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May 8, 2026

VIA ELECTRONIC MAIL ONLY

PRIVILEGED AND CONFIDENTIAL

SUBJECT TO PROTECTIVE ORDERS

Re: *Armstrong v. Newsom*: Plaintiffs' May 2026 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). These findings are corroborated by the Office of Inspector General who conducted a recent review of staff misconduct investigations and discipline and found that approximately 70 percent of cases involving complaints filed by incarcerated people were inadequate or needed improvement. *See* July – December 2025 Report Monitoring Internal Investigations, Staff Misconduct Complaint Investigations, and the Employee Disciplinary Process of the California Department of Corrections and Rehabilitation.

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 June 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/

By:

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I. CASES INVOLVING A SINGLE OFFICER AT SATF THAT EXEMPLIFY SERIOUS AND ONGOING FAILURES OF THE ACCOUNTABILITY SYSTEM

Four cases in this report involve a single officer at SATF who, despite engaging in very serious and sustained uses of force against people with disabilities, has not been held appropriately accountable for ongoing misconduct.

As explained in detail below, these cases illustrate multiple failures of the accountability system including: (1) the failure to recognize when officers are not accommodating disabilities leading to unnecessary uses of force; (2) the failure to implement appropriate discipline when violations are sustained; (3) the failure to conduct thorough investigations identifying all involved officers; and (4) the colossal failure of the system to recognize a problematic pattern involving multiple serious allegations of use of force violations involving a single officer. Each of the four allegations worked their way through the system at the same time independently of one another and with zero interventions to prevent ongoing harm to class members. The full extent of the harm caused by this officer to the incarcerated population is not known because Plaintiffs' counsel only receive a limited production of cases.

1. Officer [REDACTED] (SATF-[REDACTED] SATF-[REDACTED] SATF-[REDACTED] SATF-[REDACTED]

Between June 2024 and February 2025, Officer [REDACTED] slammed or tackled four different *Armstrong* class members to the ground. In each of these incidents, the force was either unnecessary or excessive. And in two of them, Officer [REDACTED] used force after the class members explicitly requested disability accommodations.

In the first two incidents, from June and July 2024, the Hiring Authority concluded that Officer [REDACTED] used unnecessary and excessive force when he "suplexed" two class members, but imposed only corrective action and a Level 1 penalty. The Hiring Authority said nothing about Officer [REDACTED] actions in the third incident, from September 2024, because the investigator focused myopically on the actions of another officer, closed the matter without considering Officer [REDACTED] use of force in response to a requested disability accommodation, and did not complete the investigation before the expiration of the statute of limitations. Finally, in the fourth incident, from February 2025, the Hiring Authority incorrectly found no policy violation when Officer [REDACTED] again slammed a class member with a mobility disability—who repeatedly asked Officer [REDACTED] to cuff him in front to accommodate his documented disability needs—to the ground. Despite this pattern of violating class members' rights, CDCR has taken only one formal disciplinary action against Officer [REDACTED] issuing him a single Official Reprimand.

These four incidents of misconduct demonstrate that Officer [REDACTED] should not be working in any position where he comes into contact with incarcerated people with disabilities. **Though CDCR can no longer discipline Officer [REDACTED] for this misconduct, Plaintiffs request that he be assigned to a position in which he does not interact with class members.**

(a) SATF-[REDACTED] & SATF-[REDACTED]

The first two incidents occurred within three weeks of each other and illustrate the ongoing problem of the failure of CDCR to recognize when two similar cases are making their way through the system that may have bearing on how discipline should be handled for this officer. In both incidents, Officer [REDACTED] approached an incarcerated person, and after telling the incarcerated person that he was going to escort them to their cells—but without first ordering them to turn around or "cuff up"—grabbed the incarcerated person by the arm. Then, when it appeared to Officer [REDACTED] that the incarcerated person was "resisting," he used immediate force by wrapping his arms around their waists, lifting them into the air, and slamming them to the ground.

In both incidents, the Hiring Authority found that Officer [REDACTED] had used improper force—excessive force in the first case and unnecessary force in the second. In both incidents, following a Skelly Hearing, the Hiring Authority sustained the discipline imposed. And in both incidents, upon Officer [REDACTED] appeal to the State Personnel Board ("SPB"), CDCR stipulated to a reduced penalty. As a result, despite using excessive and unnecessary force in an especially dangerous manner against two different class members, in incidents that occurred within 19 days of each other, Officer [REDACTED] ultimately received only an Official Reprimand. That outcome was inappropriate and undermines CDCR's system of progressive discipline.

(i) SATF-[REDACTED] – AIU, Sustained (L1; Reduced to Corrective Action)

This first incident occurred on June 21, 2024. It begins when Officer [REDACTED] approaches [REDACTED] ([REDACTED]), a 51-year-old class member who is in the dayroom speaking with several other incarcerated individuals. *See* BWC 1 at 15:20:21 to 15:20:3. Officer [REDACTED] believed that Mr. [REDACTED] was on "C-Status" and therefore should not have been in the dayroom at this time. *See* Investigative Report at 20. Officer [REDACTED] orders Mr. [REDACTED] to return to his cell. Mr. [REDACTED] shrugs and says, "So what you gonna do after that?" Officer [REDACTED] responds, "Alright, I'mma escort you to your cell," and reaches to grab Mr. [REDACTED] Mr. [REDACTED] backs up and evades Officer [REDACTED] grasp. *See* BWC 2 at 15:20:20 to 15:22:31. Officer [REDACTED] then immediately wraps both arms around Mr. [REDACTED] waist, lifts him into the air, and slams him to the ground, landing on top of him. *See* BWC 1 at 15:20:34 to 15:20:40. At no point during the brief interaction leading up to the force did Officer [REDACTED] direct Mr. [REDACTED] to turn around or submit to handcuffs.

The Hiring Authority correctly sustained an allegation of excessive force without injury (L4, 12**3**). *See* 402/403 at 3. It concluded that, during the incident, Mr. [REDACTED] "was non-compliant and refused to follow staff directives," but "at no time did [he] pose an imminent threat." *See* Skelly Recommendation at 2. According to the Hiring Authority, "where there is no immediate threat to staff or others, DOM Section 51020.17 mandates that a controlled use of force be considered." *Id*. Instead, "Officer [REDACTED] engaged [Mr. [REDACTED] by immediately making physical contact in an attempt to apply restraints. The evidence indicates that a controlled use-of-force option was available and should have been pursued." *Id*.

The Hiring Authority erred, however, by imposing a below-baseline, Level 1 penalty (Letter of Reprimand). *See* 402/403 at 2. The Hiring Authority found three mitigating factors (lack of premeditation, lack of understanding of consequences, honesty during the investigation[1]) and five aggravating factors (intentional and willful, sworn staff, potential serious consequences, harm to public service, and the employee did not accept responsibility). *Id*. Confronted with these factors, the Hiring Authority's decision to mitigate the penalty at all—let alone to mitigate it down two levels—was unreasonable. And mitigation was especially inappropriate because, as discussed below, Officer [REDACTED] had engaged in repeated acts of improper force.

CDCR then compounded the Hiring Authority's error after Officer [REDACTED] appealed to the SPB. In those proceedings, CDCR agreed to reduce his penalty from an Official Reprimand to corrective action, specifically a Letter of Instruction. *See* Stipulation and Release at 2.

(ii) SATF-[REDACTED] – Sustained (L2; Reduced to Level 1)

The second incident occurred on July 10, 2024, 19 days after the first. In this incident, Officer [REDACTED] approaches [REDACTED] ([REDACTED]),[2] who is seated at a table in the dayroom. *See* BWC at 22:04:30. Mr. [REDACTED] is complaining that he has been unable to get his prescribed mental health medication. During the conversation, Mr. [REDACTED] is animated but seated; he does not present as an imminent threat. Officer [REDACTED] directs Mr. [REDACTED] to stand up. *See* BWC at

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[1] Plaintiffs have repeatedly explained how honesty during the investigation should not be a mitigating factor, as CDCR policy requires officers to be honest during investigations.

[2] As of the date of this report, CDCR has assigned Mr. [REDACTED] a [REDACTED] code. According to the attachments to the Investigation Report, at the time of this incident, CDCR had not assigned Mr. [REDACTED] a DPP code, but had issued him a "Mobility Impaired Disability Vest," a "Wrist Support Brace," "Therapeutic Shoes/Orthotics," and "Incontinence Supplies." *See* DPP Summary at 93. CDCR also issued Mr. [REDACTED] a "Lower/Bottom Bunk Only" housing restriction, a "Lifting Restriction," and noted that Mr. [REDACTED] needed "Special Cuffing." *Id*.

22:04:40 to 22:04:58. Mr. complies. Officer then says, "I'm taking you back to your cell, alright? Come on." *See* BWC at 22:04:58 to 22:05:00. As he says this, Officer reaches with his left arm to grab Mr. right arm. *See* AVSS at 22:04:51. Mr. then reaches in the direction of the table to retrieve his water bottle and ID card. As he does so, Officer wraps his arms around Mr. waist, lifts Mr. into the air, and slams him into the ground. Mr. lands on his right shoulder, and his head bounces on the floor. *See* AVSS at 22:04:52 to 22:04:56. At no point during the interaction leading up to the force did Officer direct Mr. to turn around or submit to handcuffs.

The case conference for this incident took place about two weeks before the case conference for the incident discussed above. The Hiring Authority determined that Officer engaged in unnecessary force without injury (L1, 1**2**3), though medical records suggest the assault may have broken Mr. shoulder.[3] As with the incident above, the Hiring Authority found more aggravating factors than mitigating factors. But unlike for that incident, here, the Hiring Authority elected to impose the base penalty (Level 2). *See* 402/403 at 1-3. Once Officer appealed to the SPB, however, CDCR again agreed to reduce the penalty—from Level 2 to Level 1, a Letter of Reprimand. *See* Stipulation and Release at 1.

As a result, an officer who, two times in less than three weeks, unnecessarily body-slammed two incarcerated people—an extremely dangerous maneuver—received only a Letter of Reprimand and corrective action.

(b) SATF- – AIU, Not Sustained

In the third incident, Officer tackles a handcuffed class member with a mobility disability to the ground because the class member attempted to sit down while being escorted after officers refused to give him his cane. But because the class member's allegations implicated only a different officer and included details about the force that the investigators concluded were unsubstantiated by video, the Hiring Authority did not discipline Officer There is no indication in the file that the

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[3] Of note, Mr. appears to have been injured during this incident. *See* 7362 dated July 14, 2024 stating, "I'm in pain in my sholder [sic] and been asulted [sic] for no reason."; see also 7362-A dated July 16, 2024 ("On 7/10/24 at 10:00 pm I was attacked from the C/O's at yard because of it my back and sholder [sic] hurts. I need my back brass [sic]."); 7362-B dated July 16, 2024 ("I'm in pain. I need help."); 7362 dated July 17, 2024 ("On 7/10/24 at 10:00 pm yard the c/o jumped me and brock [sic] my sholder [sic]. I need to see the doctor for sling and back brass [sic]. I'm in pain."). X-Rays of Mr. right shoulder taken on July 22, 2024 reveal a "chronic appearing ununited fracture deformity proximal humerus," in other words, a broken shoulder. *See* XR Shoulder Right dated July 22, 2024.

Hiring Authority connected the actions of Officer to the two other serious use of force violations, above. And even if the investigation had been adequate and resulted in allegations against Officer the Hiring Authority would not have been able to impose any discipline because the statute of limitations had expired.

The incident occurs on September 12, 2024, the same date that the class member, ()[4] arrived at SATF. The AIU Report and body-worn camera footage suggest that, prior to the incident, Mr. had protested his housing assignment and had made statements that the primary escort officer during this incident, Officer interpreted as a threat. *See* Investigative Report at 3; BWC at 7:47:30–7:48:11.

The video begins with Officer escorting Mr. from the housing unit to the yard. *See* BWC at 19:46:14. Officer has his hand on Mr. right arm, and Mr. hands are handcuffed behind his back; Officer trails a few steps behind. *See* AVSS at 19:46:22. As they leave the building, Mr. addresses Officer saying "You just asked me if I'm all ready to leave." Officer replies, "Stop. First off, stop tensing up." Mr. replies, "I'm not threatening you," and then stops and asks if he can get his cane, saying, "Bro can I get my cane? I need my cane." *See* BWC at 19:46:20 to 19:46:27. Mr. then tries to sit down, while Officer shouts, "No, no, no stalling. Do not—" *See* BWC at 19:46:27; *see also id.* at 19:47:03–05 (Mr. explaining that he was trying to sit down); *id.* at 19:48:45-46 (same).

Rather than retrieve Mr. cane or allow him to sit down, Officer who has now moved alongside Mr. wraps his arms around Mr. upper torso and drives him forward four or five steps, before tackling Mr. to the ground. *See* AVSS at 19:46:25 to 19:46:30.

Mr. 602 alleges that Officer "drug" him outside, "'dipped' [him], placed [him] into a headlock, and smashed [his] face into the ground and choked [him]." *See* AIU Report at 1. Mr. also alleged that Officer placed his knee into Mr. back. *Id.* The AIU Report notes that the investigator did not "witness[]" these "UOF allegations . . . during review of BWC." *Id.* at 3. For that reason, the investigator found that "pursuant to CCR Section 3486.2(b)(4)(A)(1), this case meets the criteria for closure under special circumstances." *Id.* at 4. The investigator took no further investigative action and closed the investigation. *Id.*

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[4] At the time of the incident, Mr. was prescribed a cane and a mobility disability vest, and he had a lower bunk/lower tier housing restriction. He likely should have had a code instead of a code.

But the AIU Report omits the central role Officer played in the use of force. For example, this is how the investigator described his review of the AVSS and BWC from the incident:

> gives orders to to stop his actions and tells "No" several times. is observed with his feet planted in front of his body and appears to be pushing his body weight backwards. appears to lose his balance. When regains his footing, he responded to the location where is on the ground, gives orders to to stop resisting.

See AIU Report at 2.

Missing from this description is any explanation of how Mr. wound up on the ground. The investigator's description of Officer statement is also sparse on details. He summarizes statement as follows:

> detailed, he was assisting the escort of after told to take his badge and belt off and come into cell. detailed during the escort planted his feet against the ground and pushed his body back towards

Id.

But Officer's statement is far more explicit about how he tackled Mr. "I immediately wrapped both of my arms around [Mr. torso area and utilizing my body weight and driving forward with my legs I forced him to the ground in a prone position. *See* Incident Report at 23.

The investigator should have made clear that video showed Officer tackling Mr. to the ground after he asked for his cane, stopped his escort, and tried to sit down. And the investigator should have amended his report to consider whether the officers' failure to accommodate Mr. disability, as well as Officer use of force, violated policy. Had the investigator done so—and done so before the statute of limitations had expired—rather than exonerating Officer and making no findings about Officer the Hiring Authority could have appropriately considered the conduct of Officer in this case.

The Hiring Authority should have found two policy violations. *See* 402/403. First, Officers and failed to accommodate Mr. mobility disability by not providing him with his cane as he requested. Second, Officer used unnecessary force. Mr. was not presenting an imminent threat when

Officer tackled him. Requesting a reasonable accommodation like a cane and stopping an escort to sit down does not constitute an imminent threat. The officers could have avoided force entirely if they had allowed Mr. to sit down, then retrieved his cane and continued the escort. Using immediate force and tackling a handcuffed person with a mobility disability was not justified under CDCR policy.

Moreover, Mr. sustained a laceration to his forehead above his right eyebrow, for which he received medical attention—a nurse cleaned his wounds and applied "appropriate dressings," including "steri-strips." *See* Progress Note at 1 dated September 12, 2024; Nursing Face-to-Face/7362 at 1 dated September 13, 2024; *see also* Attachments at 35 (documenting bruising and abrasions or scratches on Mr. right knee; an abrasion on Mr. right hand; bruising/discolored area on right shoulder; and an abrasion/scratch and dried blood above Mr. right eyebrow). And more than a month after the incident, Mr. was still complaining of pain on the left side of his body, due to being slammed to the ground. *See* Outpatient Progress Note at 1 dated September 19, 2024; 7362 at 1 dated September 21, 2024 ("I got slammed and my ribs hurt really bad, hard for me to sleep"); 7362 at 1 dated October 10, 2024; 7362 at 1-2 dated October 13, 2024.[5] The Hiring Authority could therefore have sustained an allegation of unnecessary force causing injury (L2, 4**5**6789).

(c) SATF- – AIU, Not Sustained

In the fourth incident, Officer disregards a class member's bright yellow mobility-impaired disability vest, the class member's walker, and the class member's repeated entreaties that Officer honor his special cuffing restriction and handcuff him in front of his body. Officer instead tells the class member that he "doesn't care" about the class member's special cuffing restriction and insists on handcuffing the class member behind his back. As Officer twists the class member's arm behind his back, the class member complains of pain to his wrist and moves his body so that his arm is not twisted behind him. Officer immediately wraps his arms around the class member's waist, lifts the class member into the air, and slams him onto the ground. Despite this officer's failure to accommodate the class member's disability and his use of unnecessary and excessive force, the Hiring Authority does not sustain any allegation of misconduct.

( ) who was fifty-one years old at the time of the incident and uses a walker to ambulate, is walking on the track in the yard, wearing his yellow mobility impaired disability vest, when another incarcerated person approaches him aggressively initiating an altercation. *See* AVSS at 07:17:55; Investigative Report at 4. Mr. responds to the attack, striking the other incarcerated person, but the skirmish ends quickly: the other incarcerated person moves away from

[5] Though x-rays were ordered, Mr. refused those appointments.

Mr. and drops to the ground in a prone position, while Mr. moves away from the other incarcerated person and begins collecting personal items that scattered from his walker, which had tumbled over during the incident. *See* AVSS at 07:18:00 to 07:18:18.

When Officer approaches, Mr. is calm. *See* BWC 1 at 07:18:50 to 07:18:55. Officer orders Mr. to turn around and cuff up. Mr. responds by crossing his hands in front of his body while stating, "I'm not cuffing up. I got front cuffing." Officer replies, "**I don't care**." Over the next several seconds, Mr. explains repeatedly that he has "front cuffing," while Officer continues to order Mr. to turn around and submit to handcuffs behind his back. Eventually, Officer says, "So look, I'mma cuff you up," grabs Mr. left wrist,[6] and again directs Mr. to turn around. Mr. again attempts to explain his cuffing restriction, saying, "From the front," before exclaiming, "Hey! Why you trying to hit the alarm on me? I got front cuffing." Officer responds simply, "Cuff up." Mr. says, for the fifth or sixth time, "I got front cuffing." *See* BWC 1 at 07:18:50 to 07:19:09.

Officer then tells Mr. "Don't resist." Mr. replies, "I ain't not resisting. Hit the alarm." Officer then again instructs Mr. to turn around and repeats that instruction twice more. Mr. twice exclaims, "I got front cuffing!" and then, as Officer twists Mr. left arm behind his back to handcuff him, "You gonna break my wrist! I got front cuffing!" Mr. shifts his body so that his arm is no longer twisted behind his back. Officer immediately moves behind Mr. wraps his arms around Mr. waist, lifts Mr. into the air, and then slams him to the ground. *See* BWC 1 at 07:19:09 to 07:19:22; AVSS at 07:19:10 to 07:19:20

As the incident unfolds, a Sergeant approaching Officer and Mr. from across the yard shouts in their direction, calling Mr. by his last name four or five times. *See* BWC 2 at 07:19:11 to 07:19:15. After Officer slams Mr. to the ground, the Sergeant sighs and, referring to Officer asks, "Why the fuck is this kid doing that?" *See* BWC 2 at 07:19:15 to 07:19:19.

Once on the ground, Mr. explains to other officers who have just arrived that he told Officer about his cuffing restriction "ten times." Now on top of

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[6] Mr. had surgery to repair a radial fracture in his left wrist in April 2020. More specifically, Mr. medical records suggest he underwent a procedure called open reduction and internal fixation (ORIF). ORIF wrist surgery is a procedure used to repair severe, displaced, or unstable fractures of the wrist (usually the distal radius). It involves making an incision, re-aligning the bones, and using hardware like plates, screws, or pins to stabilize the bones internally while they heal. *See* Brandon P. Donnelly, *ORIF Wrist Surgery*.

Mr. [redacted] and cuffing Mr. [redacted] left arm, Officer [redacted] instructs Mr. [redacted] to put his other hand behind his back. Mr. [redacted] says again, "I got front cuffing man, my wrist is messed up man. I got front cuffing. I told you that. I got front cuffing." *See* BWC 1 at 07:19:30 to 07:19:40. As Mr. [redacted] is speaking, the sergeant who expressed dismay at Officer [redacted] actions arrives and tells Officer [redacted] who is still trying to handcuff Mr. [redacted] behind his back, "Hold on he's gotta get the waist [restraints]." Mr. [redacted] addresses the sergeant saying, "I told him I had front cuffing, sergeant. Ten times. Review the camera." *See* BWC 2 at 07:19:39 to 07:19:46.

Eventually, Mr. [redacted] was "escorted to [a] holding cell without further incident" while "secured in waist restraints." *See* AIU Report at 3. Mr. [redacted] later complained of pain in his left foot, right wrist, and right shoulder, injuries he attributed to Officer [redacted] slamming him into the ground. *See* 7362 at 1 dated February 5, 2025 ("I think my toe is broken. And my wrist is sprung. I had an incident with staff 2-2-25 approx 7:19 am. Now my left foot big toe is swollen and my right sholder [sic] and right wrist has pain. I was slammed by Officer [redacted] to the ground."); 7362 at 1 dated February 7, 2025 ("Still having discomfort in left big toe, right wrist area, and right shoulder area.").

During his interview with the AIU investigator, Officer [redacted] explained that he attempted to handcuff Mr. [redacted] behind his back for two reasons: first, it was an emergency situation and he only had regular handcuffs on him; second, in Officer [redacted] view, if Mr. [redacted] was "willing to push his assistive medical equipment away from him to attack another inmate" then Mr. [redacted] "did not need any assistance and he was able to cuff up behind his back without an issue." *See* [redacted] Interview at 24:26–25:30.

Mr. [redacted] filed a 602 alleging that Officer [redacted] "used excessive and unreasonable" force when he picked Mr. [redacted] up and slammed him to the ground. *See* 602 at 4. The Hiring Authority did not sustain the allegation. *See* 402/403 at 1.

The Hiring Authority's failure to sustain any allegation of misconduct was wrong in several ways. To begin with, force could have been avoided had Officer [redacted] simply listened to Mr. [redacted] Rather than forcing Mr. [redacted] to submit to handcuffs behind his back, Officer [redacted] could have directed Mr. [redacted] to sit on his walker and then waited for other officers to arrive with waist restraints. Instead, Officer [redacted] ignored Mr. [redacted] and, based in part on his own uninformed assessment of the severity of Mr. [redacted] disability, insisted that Mr. [redacted] cuff up behind his back. In fact, CDCR policy requires Officer [redacted] to accommodate Mr. [redacted] disability when applying handcuffs. *See* DOM 51020.6(g) (mechanical restraints "shall be applied" to people with disabilities to "ensure effective application while reasonably accommodating the [incarcerated person's] disability."). The Hiring Authority should have sustained an allegation of staff misconduct against Officer [redacted] for failing to perform within the

scope of his duties and training when he improperly denied Mr. a reasonable disability accommodation.

The Hiring Authority should also have sustained an allegation of either unnecessary or excessive force. Mr. neither presented an imminent threat when Officer approached, nor threatened Officer during their interaction. To the extent that Mr. "resisted" Officer at all, he did so only because Officer failed to provide him a disability accommodation and to avoid the pain caused by Officer twisting his surgically repaired left-wrist behind his back. Under these circumstances, slamming Mr. to the ground was unnecessary and dangerous. The amount of force was also much more than necessary and resulted in injury[7]: for days afterward Mr. complained of pain in his left foot, right shoulder, and right wrist. He described his pain as a 7 on a scale of 1 to 10 to the medical professionals who responded to his requests for treatment. And notes of those encounters show that Mr. sustained bruising to his left big toe and experienced pain when walking and lifting his right arm. The Hiring Authority could therefore have sustained allegations of unnecessary force causing injury (L2, 4**5**6789) or excessive force causing injury (L5, 4**5**6789). At a minimum, the Hiring Authority should have sustained unnecessary force without injury (L1, 1**2**3) and excessive force without injury (L4, 12**3**).

Instead, the only person disciplined for this incident was Mr. He received an RVR for resisting staff. He lost 90 days of credits. He lost yard recreation privileges and package privileges for 90 days. And SATF imposed property restrictions on him for 90 days. *See* RVR at 77-78; Disciplinary Hearing Results at 80-89.

(d) Conclusion

These incidents evince a pattern: Officer resorts to unjustified immediate and dangerous force against class members with disabilities who present no imminent threat. The third and fourth cases, in which he used force after class members requested accommodations for their disabilities, are particularly problematic. It is clear to Plaintiffs' counsel that Officer is not equipped to work with people with disabilities. We recognize that CDCR can no longer discipline him for these incidents. But we ask that you reassign Officer to a post in which he cannot interact with and harm class members.

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[7] *See* Cal. Pen. Code § 243(f)(5) ("'Injury' means any physical injury which requires professional medical treatment"); *see also People v. Adams*, No. B293152, 2020 WL 1969364, at *13 (Cal. Ct. App. Apr. 24, 2020) ("a swollen, sore knee that hurts when it is moved" and pain rated 7 or 8 on scale of 10 constitutes an injury for purposes of Penal Code Section 243).

Setting aside our specific concerns about Officer [REDACTED] these incidents also illustrate several problems with CDCR's accountability system—problems we have raised repeatedly over the last several years. For example, as we have pointed out before, CDCR undermines its own progressive discipline system by stipulating to lesser penalties when clear evidence establishes that misconduct occurred. The first two incidents should have resulted in penalties higher than Level 1. But the slap on the wrist that CDCR gave Officer [REDACTED] made it more likely that he would engage in dangerous conduct and harm class members in the future, which he did.

The third case highlights how inadequate and untimely investigations can result in officers avoiding appropriate discipline. There, the investigator either ignored or downplayed Officer [REDACTED] actions, focusing myopically on the only officer named in the class member's allegations. And even assuming the investigator's report had accurately described Officer [REDACTED] misconduct, the investigation was not completed until the day after the statute of limitations had expired. So, the Hiring Authority would have had no opportunity to discipline Officer [REDACTED]

In addition, the fourth incident shows an officer ignoring the obvious indicia of a class member's disability—and indeed the class member's repeated request for a reasonable accommodation—because, in the officer's own uninformed judgment, the class member's disability was not severe enough to warrant an accommodation.

Finally, in combination and viewed over time, these cases show the failure of the system to recognize a problematic pattern of behavior and how the slow pace of investigations allow a single officer to repeatedly harm class members without receiving any interventions such as interim training or guidance that might prevent future, continued misconduct. Indeed, as the timeline below illustrates, the Hiring Authority did not discipline Officer [REDACTED] for his June 2024 suplex of Mr. [REDACTED] for more than a year. And while that investigation proceeded deliberately, Officer [REDACTED] used excessive or unnecessary force against three more class members.

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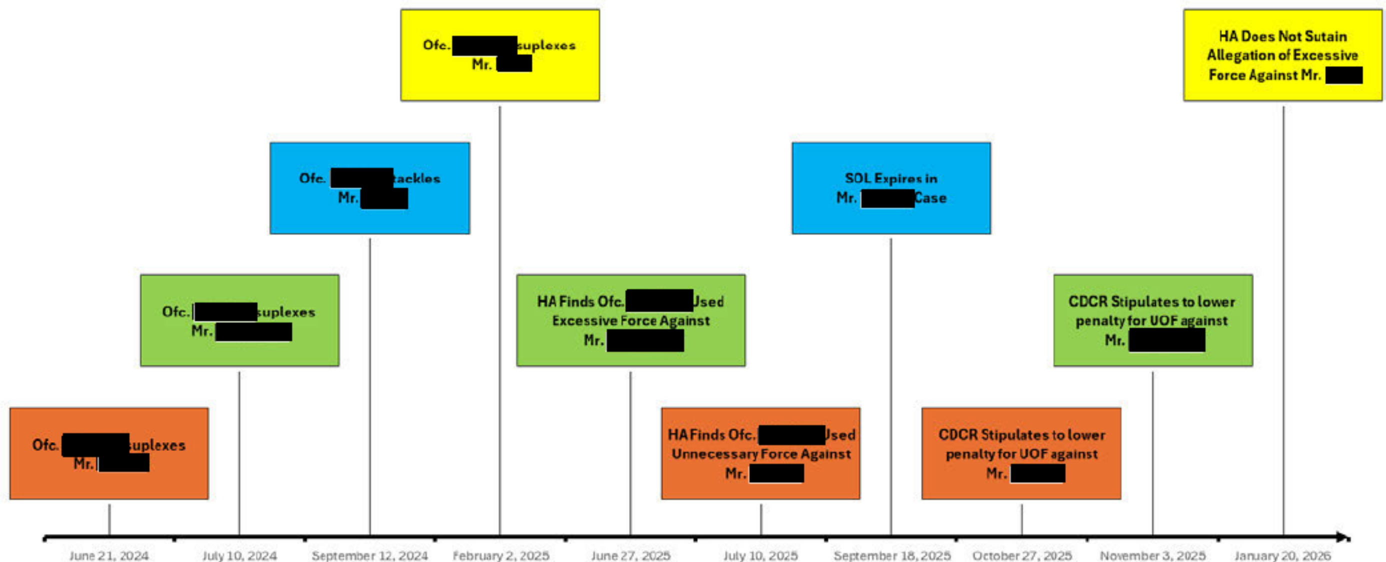

Plaintiffs' counsel request to know:

1. What, if any, information in Defendants' accountability system should have led to the Hiring Authority or other CDCR management to detect a pattern of allegations of serious use of force incidents involving the same officer?

2. What, if any, action could have been taken by the Hiring Authority had Defendants' accountability system led to the Hiring Authority or other CDCR management detecting a pattern of allegations of serious use of force incidents involving the same officer?

3. What, if any, information in Defendants' accountability system should have led investigators to connect these allegations for the benefit of Hiring Authority decision-making?

4. What, if any, action could have been taken by investigators in these cases to connect these allegations for the benefit of Hiring Authority decision-making?

5. Are there currently any other pending use of force allegations against Officer [redacted] currently under investigation by CDCR? If so, how many? What steps will be taken to ensure that investigators and the Hiring Authority are aware of the problematic pattern of sustained and non-sustained cases involving this single officer?

6. Plaintiffs' counsel request that, given conduct revealed on footage where this officer has acted in complete disregard of people's disabilities and has rushed to use

dangerous force when there is no imminent risk of harm, this officer be immediately re-assigned to a position in which he does not come into direct contact with incarcerated people with disabilities or serious mental health issues. Please report on what action is taken in response to this request.

II. OTHER FAILURES TO HOLD OFFICERS ACCOUNTABLE FOR USING FORCE

Plaintiffs' counsel continue to identify a number of cases each quarter in which CDCR's accountability system fails to hold staff accountable for serious use of force incidents. Some cases show a failure to confirm violations of policy that otherwise appear very clear in video footage. In other cases, staff are not held accountable despite violations of policy being confirmed by the Hiring Authority. In all cases, these examples represent ongoing failures of Defendants' accountability system.

The OIG's recent report corroborates problems with hiring authority decision-making. *See* Cal. Off. of the Inspector Gen., Monitoring Internal Investigations, Staff Misconduct Complaint Investigations, and the Employee Disciplinary Process of the California Department of Corrections and Rehabilitation: Semiannual Report, July–December 2025 (May 2026) ("May 2026 OIG Report"). Specifically, the OIG disagreed with nearly a quarter of all hiring authority decisions regarding whether to sustain an allegation of misconduct. *Id*. at 61 (explaining that it disagreed with 24 percent of decisions made by the CARU and 23 percent of decisions made by non-CARU hiring authorities). In one case described in the report, a CARU hiring authority initially sustained an allegation of misconduct after an officer allegedly slammed a handcuffed incarcerated person to the ground during an escort, fracturing his nose. *Id*. However, before imposing discipline, the hiring authority changed his mind and did not sustain the allegation, stating the incarcerated person's injury should not be a factor in the decision to the sustain misconduct. *Id*. The OIG disagreed, finding that "the force must be proportionate to the threat posed by the incarcerated person." *Id*.

The OIG's concerns with hiring authority decision-making are broader than just their decisions to sustain allegations. The chart below summarizing the OIG's findings indicates that the OIG also disagreed with the penalty that the hiring authority assessed in 48 percent of cases, and disagreed with the hiring authority's settlement with the disciplined employee in 86 percent of cases. The relevant category for our review, "Staff Misconduct Complaint," is highlighted in yellow:

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Table 2. OIG Disagreements With Hiring Authorities' Decisions

Case Type	Disagreement with Allegation Findings	Disagreement with Penalty	Disagreement with Settlement	Disagreement at Any Juncture
Administrative Disciplinary and Criminal	13% (24/178 cases)	16% (23/145 cases)	37% (20/54 cases)	30% (53/178 cases)
Staff Misconduct Complaint	23% (32/141 cases)	48% (14/29 cases)	86% (6/7 cases)	27% (38/141 cases)
Totals	**18% (56/319 cases)**	**21% (37/174 cases)**	**43% (26/61 cases)**	**29% (91/319 cases)**

Source: The Office of the Inspector General Tracking and Reporting System.

The cases below include examples of the failure to identify violations and the failure to impose appropriate discipline:

1. SATF-[REDACTED] – AIU, Not Sustained

In this incident, an officer used unnecessary and excessive force when he slammed a class member with a mobility disability to the ground while the class member was handcuffed and flanked by two other officers. Plaintiffs' counsel reported on an incident where this same officer similarly body slammed another incarcerated person in our last quarterly report. *See* Plaintiffs' February 2026 Review of CDCR's Accountability System at the Six Prisons at 7–8 (Feb. 6, 2026). The Hiring Authority did not sustain any misconduct in either case and, similar to the cluster of cases reported above, there is no apparent acknowledgement of the pattern of problematic behavior exhibited by this officer.

Prior to the primary use of force, [REDACTED] ([REDACTED]), a 72-year-old class member, and Officer [REDACTED] were in a verbal dispute related to photos that Mr. [REDACTED] claimed were missing after a cell search. Over the course of about two minutes, the dispute escalates, with Mr. [REDACTED] refusing to follow Officer [REDACTED] orders to return to his cell. *See* BWC 1 at 3:30:30-32:24. The dispute culminates with Officer [REDACTED] radioing that he has a disruptive inmate, pointing his pepper spray at Mr. [REDACTED] face, and ordering Mr. [REDACTED] to "get on the ground." *Id*. at 3:32:25-33. Mr. [REDACTED] does not get on the ground, but instead turns his back to Officer [REDACTED], places his hands at his side, and suggests that Officer [REDACTED] place him in handcuffs. *Id*. at 3:32:34-36. Before restraining Mr. [REDACTED], Officer [REDACTED] forcibly removes Mr. [REDACTED] cane from his hands and tosses it to the ground. *Id*. at 3:32:38-41. Ultimately, Officer [REDACTED] handcuffs Mr. [REDACTED] behind his back. *Id*. at 3:32:43-51.

By the time that Officer [REDACTED] finishes applying the handcuffs, five officers, including Officer [REDACTED], surround Mr. [REDACTED]. *See* AVSS at 3:32:50. Officer

then begins to escort Mr. *Id.* at 3:32:54. Depending on the camera angle, Mr. then appears either to move or stumble in Officer direction, or to resist the escort slightly. *See* AVSS (linked above) at 3:32:54-58 (showing Mr. stepping in Officer direction); BWC 2 at 3:32:54-57 (same); BWC 3 at 3:33:02-06 (showing Mr. torso remain relatively stationary). Officer tugs on Mr. arm and says, "I'm walking you." *See* BWC 1 (linked above) at 3:33:05; BWC 3 (linked above) at 3:33:02. Mr. responds, "Walk, then," and shuffles or stumbles in Officer direction. *See* BWC 3 (linked above) at 3:33:04. Officer again says "I'm walking you," and Mr. appears to say "I'm gonna walk." *See* BWC 3 (linked above) at 3:33:06. Officer says, "I'm walking you," once more as Officers and move towards Mr. from behind and the left, respectively, and place their hands on Mr. arms. *See* BWC 2 at 3:32:57 (linked above). Officer then wraps his arms around Mr. waist, lifts him off the ground, drops backwards, and slams Mr. onto the ground. *See* BWC 1 (linked above) at 3:33:08-11; AVSS (linked above) at 3:32:58-33:03. Officer was on the scene for less than twenty seconds before he body slammed Mr.

During the IERC's review of the incident, a captain determined that the use of force may have been unnecessary or excessive and requested an investigation. In the request, he wrote that Mr. "had been restrained and was being escorted without his [cane]"; that Mr. neither made "threatening remarks" nor "physically pose[d] a threat to staff safety as he was being escorted"; and that "[i]t appeared as though there was a sufficient amount of staff who responded to this incident to complete the escort without lifting and forcing a restrained [Mr. to the ground." *See* Memorandum re: Request for Administrative Review (Oct. 17, 2024); *see also* AIU Report at 2. The AIU then conducted a generally thorough investigation into the use of force, gathering video and other evidence and interviewing officers. Following the investigation, the Hiring Authority did not sustain the allegation of excessive and/or unnecessary force against Officer

The Hiring Authority's decision was wrong. The Hiring Authority should have sustained allegations of misconduct against Officers and First, Officer failed to accommodate Mr. mobility disability by ripping Mr. cane away from him and not returning it before escorting Mr. out of the unit. Officer failure to return Mr. cane also likely contributed to the perception that Mr. was resisting the escort, when in fact, it appears he was stumbling in the direction Officer pulled him and then attempting to regain his balance. Second, at the time Officer used force, Mr. did not present an imminent threat. Mr. willingly submitted to handcuffs and was attempting to comply with the escort. An immediate use of force was therefore not justified under CDCR policy. *See* 15 C.C.R. § 3268(4) (allowing the use of immediate force only "to respond to a situation or circumstance that constitutes an

imminent threat to institution/facility security or the safety of persons"); DOM § 51020.4(a)(4)(A) at 1 (same).

Even assuming that Captain interpretation of events was wrong and Mr. resisted his escort, justifying some amount of immediate force, Officer used significantly "more force than [was] objectively necessary to accomplish a lawful purpose." *See* DOM § 51020.4(a)(3)(A). Put simply, body-slamming a handcuffed senior citizen who has a mobility disability, and who is surrounded by four other officers, is objectively unreasonable. What's more, by using force in this situation, and this level of force, Officer also failed to reasonably accommodate Mr. disability. *See Armstrong v. Newsom*, 484 F. Supp. 3d 808, 824 (N.D. Cal. 2020) ("A failure to provide a reasonable accommodation can occur where a correctional officer could have used less force or no force during the performance of his penological duties with respect to a disabled person").

Plaintiffs note that Officer has a history of body slamming *Armstrong* class members. In our last report, we wrote about an incident during which Officer grabbed a blind class member around the waist, picked him up several feet off the ground, and slammed him head-first into the asphalt. *See* Plaintiffs' February 2026 Review of CDCR's Accountability System at the Six Prisons at 7–8 (Feb. 6, 2026) (discussing SATF- The use of force was very similar to the use of force in the instant case. That incident occurred a little less than three months before the incident described above. CDCR's failure to hold Officer accountable creates an unsafe situation for class members and staff.

2. SATF- – AIU, Not Sustained

In this incident, officers' failure to reasonably accommodate ( ) a 69-year-old class member with a mobility disability, lead to an unnecessary use of force. Mr. uses a walker and has a special cuffing restriction. According to the investigation report, officers were escorting Mr. across the yard following a verbal dispute with officers in his housing unit. Video of the escort shows two officers flanking Mr. accompanied by a third officer. *See* AVSS at 3:48:11. Mr. does not have his walker, and his hands are cuffed behind his back. *Id.* at 3:48:29. The officer on Mr. left, Officer is holding Mr. by the arm. *Id.*

Shortly after the group reaches the basketball court, Mr. slows down and says, "Excuse me, can I pull my pants up?" *See* BWC at 3:48:28. Officer responds, "You gotta ask before. I don't know what your intentions are." *Id.* at 3:48:29-30. Mr. replies, "Yeah well you got eyes, shit. I just got finished telling you, [turns to read the officers name] stop pulling on my arm." *Id.* at 3:48:32-41. Officer tells Mr. to stop looking at him, and when Mr. looks at him again, Officer shouts "Look forward!" *Id.* at 3:48:40-42. Mr. then

turns to the officers on his right and asks, "What's wrong with your boy?" referring, presumably, to Officer *Id.* at 3:48:43-46.

Then, again addressing Officer Mr. says "Look man," while appearing to slow down the escort. *Id.* at 3:48:49-50. Officer shouts, "Don't stop my escort, man." *Id.* Mr. begins to ask "Why are you? Why are you?" when Officer forces Mr. to the ground. *Id.* at 3:48:51-52; AVSS (linked above) at 3:48:50-52. When Officer then radios for a "resistive inmate," Mr. shouts: "How am I resisting man? I asked you ten times to stop pulling on me. I asked you three times: would you stop pulling on me. I'm an old man. I got problems with my knees. I got a walker, you didn't bring that?!" *Id.* at 3:48:57-3:49:12. He continues to explain that he "can't walk as fast" as Officer *Id.* at 3:49:17-24. When a fourth officer arrives and asks Mr. what's going on, Mr. says: "I got a walker. I told them I can't be walking that fast. And he gone tell me don't look at him? And then when I say 'listen my pants coming down, I can't walk as fast as you,' he's pulling on me and acting all rough. He's abusing me. And then he's gone push me down?" *Id.* at 3:49:31-49.

As a result of the use of force, Mr. suffered injuries to his shoulder and knee, and Officer injured his knee. *See* 7219 at 11 (7219 at 13 (

Mr. filed a 602 alleging that Officer failed to accommodate his mobility disability during the escort, which resulted in an unnecessary and excessive use of force. *See* 602 at 4-5. The Hiring Authority, however, "exonerated" Officer of the allegation. *See* 402/403 at 1.

The Hiring Authority should have sustained allegations of misconduct against Officer First, Officer and the other escorting officers failed to accommodate Mr. mobility disability by not providing him with his walker or any assistive device, then walking him across uneven terrain at a pace that he was unable to maintain. That failure alone should have been sufficient evidence to sustain an allegation of staff misconduct. Second, Mr. was not an imminent threat at the time Officer used force. Mr. was repeatedly slowing down the escort because his disability was not accommodated, not because he was being resistive. And even if he did not have a mobility disability, his pants were falling down; slowing down the escort to allow him to secure his pants around his waist is also not resistance. Officer was therefore not permitted to use immediate force merely because Mr. could not keep up with the pace of the escort.

Force likely could have been avoided in this situation had the escorting officers reasonably accommodated Mr. disability by allowing him to use his walker

during the escort and observing his special cuffing chrono,[8] or simply walking more slowly, as Mr. ██████ repeatedly requested. Instead, Officer ████████ failures to accommodate Mr. ██████ resulted in an unnecessary use of force that injured Mr. ██████ and Officer ███████

In addition, the investigation into this incident was incomplete. While Mr. ██████ was on the ground after the use of force, he repeatedly stated that he asked to be able to use his walker and for the officers to walk more slowly. The investigator should have reviewed and included in the case file additional video of the officers cuffing Mr. ██████ and starting the escort to determine whether Mr. ██████ had asked for accommodations. Instead, the video in the case file starts only 30 seconds before the use of force, well after the escort began.

3. LAC-███████ – AIU, Sustained (L4 for two officers, L3 for one officer)

In this case, the CARU found that three officers involved in a use-of-force incident omitted material facts in their incident reports, a violation with a baseline Level 4 penalty. However, the officers' incident reports not only omitted material facts, but also contained intentionally false and misleading statements, a violation with a baseline Level 7 penalty. The failure of the CARU to sustain the more serious allegation resulted in a failure to hold the officers sufficiently accountable for their serious misconduct.

The BWC video shows ███████████ (████████████) standing in a hallway, in waist chains, in the ████████████████████████ leaning against a wall next to an open ███████████████████████████ cell. Lieutenant ███████ Officer █████ and Officer ██████ are surrounding Mr. ██████ Mr. ██████ is speaking peacefully with the officers but is refusing to enter the ██████ cell. While Mr. ██████ is speaking with Lieutenant ███████ Officer ██████ says: "ready?" A moment later, he sneaks up behind Mr. ██████ grabs his waist restraints, and uses a great deal of force to yank Mr. ██████ backwards approximately ten feet. In the same motion, he hurls Mr. ██████ to the ground in the cell. *See* BWC (linked above)at 18:55:38. Officer ██████ then lifts Mr. ██████ by the waist restraints onto the bed in the ██████ cell. *See* BWC(linked above) at 18:55:43. The officers then strip off his clothes and remove the restraints. Lieutenant ███████ Officer █████ Officer ███████ then exit the cell and secure the door. *See* BWC (linked above) at 18:57:18.

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[8] DOM 51020.6. ("Incarcerated persons who have a disability that prevents . . . application of restraint equipment in the prescribed manner shall be afforded reasonable accommodation under the direction of the Response Supervisor. Mechanical restraints shall be applied to ensure effective application while reasonably accommodating the incarcerated person's disability.")

CDCR opened an investigation into the use of force when, during the first level of IERC review, a captain found that the officers' incident reports were not consistent with video of the incident. Specifically, the captain wrote that "Officer ███ reported a perceived threat when he stated that ███ attempted to pull forward and lunge towards Officer ███ however, the video evidence does not show that ███ lunged toward Officer ███ *See* Exhibits at 6.

Following an AIU investigation, the CARU correctly identified that the use of force was unnecessary because Mr. ███ was not an imminent threat. *See* IRT at 6. In addition, the CARU also found that Officers ███ and ███ "failed to include a critical fact" in their incident reports, when they wrote that Officer ███ "assisted" Mr. ███ to the bed, rather than writing that Officer ███ lifted Mr. ███ by the waist restraints onto the bed. *See* 402/403 ███ 402/403 ███ NOAA ███ at 19; NOAA ███ at 19. The CARU determined that this "materially understate[d] the level of physical engagement that occurred." *See* 402/403 ███ and 402/403 ███ at 2. The CARU also found that Lieutenant ███ failed to review the officers' incident reports to ensure accuracy and content. *See* 402/403 ███ at 2.

With respect to discipline, the CARU determined that all three officers violated category E.4 on the Disciplinary Matrix for "making evasive statements, failing to report, or omitting material facts or information to a supervisor by sworn staff." Category E.4 carries a baseline penalty of Level 4, and a range between Levels 2 and 7. The CARU imposed Level 4 penalties on Officer ███ and Lieutenant ███ (10% salary reduction for 12 pay periods) and a Level 3 penalty on Officer ███ (5% salary reduction for 6 qualifying pay periods). Ultimately, after the officers appealed the discipline to the State Personnel Board, the CARU agreed to reduce the discipline—the CARU reduced Officer ███ penalty to a 10% salary reduction for 10 pay periods (still Level 4), Officer ███ penalty to a 5% salary reduction for 5 pay periods (still Level 3), and Lieutenant ███ penalty to a 10% salary reduction for 6 pay periods (below a Level 4 penalty). *See* Stipulations and Releases for Officer ███ Officer ███ and Lt. ███

Though it is appropriate that the CARU imposed some adverse action in this case, the CARU made a host of errors that resulted in insufficient accountability for the officers. The most serious error, by far, was failing to conclude that the Officers ███ and ███ made intentionally false or misleading statements in their incident reports (Matrix category E.5, 456789). Both officers wrote in their incident reports that the force against Mr. ███ was justified because Mr. ███ pulled away from Officer ███ and lunged toward Officer ███ and that Mr. ███ "fell" to the ground. *See* ███ Incident Report at 34 ("Inmate ███ pulled away when I grabbed his waist chain from the middle of his back, he attempted to pull forward and lunge towards Officer ███ With my right hand I grabbed the chain portion of the waist restraint and pulled

back towards me. With a combination of [sic] and my body weight coupled with his forward momentum and me pulling backward simultaneously, he spun around causing inmate to fall to the ground inside the cell.”); Incident Report at 35 (“While the inmate was being escorted by Officer inmate without warning lunged forward towards me, causing officer [sic] utilizing physical force, to pull the restraints towards him causing the inmate to land on the floor inside of cell #1.”). But the video footage does not show Mr. lunging toward Officer nor does it show Mr. falling to the ground. Instead, it shows Officer grabbing Mr. without warning, dragging him ten feet backward by the waist restraints, and then tossing him to the ground. What is particularly damning is Officer asking Lieutenant if he was “ready;” that question suggests that Officer had a premeditated plan to use force and undermines any assertion that he used force in response to any lunge by Mr. Put simply, the officers lied in their reports to manufacture a threat where none existed and to minimize the impropriety of the force Officer used.

For reasons unclear, the CARU did not, in either the 402/403s or the NOAAs, address these false statements in the incident reports. This failure is especially notable because the falsity of these statements, identified during the first level of IERC review, led to the opening of the investigation in the first place. Instead, the CARU focused on the much less important, albeit still misleading, statements the officers made regarding lifting Mr. onto the bed by his waist chains. Had the CARU identified the intentionally false statements made by the officers in their incident reports, category E.5 of the Matrix, along with its higher baseline Level 7 penalty, would have applied and the CARU likely would have imposed a more serious punishment on the officers.

The CARU also erred by applying the wrong Matrix category to the dishonesty violation that the CARU did identify. Category E.4, which is what the CARU applied, covers “making evasive statements, failing to report, or omitting material facts.” Category E.5 applies to “making intentionally false or intentionally misleading statements regarding a material fact or intentionally omitting a material fact.” Officers and both indicated that Officer “assisted” Mr. to the bed when, in fact, he used force to lift him by the waist chains onto the bed. Their description of Officer conduct was “intentionally misleading.” It was not “evasive” and did not involve a negligent omission of a material fact. Accordingly, the CARU should have found that category E.5 and its higher penalties applied to this misconduct.

The CARU also erred by misapplying aggravating and mitigating factors. The CARU found a host of aggravating factors and two mitigating factors—“the misconduct was unintentional and not willful” and “the misconduct was not premeditated.” But neither of those mitigating factors should have applied here. The evidence strongly suggests that the officers intentionally lied on their incident reports. Accordingly, the

CARU should have found additional aggravating factors for intentionality and premeditation.

4. COR- – AIU, Sustained (Letter of Instruction)

In this case, the Hiring Authority sustained an allegation of unnecessary force, determining that the officer violated policy by using force when he threw a handcuffed class member to the ground. However, the Hiring Authority failed to apply the appropriate matrix category and instead only issued corrective action.

In this case, Officer is escorting ( ) from his cell in the to the recreation yard. *See* BWC. Upon opening Mr. cell door, Officer grabs Mr. bicep, and Mr. says that he can walk on his own and the officer does not have to hurt him. He then takes a few steps out of his cell, and another officer searches Mr. with a handheld metal detector wand. *See* BWC (linked above) at 17:48:40; AIU Report at 4. Mr. expresses his frustration because he believes that he is being singled out for additional searching. After about 15 seconds, the escort continues, but Mr. stops again and tells Officer not to hurt him by grabbing his arm. *See* BWC (linked above) at 5:48:49. Officer tells him that he is not hurting him, and Mr. becomes loud and agitated. Officer quickly grabs Mr. who is handcuffed and has a mobility disability, and pulls him to the ground. The fixed camera provides a clearer view of the force. *See* AVSS.

The Hiring Authority sustained the allegation of unnecessary force, finding that "there was no imminent threat that required the use of physical force to pull IP to the ground." *See* Closure Documents at 7 (Letter of Instruction). The Hiring Authority determined that Officer failed to perform within the scope of his training (D26, **1**2345) and used unnecessary force (L1, 1**2**3). The Hiring Authority found several mitigating factors and several aggravating factors but only imposed corrective action. *See* 402/403. It is unclear why the Hiring Authority did not impose adverse action. Consistently failing to apply the base penalty set forth in the matrix—and only imposing corrective action—when officers engage in dangerous and violent behavior sends a message that CDCR does not take seriously enough staff's repeated use of improper force.

5. COR- – AIU, Not Sustained

In this case, an officer used unnecessary force against a handcuffed class member during an escort in COR's . The Hiring Authority failed to sustain the allegation of unnecessary force. Two officers are escorting ( ) from his second-tier cell in the to the recreation yard. *See* BWC at 17:41:02 to 17:41:08; AVSS. Mr. is handcuffed behind his back, with Officer holding Mr. bicep and the second officer a couple steps behind. When they reach the

bottom of the stairs, Mr. ████ stops and tells Officer ████ to let go of him and asks him what he is doing. *See* BWC (linked above) at 17:41:10 to 17:41:12. He appears to be reacting to Officer ████ grabbing him or pulling him. Officer ████ tells him to look forward and keep walking. Mr. ████ complies, and they take a few more steps. As he continues walking, Mr. ████ turns his head very slightly to look at the officer—the movement is so small it is basically imperceptible on the fixed camera footage—and Officer ████ immediately pulls him to the ground. *See* BWC (linked above) at 17:41:12 to 17:41:18; AVSS (linked above). Mr. ████ received a serious RVR for "Resisting Staff" for his actions prior the force. *See* CDCR Rules Violation Report.[9]

The Hiring Authority should have sustained an allegation of unnecessary force. As we have reported many times in our quarterly reports, the escort officer was not justified using force in this case. Mr. ████ slightly turning his head towards the officer does not represent an imminent threat or resistance. *See* 15. C.C.R. § 3268(4) (allowing an immediate use of force only in response to an "imminent threat"); DOM § 51020.4(a)(4)(A) (same); *see also* 15. C.C.R. § 3268(5); DOM § 51020.4(a)(5)(A) (defining "imminent threat" as "any situation or circumstance that jeopardizes the safety of persons or compromises the security of the institution, requiring immediate action to stop the threat"). Instead of resorting to a dangerous use of force on a restrained class member, Officer ████ had many options: he could have stopped the escort, given another verbal warning to Mr. ████ to look forward, or threatened an RVR. But quickly throwing him to the concrete floor was not allowed under policy and was dangerous. Such unnecessary uses of force further strain relationships between staff and the incarcerated population. In our quarterly reports, we have written about many unnecessary and excessive uses of force that have occurred in COR's ████. Officers repeatedly violating policy in ways that can and do harm class members, in view of the entire building, creates a terrible culture and dynamic between staff and the incarcerated population.

6. KVSP-████ – AIU, Not Sustained

Officers in this case tricked an incarcerated class member into leaving his cell in order to transfer him—against his will—resulting in a foreseeable use of force incident that unnecessarily endangered themselves, the class member, and institutional safety and security.

On the morning of December 5, 2024, an ICC committee found that ████ ████ (████) could be released from the ████ (where he had been

[9] Neither the body-worn camera footage nor the fixed camera footage appear to show Mr. ████ resisting at any time after he was ordered to continue walking. He did slightly turn his head towards Officer ████ while walking, but that behavior does not amount to "resisting" and should not have justified the issuance of an RVR.

housed due to safety concerns) and transferred to [REDACTED], temporarily, pending transfer to SVSP. *See* Classification Committee Chrono at 14. Mr. [REDACTED] claims that the committee was held in absentia despite his stated desire to appear in person to voice his concern that his life would be in danger on [REDACTED] *See* 602 at 1-2. (Mr. [REDACTED] made separate misconduct allegations against [REDACTED] regarding denial of his due process rights.) On being informed that he would be transferred from the [REDACTED] to [REDACTED] that day, Mr. [REDACTED] repeated his objection to the move because he was [REDACTED], and because he believed that [REDACTED] was not appropriate housing for his case factors, and that his life would be in danger there. *See* 602 at 3. He requested to speak with the Captain, unsuccessfully. *See* 602 at 3. At this point, [REDACTED] staff were aware that a controlled use of force might become necessary in order to effect his transfer.

Instead of initiating controlled use of force protocols, which are designed to put people on notice that force is imminent and to allow them time and opportunity to comply in order to avoid force altogether, staff lured him out of his cell to receive his insulin and then coordinated to force his immediate transfer, while he was out of his cell, by pulling him in the direction of [REDACTED], rather than back to his cell. *See* BWC; AIU Report at 7; and 602 at 3. Mr. [REDACTED] who claims staff did not tell him he would be transferred at this time, acknowledges that he resisted the officers' pull toward [REDACTED] resulting in Officers [REDACTED] and [REDACTED] using physical force to pull him to the ground. *Id*. Mr. [REDACTED] continued to object, stating "Nah, Nah, that's bullshit." *See* BWC (linked above) at 16:09:10. Officer [REDACTED] assisted in gaining compliance from Mr. [REDACTED] and placing him in leg restraints until his eventual placement on a gurney. *See* AIU Report at 7. Although the escorting officers forced his transfer to [REDACTED], documents confirm, consistent with his assertions, that he should not be housed on [REDACTED], and he was quickly returned to the [REDACTED] where he remained. *See* 602 at 4; *see also* Intrafacility Transfer 24.1 notes dated 12/5/2024 (order given at 16:46 PST transferring back to [REDACTED] approximately 20 minutes after being received in [REDACTED]; Disciplinary Hearing Results at 48 (1/10/2025 indicating still housed in [REDACTED] ([REDACTED]).

Mr. [REDACTED] received a 115 for Willfully Resisting a Peace Officer. During his RVR hearing, Mr. [REDACTED] admitted to pulling his left arm away from Officer [REDACTED] but clarified, "I did because I was expecting to go back to my cell and not out of the building. Nobody told me I was going to [REDACTED]." *See* RVR at 52.

The CARU did not sustain any force violations in this case. *See* 402 at 2, 8; *see also* 3035. The review focused narrowly on the question of whether Mr. [REDACTED] was "resisting" giving rise to the need for immediate force. *See* 3035. However, the larger question of whether staff violated policy by circumventing the controlled use of force process in this case was never considered. Had staff utilized controlled force, it is possible that no force was necessary. Furthermore, the actions of the officers in this case escalated the encounter, making an immediate use of force almost inevitable, when policy instead requires staff to attempt to deescalate encounters, including through the use of

verbal persuasion. *See* 15 C.C.R § 3268(b)(1). Failing to tell Mr. [REDACTED] that he would be transferred if he exited his cell—while staff were well aware that he was attempting to remain in the [REDACTED] due to safety concerns—resulted in a very foreseeable immediate use of force incident that occurred in an open, busy, area of the prison that placed multiple other staff and incarcerated people at risk. This deception likely eroded his trust in staff and impacted his willingness to seek help from staff including to leave his cell for medical treatment for his serious condition in the future.

Plaintiffs' counsel have reviewed multiple cases where staff have tricked class members into exiting their cells for one purported purpose only to force an involuntary transfer on them once out of their cell.[10] In none of these cases has CDCR confirmed any violation of policy. **Please confirm whether CDCR views this practice as a violation of controlled use of force policies.**

III. FAILURE TO HOLD STAFF ACCOUNTABLE DUE TO THE FAILURE TO RETAIN VIDEO FOOTAGE

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 but continue to find a number of cases each quarter where video has not been retained.

Plaintiffs' counsel did not inventory whether video was retained appropriately in all cases, however, through our random review of select cases we continue to encounter multiple cases where video was not retained. Below are several examples of cases with video retention issues.

1. SATF-[REDACTED]

A class member alleged in a grievance filed on August 18, 2024, that staff used excessive and unnecessary force against him on August 5, 2024. *See* 602 at 3-4. The investigator in this case relied on BWC footage preserved as part of the RVR hearing process, which only captured 90 seconds of the interaction between the class member and staff before the use of force incident begins. *See* AIU Report at 5. In the investigation report, the investigator incorrectly noted that "[n]o additional AVSS or BWC files were available for review, as the video retention period was exceeded at the time the allegations were made." *See* AIU Report at 5. In fact, the class member reported the allegations less than two weeks after the incident and AIU was assigned the case within

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[10] One such case was previously reported in Plaintiffs' May 20, 2024 Report at 32.

three weeks of the incident. An investigator was assigned on October 10, 2024, still within the retention period. *See* AIU Report at 1. It is also not clear why additional video was unavailable, as the use of force was a triggering event that should have led to the preservation of video.

2. SATF-[redacted]

A class member alleged that on January 2, 2025, staff committed an act of sexual misconduct while the class member was in a holding cell. The allegation was forwarded to AIU for investigation on January 9, 2025, an investigator was assigned the case on February 20, 2025, and it was reassigned to a different investigator on March 14, 2025. *See* AIU Report at 1. The investigator did not request video evidence until April 7, 2025, five days after the video was no longer available. *See* AVSS/BWC Request at 61. As a result, the investigator failed to obtain video evidence vital to investigate whether the alleged serious staff misconduct occurred.

3. LAC-[redacted]

A class member alleged that on August 15, 2024, at about 5:50 pm, a named sergeant forced another incarcerated person into a cell despite possible safety concerns. The investigator was assigned to the case on September 5, 2024. *See* AIU Report at 1. The investigator did not obtain video and claimed in the investigation report that "[d]ue to the lack of specific information from both [the class member and the alleged victim], no AVSS or BWC footage could be identified or requested." *See* AIU Report at 6. However, the class member's 602 in fact provided specific information about the date, time, and subject. *See* 602 at 3.

4. LAC-[redacted]

A class member made a verbal allegation that on July 18, 2024, a named sergeant kicked his walker and kicked him in the leg, as well as made PREA-related allegations. LAC staff reported reviewing the AVSS and not seeing any interaction between the subject and claimant. *See* Exhibits at 4. However, that AVSS was not preserved. AIU was assigned the investigation on August 16, 2024, within a month of the incident, but the investigator was not assigned until January 9, 2025, outside the 90-day retention period. The investigation was then reassigned on July 3, 2025. *See* AIU Report at 1. Neither LAC or AIU took any action to preserve the AVSS footage, or attempt to obtain additional footage. Accordingly, AIU was unable to verify the allegations, including whether the sergeant kicked the class member's walker.

5. LAC-[redacted]

A class member alleged that on October 8, 2024, a named control booth officer endangered him by stating that the class member was delaying showers. *See* 602 at 3.

The class member filed a grievance the same day. The investigator requested footage on January 3, 2025, within the retention period. *See* NICE Request at 14. Apparently, no BWC was located for the officer, only AVSS—but whether there was misconduct turned on what the officer said, and thus BWC was necessary to investigate the allegation. *See* AIU Report at 4. The AIU Report offers no information about why the BWC footage was missing, despite it being requested within the retention period.

In at least five other cases from LAC alone this quarter, CDCR failed to retain video footage necessary to investigate the staff misconduct allegations. *See* **LAC-[redacted]**; LAC-[redacted], LAC-[redacted], LAC-[redacted], LAC-[redacted].

IV. FAILURE TO HOLD STAFF ACCOUNTABLE DUE TO THE FAILURE TO COMPLY WITH THE STATUTE OF LIMITATIONS

Plaintiffs' counsel continue to encounter cases each quarter where discipline cannot be imposed because the statue of limitations has expired. As Defendants have acknowledged, the significant backlog of open, pending investigations means that many cases are reaching or are past the statute of limitations to impose discipline. The OIG confirmed this issue in their recent report. *See* May 2026 OIG Report at 33. According to the OIG, the AIU closed 5,379 cases in 2025 and finished the year with 13,393 open investigations. *Id*. "Of the 5,379 investigations the [AIU] closed in 2025, the deadline to impose discipline had expired before the investigations concluded in 265 investigations, or 5 percent." *Id*. However, "[o]f 13,393 investigations that were open at the end of the year, the deadline to impose discipline had already expired in 1,774 investigations, or 15 percent." *Id*. As Defendants have warned, the issue of cases being lost to the statute of limitations is worsening.

One of the problems that the OIG identified is understaffing. The total number of OIA cases continues to grow each year (10,963 in 2022; 12,659 in 2023; 12,602 in 2024; and **24,224** in 2025), but the total number of investigators has remained relatively constant:

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Table 5. Investigator Staffing Within the Allegation Investigation Unit

Date	Filled Positions	Vacant Positions	Allocated Positions
January 1, 2024	95	14	109
January 1, 2025	88	33	121
January 1, 2026	95	28	123

Source: The California Department of Corrections and Rehabilitation.

Id. at 34.

With more allegations of misconduct to investigate but no increase in staffing, AIU investigators are carrying exceptionally large caseloads and are not able to meet the demand. According to the OIG, "even at its current allocated capacity of 123 total investigators, each investigator would still need to carry an average of 86 active investigations to process all investigations being referred to the [AIU]." *Id*. Those caseloads are unsustainable.

Below, Plaintiffs describe specific cases where the expiration of the statute of limitations precluded Defendants from imposing appropriate discipline.

1. LAC-[redacted] – AIU, Sustained (Letter of Instruction and Training, SOL Expired)

In this case, CDCR could only impose corrective action against an officer who engaged in serious misconduct—failing to effectively communicate with a deaf class member and then forging the class member's signature—because delays in the investigation resulted in OIA delivering the investigation report to the CARU on the date the statute of limitations expired. This failure is particularly egregious because CDCR knew nine months before the expiration of the statute of limitations that misconduct had occurred that likely warranted adverse action: following an LDI inquiry, an AIU manager had elevated the case for an OIA investigation, which generally occurs only when the LDI uncovered serious misconduct. This case therefore strongly suggests that CDCR is failing to appropriately prioritize cases during the AIU understaffing crisis, despite CDCR's claims to be doing so.

[REDACTED] ([REDACTED]) whose primary method of communication is written notes, filed a 602 on November 8, 2024, alleging that he did not receive indigent envelopes from Officer [REDACTED] on November 7 and that Officer [REDACTED] forged his name on the indigent envelope list, falsely indicating that Mr. [REDACTED] declined indigent envelopes. *See* Exhibits at 3. CDCR received the allegation on November 13, 2024, and determined that the statute of limitations would expire on November 12, 2025.

Officer [REDACTED] BWC footage confirmed Mr. [REDACTED] allegation. On the morning of November 7, 2024, Officer [REDACTED] was going cell to cell in Mr. [REDACTED] housing unit with a form titled "INDIGENT SUPPLIES SIGNUP LIST." *See* Exhibits at 62 (screenshot showing form). The indigent supplies list contains a column for "Inmate Signature upon receipt," so a person can confirm they received the supplies. Before reaching Mr. [REDACTED] cell that day, Officer [REDACTED] signs in the "signature" column for Mr. [REDACTED] *See* BWC at 9:09:25; *see also* Exhibits at 62-66 (screenshots from BWC). Officer [REDACTED] then approaches Mr. [REDACTED] cell, which is dark, and waves envelopes by the cell door. BWC at 9:09:35. A sign outside the door indicates that Mr. [REDACTED] has a hearing disability. *See id.* Officer [REDACTED] waves the envelopes once more, peers in the door, and steps back after about 15 seconds near the cell. *Id.* at 9:09:48.

CDCR initially routed Mr. [REDACTED] 602 to an LDI at LAC, who received the inquiry on November 22, 2024. The LDI reviewed the BWC footage, interviewed Mr. [REDACTED] Officer [REDACTED] other staff, and incarcerated witnesses, and reviewed documents. The LDI completed his inquiry on January 14, 2025. On February 21, 2025, an AIU manager elevated the case to OIA for an investigation. *See* Allegation Inquiry at 33, Exhibits at 33. That same day, the AIU assigned an investigator to the case. At this point, there were almost nine months remaining within the statute of limitations period. *See* AIU Report at 1.

The AIU investigator, however, performed no apparent investigation. On October 27, 2025, OIA assigned a new investigator to the case, just 18 days before the expiration of the statute of limitations. *Id.* Given the short time frame, the investigator conducted an acceptable investigation. He used BWC screenshots to confirm that Officer [REDACTED] signed Mr. [REDACTED] name to the column acknowledging receipt of supplies. In his November 5, 2025 interview with the investigator, Officer [REDACTED] admitted that Mr. [REDACTED] was asleep on the day in question and that he knew Mr. [REDACTED] required accommodations for his hearing disability (generally making written notes on his tablet), but that he nevertheless signed Mr. [REDACTED] name to the list even though he did not communicate with Mr. [REDACTED] at all.

The investigator did not, however, finalize the investigation report until November 12, 2025, the day the statute of limitations expired. The CARU held the 402/403 conference the same day. The CARU sustained allegations that Officer [REDACTED] violated D26 (failure to perform within the scope of duty) and E10 (falsification of material facts in reports or official records) by forging Mr. [REDACTED] signature on the

indigent supplies list. *See* 402, 403. Under the matrix, the falsification of material facts in reports or records carries a base penalty of Level 9 (which is termination), with a range of potential penalties between Level 7 and Level 9.

For reasons not clear from the case file, however, the CARU did not complete the 402/403 process until November 13, 2025, the day after the expiration of the statute of limitations. As a result, the CARU could not impose any adverse action, writing on the 403, "[d]ue to the time constraints and short statute of limitations, corrective action will be issued." The CARU issued Officer [REDACTED] a letter of instruction stating that he failed to effectively communicate with Mr. [REDACTED] and forged Mr. [REDACTED] signature. Officer [REDACTED] also had to participate in one 30-minute training.

The inexcusable delays in this case made it impossible for CDCR to impose appropriate discipline against Officer [REDACTED] for his misconduct. Defendants have represented to Plaintiffs that, notwithstanding the AIU backlog of cases, CDCR has put in place processes to ensure that it prioritizes investigations into the most serious misconduct. This case suggests that CDCR's system of prioritization is not working. Nine months before the statute of limitations, an AIU manager elevated the case for an OIA investigation. The elevation of cases occurs rarely. And when it does occur, it is tantamount to someone in CDCR shouting at the AIU to pay attention to the case. Yet CDCR still failed to process this case in time to impose adverse action against an officer who deserved such discipline.

2. LAC-[REDACTED] – AIU, Sustained (Letter of Instruction and Training, SOL Expired)

In this case, an officer endangered a class member on suicide watch by failing to maintain constant observation of the class member, who tried to commit suicide by drowning himself in his sink. Despite the fact that the investigation originated after the OIG noted the misconduct, CDCR delayed substantially in conducting the investigation. As a result, the statute of limitations expired before the investigation was complete and CDCR could not hold the officer accountable.

On the November 16, 2023, Officer [REDACTED] was assigned to provide constant observation of [REDACTED] ([REDACTED]) who was housed in cell 149. While assigned to monitor Mr. [REDACTED] Officer [REDACTED] walked away from Mr. [REDACTED] cell for nearly three minutes. Then, even after he returned to the cell, he failed to adequately observe Mr. [REDACTED] Mr. [REDACTED] placed his mouth, nose, and eyes underwater in the sink in his cell for some period of time without Officer [REDACTED] noticing. In fact, Officer [REDACTED] only recognized that Mr. [REDACTED] was trying to drown himself when an incarcerated person pointed out that Mr. [REDACTED] head was submerged in the sink. *See* BWC at 15:04:42. During the AIU investigation interview, Officer [REDACTED] admitted that he left his post observing Mr. [REDACTED] without being relieved, that he failed to properly

monitor Mr. █████ when he was at the post, and that his failures to abide by policy endangered Mr. █████ *See* IR at 10-11.

Notwithstanding this ironclad video and testimonial evidence of policy violations, CDCR was unable to impose adverse action in this case because of the expiration of the statute of limitations. The procedural history of the case is filled with multiple, inexcusable delays. In January 2024, the IERC initially reviewed the use of pepper spray and found no policy violations. In June 2024, the OIG reviewed additional footage prior to the use of force and identified the policy violations discussed above. The OIG notified CDCR of the violations on June 16, 2024, which CDCR treated as the date of discovery, meaning the statute of limitations would expire on June 15, 2025. The LAC Warden sat on the case for nearly three months, until September 13, 2024, when he submitted a request for administrative review to OIA. The CST received the allegation on September 26, 2024, and assigned the investigation to the Southern Region on September 27, 2024. At that point, the AIU still had more than 8 months to complete the investigation.

On October 4, 2024, the AIU initially assigned the investigation to one investigator, who appeared not to perform any investigative tasks. On January 17, 2025, the AIU then assigned the investigation to another investigator. That investigator requested video in March 2025 and some documents in August 2025. The investigator did not, however, interview Officer █████ until September 16, 2025, which was already after the statute of limitations expired. The investigator completed the investigation report on September 22, 2025.

In a 402/403 on October 24, 2025, the CARU sustained the allegation that Officer █████ violated policy by not providing constant observation of Mr. █████ *See* 402/403. The CARU identified that Officer █████ negligently endangered Mr. █████ (D2 on the Disciplinary Matrix, 1**2**3456) and failed to observe and perform within policy (D26, **1**2345). Even though these violations carried a baseline penalty of Level 2 and Officer █████ conduct placed Mr. █████ in serious danger that came to fruition, the Hiring Authority only imposed corrective action (a Letter of Instruction). *See* 403.

It is unclear from the file whether the Hiring Authority believed that corrective action was the appropriate discipline for this policy violation or would have imposed adverse action if the statute of limitations had not expired. Either way, the result of this case is problematic. Corrective action is not an appropriate response for an officer who failed to directly observe an incarcerated person on suicide watch such that the officer did not notice that the incarcerated person was trying to drown himself in the flooded sink.

As with the prior case, this case, where the OIG identified misconduct, suggests that Defendants' process for prioritizing cases with serious misconduct is not working.

3. LAC-█████ – AIU, Sustained (Training, SOL Expired)

In this case, LAC staff kept █████ (█████ █████[11]) in a holding cell for two days, but CARU could only issue corrective action because the AIU investigator delayed the investigation and completed it four days after the statute of limitations expired. This is especially problematic because after an initial LDI inquiry, the case was elevated to the AIU eight months before the statute of limitations expired. Further, the AIU investigation largely relied on the interviews and findings from the prior LDI inquiry, making it a relatively easy case to close well within the statute of limitations. The handling of this case, as with the prior two, indicates the AIU is failing to correctly prioritize cases to avoid losing cases to the statute of limitations.

Mr. █████ filed a 602 alleging that on September 23, 2024, Sergeant █████ and Sergeant █████ left him in holding cells for multiple days. Mr. █████ wrote that while in the holding cells, he did not receive his medication, staff gave him cold meals with no utensils, and he had no blanket or toothbrush. Mr. █████ who has a mobility disability and had a walker and cane at the time, reported that his "body ached, [his] bones ache as [he] st[oo]d and squatted for over '4' hours in the gym cage." He wrote that after some time, he was moved to a medical holding cell. *See* 602 at 3-4.

The 602 was initially routed to an LDI. The LDI interviewed Lieutenant █████ Sergeant █████ and Sergeant █████ who all stated that Mr. █████ was kept in a "medical holding cell" for about two days. *See* LDI Inquiry at 8-11. Records confirmed that Mr. █████ was placed in a holding cage starting on September 23, 2024, at 6:05 p.m., but staff failed to house him in the █████ until two days later on September 25, 2024, around 1:00 p.m. *See* Holding Cell Log, Out-Count Roster, Bed Assignments at 59-72 (cited in the LDI Inquiry at 10). Policy requires supervisory approval to keep a person in a holding cell for more than four hours. *See* LOP 511 at 81. Lieutenant █████ reported that Associate Warden April Chapman initially approved placement for "a holding cell overnight [on September 23]…[and] instructed him to work on housing the next day." The investigator failed to interview AW Chapman, but there is no evidence that she or any supervisor approved holding Mr. █████ beyond the initial overnight placement. The documents and the officers' own admissions demonstrate that Mr. █████ was held in a holding cage or holding cells for almost two days without the necessary supervisory authorization. Officer █████ also said that he "believed [Mr. █████ allegations to be true" regarding receiving cold meals. He explained that Mr. █████ would not have received a toothbrush, and he did not know whether utensils would have been provided. *See* LDI Inquiry at 10. An LVN also confirmed that

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[11] On October 1, 2025, eight days after the incident, Mr. █████ mental health deteriorated and he was placed in a █████.

Mr. ███ did not receive his medication while in the holding cell. *See* LDI Report at 8.[12]

The AIU captain who reviewed the completed inquiry referred the case for investigation on February 18, 2025, with more than eight months remaining until the October 23, 2025 statute of limitations expiration date. The AIU investigator, however, did not complete the case until October 27, 2025, which was four days after the statute of limitations expired. The case should have been easy to resolve, as the LDI inquiry included much of the evidence necessary to confirm misconduct. Indeed, the AIU investigator conducted no interviews of their own, and the AIU Report consists largely of summarizing the LDI inquiry findings. *See* AIU Report.

The Hiring Authority sustained a finding of misconduct for failure to perform within the scope of training, which carries a penalty range of 1 to 5. However, AIU's failure to complete the investigation on time meant that CARU could only impose corrective action, in the form of training. "Corrective Action will be implemented in the form of 844 training for Local OP 505 Restricted Housing Unit and Local IP 511 Holding Cell **due to the statute of limitations date expiring**." *See* 402 at 1 (emphasis added). AIU's failure prevented CARU from holding the officers accountable for leaving Mr. ███ in holding cells, including in painful conditions for his mobility disability, for almost two days. This case suggests that AIU is failing to appropriately prioritize cases. AIU elevated the case for investigation after the LDI inquiry, and the investigation took almost no additional work. AIU should have promptly completed the investigation upon referral so that CARU could hold the officers accountable.

V. FAILURE TO CONFIRM ACCIDENTAL OR UNINTENTIONAL MISCONDUCT

Each quarter Plaintiffs' counsel identify multiple cases where, despite potentially being no harm/no foul, there is definitive proof that staff misconduct occurred and CDCR fails to confirm the violation. The *Armstrong* Court was clear: "[a]ll such allegations shall be tracked, even if the non-compliance was unintentional, unavoidable, done

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[12] The LDI did not request AVSS or BWC, claiming that Mr. ███ did not provide "substantial details of evidentiary value (subjects, witnesses, time, or place) to capture the alleged event." *See* LDI Inquiry at 12. However, Mr. ███ 602 specified the date (beginning September 23, 2024), location (███ gym), and subjects (Sergeants ███ and ███ in his 602. The LDI should have reviewed AVSS footage from the Facility C gym and the medical holding area to identify the time of any interactions between Mr. ███ and staff, and then requested BWC footage from Sergeants ███ and ███ accordingly, to assess Mr. ███ allegations about the officers' treatment of him—including his comments about how uncomfortable the holding cage was given his mobility disability.

without malice, done by an unidentified actor or subsequently remedied." *See* Dkt. 2479 at 2. The following is a clear example of one such case:

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

In this case, an officer failed to reactivate his body-worn camera after an unclothed body search, in violation of policy. The investigation report provided all of the relevant information to the Hiring Authority to confirm the policy violation—the investigator correctly summarized the video evidence and properly identified the relevant policy, and the officer admitted to the investigator that he forgot to reactive his body-worn camera. However, for reasons that are completely unclear, the Hiring Authority still did not sustain the allegation.

The facts of this incident are straightforward. Officers in COR's [REDACTED] are escorting people one-by-one to the small management cages on the yard. After completing the unclothed body search, Officer [REDACTED] applies waist chains to Mr. [REDACTED] and escorts him to a cage on the yard. He closes the door of the cage and begins to remove the waist chains when Mr. [REDACTED] asks him why his body-worn camera is off. *See* BWC at 9:06:28. The two engage in a brief back-and-forth about whether the body-worn camera should be on, and then the two officers walk away to continue their duties.

Mr. [REDACTED] 602 alleged, correctly, that Officer [REDACTED] body-worn camera was deactivated when it should not have been. The investigator accurately summarized the relevant body-worn camera footage and relevant policy and interviewed Officer [REDACTED] about his failure to reactivate his camera. *See* AIU Report at 2-4. Officer [REDACTED] told the investigator that "there are times when he would forget to deactivate his BWC at the completion of the unclothed body search," including the time in question. *Id*. at 4. The Hiring Authority, however, did not sustain the allegation.

Although the officer failed to reactive his camera only for several minutes, the Hiring Authority should have sustained the allegation. Failing to sustain misconduct, even relatively low-level misconduct, undermines class members' trust in the accountability system. Mr. [REDACTED] was correct that Officer [REDACTED] was required by policy to have his body-worn camera activated. He filed a 602 to report that policy violation. In response, he received a closure letter that his 602 was inexplicably not sustained.

VI. AN EXAMPLE OF THE ACCOUNTABILITY SYSTEM WORKING

The measure of a functional accountability system is not how well the system works to exonerate staff when misconduct did not occur (which CDCR's system appears to do well), but instead how well it functions to hold staff fully accountable when there is

evidence that staff misconduct has occurred. Below, we discuss a case where the system worked effectively to hold an officer accountable for serious and somewhat complex misconduct. We are including this case because it represents the rare case where the process and the result complied with Court's orders and the Remedial Plans.

1. LAC- – OIA, Sustained (L9)

In this case, CDCR terminated Officer after finding that she conspired to facilitate an attack on a class member and deactivated her BWC to conceal her misconduct. CDCR took many positive steps during the investigation. LAC staff, upon reviewing video of the incident, promptly asked OIA to investigate. OIA then conducted a criminal investigation and referred Officer to the district attorney, though the district attorney declined to prosecute. Following the subsequent administrative investigation, the LAC warden fired Officer CDCR fought Officer appeal before the SPB, which then issued a reasoned decision upholding her firing.

On January 20, 2022, multiple incarcerated people attacked class member ( ) in his cell at LAC. Mr. suffered an injury requiring six stitches. Mr. filed a 602 on January 27, 2022 alleging that Officer (the tower officer) conspired with three incarcerated people to open Mr. door so that they could attack him. *See* OIA Exs. at 38-40. An LAC lieutenant reviewed the grievance, apparently to assess safety concerns Mr. expressed in the 602. *See* OIA Criminal Report at 4. The lieutenant discovered video evidence showing that Officer deactivated her BWC and allowed people into Mr. cell to attack him. *See* Criminal Evidence at 14. Within three days, the LAC warden submitted a request for OIA investigation. Criminal Evidence at 21-24. Officer was reassigned to the mailroom.

An OIA special agent conducted a criminal investigation. The investigation showed that Officer deactivated her BWC while speaking with three incarcerated people through the tower window. *See* Criminal Report at 6. Several minutes later, Officer opened Mr. cell while one of those people stood near Mr. cell and looked toward the tower. That person then entered the cell to attack Mr. while the other two people who Officer spoke with watched the attack. The attack continued for almost two minutes without Officer sounding her alarm. *See* AVSS 1076 at 10:54:15; *see also* BWC at 10:54:23 (opening Mr. cell). According to the special agent, Officer participated in "a well-coordinated, pre-planned attack" on Mr. including ensuring the attack occurred while no other officers were in the building. *See* Criminal Report at 8. When interviewed, Mr. reported that Officer targeted people with disabilities, *id.* at 17, and the investigator uncovered evidence that Officer orchestrated at least one other assault. *Id.* at 10-12. Finally, the investigator found that, after the assault, Officer reviewed SOMS records on Mr. and his assailants numerous

times while reassigned to the mailroom. *Id.* at 21; *see also* OIA Admin Report at 12. Officer [REDACTED] refused to be interviewed during the criminal investigation. *See* Criminal Report at 22. Ultimately, around July 31, 2023, CDCR referred the case to the district attorney for potential prosecution. *Id.* at 24. Though the case file does not contain documentation of the district attorney's charging decision, the existence of a subsequent administrative investigation by CDCR indicates the district attorney decided not to charge Officer [REDACTED]

LAC requested an administrative investigation on September 13, 2023, and OIA conducted a subject interview-only investigation, interviewing Officer [REDACTED] more than six months later, on March 28, 2024. *See* OIA Admin. Report at 5. OIA completed the administrative investigation on May 10, 2024. *Id.* at 14.

On June 24, 2024, the Hiring Authority found in a 402 that Officer [REDACTED] committed no fewer than 14 separate categories of misconduct, including, but not limited to, intentional endangerment (D3), improperly accessing confidential information (D12), intimidation, threat, or assault with the intent to inflict serious injury (D16), and intentionally disabling her BWC (E19). *See* 402/403. The Hiring Authority terminated Officer [REDACTED] and issued the NOAA on July 29, 2024. *See* NOAA. Officer [REDACTED] appealed to the SPB. After a hearing over several days, the SPB issued a resolution and order on September 15, 2025, finding that Officer [REDACTED] "facilitated an inmate assault, deceitfully attempted to cover up her part in that scheme, and violated other CDCR policies." *Id.* The SPB upheld her termination. *Id.*

CDCR deserves credit for many aspects of the handling of this case. LAC promptly recognized the potential misconduct and referred the case to OIA. OIA properly treated the investigation as a potential criminal matter, preserving the opportunity to charge Officer [REDACTED] by not interviewing her before a decision whether to charge her had been made. The investigation itself was comprehensive and gathered enough evidence to survive an SPB appeal. The Hiring Authority made an appropriate decision to terminate Officer [REDACTED] based on the extremely serious nature of her misconduct. And CDCR did not settle the case before the SPB and successfully obtained an SPB decision in its favor. Though not every part of the investigation was perfect,[13]

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[13] The criminal investigation took nearly a year and a half due to unexplained delays, and the staff misconduct investigation that consisted only of interviewing Officer [REDACTED] took more than six months from referral. Delay is a persistent problem in CDCR investigations, and can lead to lost, stale, or unavailable evidence, faded or unreliable memories, and unavailable witnesses. CDCR is fortunate that the delays in this case did not jeopardize the investigation. In addition, the delays allowed Officer [REDACTED] to continue working at LAC in the mailroom for well more than a year. During that time period, she not only received her pay, but she also used her position to engage in

CDCR's conduct in this case was generally compliant with the Remedial Plans and Court orders and met Plaintiffs' expectations for how CDCR should investigate and address serious allegations of misconduct.

Finally, we note that many class members raise similar allegations about officers coordinating in-cell assaults. Plaintiffs have previously described incomplete and biased investigations into these types of allegations. This case demonstrates that such misconduct does occur and that CDCR must take such allegations seriously by conducting prompt and comprehensive investigations.

VII. 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.

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additional, serious misconduct—improperly accessing SOMS information on Mr. [redacted] and his assailants, and potentially attempting to interfere in the investigation.