring Authority conducted a *Skelly* hearing. After the *Skelly* hearing, on June 25, 2025, the Hiring Authority offered to resolve the case by

---

[9] *See, e.g.*, https://www.medicinenet.com/what_are_the_stages_of_rigor_mortis/article.htm.

[10] Potentially due to the investigator's long delay in initiating the investigation, Officer [redacted] did not recall this conversation from June 2024 when the investigator interviewed her on February 12, 2025. *See* OIA Report at 8. The investigator did not show Officer [redacted] the video of the conversation to refresh her memory.

reducing the case to a "modified penalty of a suspension without pay for ninety (90) qualifying work days." *See* [redacted] *Skelly* Results at 1. A 90-day suspension is a level 7 penalty, which is at the lowest end of the range of possible penalties for intentional dishonesty during an investigation. Officer [redacted] returned to work as of October 31, 2025. *See* NOAA at 2.

The Hiring Authority's decision to reduce the discipline to a Level 7 penalty—before Officer [redacted] even appealed to the SPB—is inexplicable and dangerous. The record contains ample evidence that Officer [redacted] did not conduct proper welfare and security checks, which are intended to prevent people from committing suicide, and that Mr. [redacted] died as a result. The evidence also showed that Officer [redacted] lied about seeing Mr. [redacted] alive during these checks. Officer [redacted] admitted on camera after the incident that he did not see Mr. [redacted] Further, the fact that Mr. [redacted] was "cold" within 20 minutes of Officer [redacted] final check, on a June day at LAC, and had developed rigor mortis suggests that Mr. [redacted] had been hanging for a longer period of time, possibly including all of Officer [redacted] checks that day. The NOAA issued June 17, 2025, sets forth these supporting facts in detail, and the 403 identifies numerous aggravating factors. Yet a week later, the Hiring Authority agreed to a lower penalty. The evidence in this case, which resulted in the death of an incarcerated person, was airtight, with a contemporaneous statement contradicting Officer [redacted] claims in the OIA interview months later. Officer [redacted] should never work as a CDCR officer again. CDCR's accountability system failed by allowing that to happen.

Plaintiffs also note that the OIG monitored this case as OIG Case 24-0088560-DM and critiqued CDCR's performance in a summary publicly available on OIG's website. *See* Case 24-0088560-DM at 2.[11] The OIG criticized the Hiring Authority for the settlement agreement "even though the officer lied to the Office of Internal Affairs about the incident." The OIG also criticized the CDCR attorney because they "advised the hiring authority to enter into a settlement agreement reducing the penalty without sufficient justification."[12] *Id.*

2. RJD-[redacted] – AIU, Sustained (Letter of Instruction and Training)

In this case, even though an officer engaged in conduct that was obviously threatening toward incarcerated people—helping another officer "rack" a rifle (*i.e.*,

[11] Although the OIG case summaries do not include subject names, the case in question is this case based on the common date of the incident, allegations, discipline, date of OIA interview, and ultimate resolution.

[12] The OIG also criticized the investigation, noting, *inter alia*, that the investigator "delayed the investigation, taking 179 days after the case was assigned to complete the first interview and 264 days after assignment to complete the investigation." *Id.*

pumping the gun to make the sound of chambering a round) over the PA system in the housing unit—the CARU failed to sustain that allegation. In addition, although the CARU did sustain allegations against the officer who helped the other officer rack the rifle for failing to intervene to stop misconduct and for endangerment, for which the baseline penalty is Level 5 discipline, the CARU improperly imposed an inappropriate Level 1 penalty (Letter of Reprimand) that is far outside the range for the violations. The CARU then withdrew the adverse action in its entirety and improperly imposed only corrective action.

During the incident, Officer [redacted] and Officer [redacted] were both in the control booth. The investigation report accurately describes what is shown on the video:

> "At approximately 6:43:56 AM [redacted] asked [redacted] to hold the mic down on the public address system. [redacted] is observed with the Mini-14 Rifle, places it next to the microphone, releases the magazine setting it down, slides the handle forward, picks up the magazine and taps it against the stock of the weapon multiple times, places the magazine down and pulls the slide handle multiple times thus making a metallic noise and mimicking the loading of the weapon, inserts the magazine and places the weapon down. Both [redacted] and [redacted] can be heard laughing and Incarcerated Persons can be observed in the dayroom. [redacted] releases the microphone at approximately 6:44:22 AM. [redacted] keys the microphone at approximately 6:44:27 AM and states, 'it's going to be [redacted] up here.' Both [redacted] and [redacted] continue to laugh and the BWC footage ends at approximately 6:44:39 AM."

See AIU Report at 3-4. In short, Officer [redacted] held down the button on the microphone for 20 seconds (from 6:44:06 to 6:44:25) while Officer [redacted] repeatedly "racked" and made other sounds with the gun in the control booth.

In a 602, [redacted] ([redacted]) claimed that *Coleman* and *Armstrong* class members "are suffering from depression, anxiety, and other mental health related problems triggered or aggravated" by officers' conduct in the housing unit, such as the instant incident involving Officers [redacted] and Officer [redacted] "racking" the gun.[13] *See* 602 at 10.

Defendants have not yet produced the investigation file for the case against Officer [redacted] but have produced the investigation file for the case against Officer [redacted]. Our analysis here pertains only to the case against Officer [redacted].

[13] Mr. [redacted] also made allegations about other misconduct, including officers verbally abusing incarcerated people.

The CARU did not sustain allegations against Officer [redacted] for failing to report Officer [redacted] misconduct, for misusing a duty weapon, and for threatening or intimidating incarcerated people. The CARU did sustain allegations against Officer [redacted] for endangerment and for failing to intervene in or attempt to stop staff misconduct by Officer [redacted] The CARU imposed a Level 1 penalty (Letter of Reprimand), even though the CARU noted that the baseline penalty was Level 5. *See* 402/403 at 2-5. After a *Skelly* hearing, the CARU withdrew the adverse action and imposed corrective action—a letter of instruction and training. *See* Closure Documents at 24.

The CARU erred in this case in two ways: (1) by imposing an inappropriate penalty for the sustained allegation of failing to stop misconduct of another officer; and (2) by failing to sustain the allegation that Officer [redacted] intimidated or threatened incarcerated people.

With respect to the penalty for the sustained allegations, the initial Level 1 penalty and the ultimate corrective action imposed violated CDCR's regulations and was the result of a misapplication of mitigating and aggravating factors. The CARU properly identified that failure to intervene in or attempt to stop misconduct by another employee carries a baseline penalty of Level 5. *See* Employee Disciplinary Matrix (D29). The CARU, however, then decided that mitigating factors warranted a Level 1 penalty, which is substantially outside of the range for that violation (Level 4 to 9). The CARU, in the 402/403, explained the below-range penalty as follows:

> It was determined that while Officer [redacted] did engage in staff misconduct which fell under a penalty range of 5, he played a secondary role in the misconduct. His actions were not premeditated or intentional. During the course of his AIU investigative interview, he accepted responsibility of his actions and acknowledged that the misconduct was in violation of departmental policies. These factors along with his length of service at the time of the misconduct has led the Hiring Authority to determine that a Letter of Reprimand is appropriate.

See 402/403 at 5.

CDCR's regulations do not permit a hiring authority to impose a penalty outside of the range specified for a specific violation. The regulations provide that "[t]he hiring authority shall impose the base penalty unless aggravating or mitigating factors ... are identified. *The aggravating and mitigating factors shall be considered in determining the appropriate penalty level within the penalty range*." *See* 15 C.C.R. § 3392.5(c)(5) (emphasis added). The regulations further provide that "[a]ggravating and mitigating factors may increase or decrease the penalty *within the identified penalty range*. Mitigating factors may be used to reduce the penalty level from the base penalty. Aggravating factors may increase a penalty from the base penalty up to and including

dismissal." *See* 15 C.C.R. § 3392.5(c)(8) (emphasis added). Nowhere do the regulations permit a below-range penalty. Accordingly, the lowest penalty that could have been imposed in this case is a Level 4 penalty at the bottom of the range for failing to stop misconduct of another officer.

Putting aside the regulations, the CARU's analysis of the mitigating and aggravating factors was flawed. The CARU wrongly concluded that Officer [redacted] conduct was not intentional and that he played a secondary role in the misconduct. Officer [redacted] intentionally pressed the PA button for 20 seconds to broadcast the sounds of the gun being "racked" to the incarcerated population. And he was a necessary participant in the misconduct, as Officer [redacted] was not able to push the PA button and "rack" the gun at the same time. The CARU also erred in concluding that Officer [redacted] "accepted responsibility of his actions and acknowledged that the misconduct was in violation of departmental policies." *See* 402/403 at 5. At the end of the interview, the investigator asked whether Officer [redacted] believed that any of the allegations against him were true. He answered no. *See* Officer [redacted] Interview at 40:43. Lastly, the CARU only identified two aggravating factors—that Officer [redacted] was sworn staff and that serious consequences occurred or could have resulted from the misconduct. *See* 402/403 at 5. The CARU should also have found that the conduct resulted in harm to public service (as the threat to incarcerated people constituted an abuse of authority, *see* discussion below) and was committed with malicious intent (as there is no other possible intent for engaging in the conduct, and Mr. [redacted] in his 602, confirmed that the conduct was harmful for him and others). And, consistent with the discussion above, the CARU should have found that misconduct was intentional and that Officer [redacted] did not accept responsibility.

Under these circumstances, mitigating the penalty at all—let alone from a baseline of Level 5 to a Level 1 penalty far outside the range and then ultimately to corrective action—was inappropriate. Officer [redacted] engaged in harmful behavior that violated clear policies and that created a hostile, non-rehabilitative environment. He should have received significant adverse action. Instead, he received corrective action, which under the circumstances was essentially a slap on the wrist.

The CARU should have sustained the allegation for threatening or intimidating incarcerated people. Officer [redacted] admitted during his interview that his conduct was intimidating to incarcerated people. The investigator asked, "[l]ooking back now that we're here today, did you think that anything was wrong with holding down the microphone and allowing or watching [redacted] rack his weapon?" Officer [redacted] responded, "[n]ow seeing the video and everything, I can see where the intimidation part could come." *See* [redacted] Interview at 31:50. That admission, standing alone, should have been enough to sustain the intimidation/threat allegation. Moreover, Officers [redacted] and [redacted] conduct was intended to threaten all of the people who were in the housing unit at the time. There was no other reason to broadcast the

sounds of the gun being "racked." Their conduct communicated to the residents of the building that Officer [redacted] was armed and ready to use the weapon against incarcerated people. The intent to intimidate was highlighted by their laughter and by Officer [redacted] statement, after he had "racked" the rifle, that "it's going to be [redacted] up here." Though Officer [redacted] was the one who handled the weapon, he was only able to broadcast the threatening gun sounds because Officer [redacted] held the PA button for him for 20 seconds, including for a long period after he knew what Officer [redacted] was doing.[14]

3. SATF-[redacted] – AIU, Sustained (Corrective Action, SOL Expired)

In this case, the Hiring Authority appropriately sustained the allegation that an officer used unnecessary or excessive force when he pepper sprayed a class member in the face.[15] But because the Hiring Authority delayed and allowed the statute of limitations to expire before reviewing the incident, the Hiring Authority imposed no adverse action. Even though the base penalty for this misconduct is a Level 2 (L1, 1**2**3), the Hiring Authority could only impose corrective action, in the form of on-the-job training. Worse, it appears that, due to an administrative error, the officer never even received that training.

The facts here are undisputed. [redacted] ([redacted]) was acting erratically on the tier, and officers suspected that he was under the influence of drugs. During the course of the incident, he ran away from officers into one of the showers in the unit. After an alarm was activated, nine officers arrived to address Mr. [redacted] behavior and had the incident under control using de-escalation techniques. Officer [redacted] then arrived. By that point, most of the officers were shouting at Mr. [redacted] to get on the ground. Mr. [redacted] was in the back of a shower, which has a grilled door that can be closed, and was surrounded by officers. Officer [redacted] forced his way to the front, ordered Mr. [redacted] to get down, and, when he did not comply, pepper sprayed Mr. [redacted] in the face. *See* BWC at 9:26:18.

The Hiring Authority sustained an allegation of unnecessary and/or excessive force against Officer [redacted] but allowed the statute of limitations to expire before reaching that decision. Mr. [redacted] made a verbal allegation on December 1, 2023. *See* Memorandum re: Referral for Determination of Use of Force Allegation at 1. The AIU

---

[14] The Hiring Authority likely should also have sustained the allegations for failing to report the misconduct and for mishandling a duty weapon. Plaintiffs have not analyzed those allegations, as they carry less significant penalties than threatening incarcerated people.

[15] The Hiring Authority sustained an allegation of " unnecessary and/or excessive force," but the 402/403 does not indicate whether the Hiring Authority determined that Officer [redacted] used unnecessary force, excessive force, or both. *See* 402/403 at 1.

investigator completed her investigation on April 9, 2024. *See* AIU Report at 8. But the Hiring Authority did not complete his review until eight months later, on December 9, 2024, after the statute of limitations had expired. *See* 402/403 at 1. Accordingly, the Hiring Authority could only impose corrective action (here, on-the-job training). *Id.* Even then, a Clarification Memorandum dated August 6, 2025, states that Officer [redacted] never even received that training. *See* Clarification Memorandum re: AASTS No. [redacted] **Please explain whether Officer [redacted] has received the on-the-job training the Hiring Authority ordered. If so, please explain when he received that training.**

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

In this case, officers used unnecessary force against an *Armstrong* class member by grabbing him solely for failure to follow an order.

Video shows [redacted] ([redacted]) slowly walking through the dayroom while talking on a tablet. Officer [redacted] says "[redacted] let's go." *See* BWC 1 at 13:19:46. Mr. [redacted] continues to walk slowly forward past Officer [redacted] towards the housing unit cells. Without warning, Officer [redacted] grabs Mr. [redacted] left forearm and pulls it behind his back, while Officer [redacted] grabs the tablet and pulls Mr. [redacted] right wrist behind his back. *See* BWC 1 (linked above); BWC 2 at 13:20:11. Officer [redacted] says "turn around" while grabbing Mr. [redacted] *See* BWC 1 (linked above) at 13:19:57. Mr. [redacted] pulls his left elbow upwards away from Officer [redacted] and one of the officers says "stop resisting," but the officers soon have Mr. [redacted] hands pulled behind his back. Officer [redacted] then slams Mr. [redacted] face-first into the wall. Officers handcuff Mr. [redacted] *See* AVSS at 1:20:08. The 7219 documents that Mr. [redacted] had a swollen knee following the incident, and Mr. [redacted] reported he had a history of a dislocated shoulder. *See* 7219 at 38; AIU Report at 7. Officer [redacted] issued Mr. [redacted] an RVR for resisting staff.

The force here was unnecessary because, according to the officer's incident reports, the officers initiated force due to Mr. [redacted] allegedly failing to follow an order, which by itself is not an appropriate justification for immediate force. *See* Incident Reports at 28, 29; DOM § 51020.4. Officer [redacted] twisted Mr. [redacted] alleged failure to comply with an order into an attempted justification for using force, claiming that "[redacted] apparent emotional state and refusing to listen to direct orders, [sic] presented a reasonable likelihood that he could become violent." *See* Incident Report at 29. Under Officer [redacted] logic, however, any failure to follow orders means a person may become violent, justifying force. In the abstract, that approach violates existing policy. Moreover, the video does not support the claim that Mr. [redacted] was violent or likely to become so. He shows no emotion in the video that an officer could reasonably interpret as a precursor to violence; in Officer [redacted] own telling, he simply "ignored" Officer [redacted]. *Id.*

The officers also violated CDCR's policies requiring de-escalation and verbal persuasion prior to using force. From the video, it is not clear that Mr. [redacted] heard Officer [redacted] order him to go back to his cell. Even if he did, the situation allowed for substantial de-escalation, because Mr. [redacted] did not pose any threat. Many other incarcerated people were still in the dayroom, suggesting there was not urgency for Mr. [redacted] to return to his cell. Officers could have provided another order or could have threatened him with an RVR. Instead, both officers immediately initiated force against Mr. [redacted] by grabbing him and forcefully removing his tablet.

The CARU found the force appropriate, despite the video evidence and officers' statements in their incident reports. Plaintiffs previously reported on a similar case at LAC, in which officers approached a class member at a water fountain in the dayroom, ordered him to return to his cell, and then used immediate force for failing to comply with an order, resulting in an injury that required stitches. As here, the Hiring Authority in that case failed to impose discipline. *See* Plaintiffs' August 16, 2024 Report at 16-17. Even though the CARU resolved the instant case, the officers avoided accountability for their improper use of force.

IV. 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.