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PRIVILEGED AND CONFIDENTIAL

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[redacted]

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

Dear [redacted]:

We write regarding our review of Defendants' system for holding staff accountable for misconduct. The enclosed report is based on our review of investigation and discipline files produced from CSP-Los Angeles County ("LAC"), California Institution for Women ("CIW"), R.J. Donovan Correctional Facility ("RJD"), California Substance Abuse Treatment Facility ("SATF"), CSP-Corcoran ("COR"), and Kern Valley State Prison ("KVSP") (collectively "Six Prisons"). Plaintiffs continue to find that investigations and discipline fail to comply with the *Armstrong* Court Orders, as affirmed in relevant part by the Ninth Circuit, and with the RJD and Five Prisons Remedial Plans. *See* Dkts. 3059, 3060, 3217, 3218, 3393; *Armstrong v. Newsom*, 58 F.4th 1283, 1288 (9th Cir. 2023).

Plaintiffs have again found substantial evidence that CDCR's accountability system is failing. For this report, Plaintiffs analyzed half of all AIU cases for the six prisons in Q4 2024.[1] *See* AIU Table. Plaintiffs' analysis, which amounted to a review of

[1] Plaintiffs randomly selected half of the AIU cases produced for each prison in the Q4 2024 production sent by Defendants for review.

181 randomly selected AIU cases, involved reviewing each case and placing the case in one of five categories depending on whether there was an accountability failure and, if so, which type. **Plaintiffs' review found that CDCR's accountability system failed in more than 49.2% of cases.** The categories are intended to capture the key areas CDCR must improve in order to come into compliance with the *Armstrong* Court orders and the RJD and Five Prison Remedial Plans. In 30.4% of cases, Plaintiffs found that CDCR failed to conduct complete and unbiased investigations, making it impossible to determine whether staff misconduct occurred. In 14.9% of cases, evidence showed that staff misconduct did occur, yet the allegation was not sustained. In 3.9% of cases, CDCR sustained the allegation but the Hiring Authority did not issue appropriate discipline. The finding that approximately half of all cases failed to come into compliance with remedial plan requirements, when projected over CDCR's entire system, represents a colossal failure of accountability in hundreds of cases of alleged misconduct.

The finding that the system is failing in approximately half of the cases is entirely consistent with two prior reviews conducted by Plaintiffs' counsel using the same methodology. Specifically, Plaintiffs' November 2024 analysis of staff misconduct cases produced for KVSP Q3 2024 found that Defendants' accountability system failed in close to 50% of cases and Plaintiffs' April 2024 analysis of staff misconduct cases produced for LAC Q4 2023 found that the system failed in more than 55% of cases.[2]

Plaintiffs' findings are also corroborated by the Office of Inspector General ("OIG") monthly "Case Block" reports for local inquiries and use of force reviews. In their most recent local inquiry report, for December 2024, the OIG rated 46% of cases "poor" overall. The number of cases rated "poor" was even higher, 87% of cases, when the OIG monitored retroactively, suggesting that CDCR performs much better in cases when they know the OIG is looking. *See* OIG January 2025 Report at 1. The most recent monthly use of force "Case Block" review highlighted significant accountability concerns in six notable cases reviewed by the OIG. *See* OIG December 2024 UOF Report at 1-4.

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[2] *See* [redacted], Additional Evidence of Accountability System Failures in Review of All Cases from KVSP Q3 2024 (December 10, 2024); [redacted], Additional Evidence of Accountability System Failures in Review of All Cases from LAC Q4 2023 (April 24, 2024).

Plaintiffs have discussed in their previous quarterly reports how Defendants' system fails to hold staff accountable in three critical ways. First, investigators fail to collect relevant evidence, including video evidence, needed to evaluate an allegation. Investigative failures in these cases make it impossible to determine if misconduct occurred. Second, even when evidence shows misconduct occurred, Defendants frequently fail to sustain allegations of misconduct. Third, even when Defendants sustain an allegation, they often fail to impose appropriate discipline. Plaintiffs have identified these three types of accountability failures in dozens of cases spanning more than two years and all six prisons. This quarterly review quantifies the scope of accountability failures by type. The fact that Plaintiffs discovered that Defendants failed in 49.2% of cases does not mean that Defendants system worked in the remaining cases. Only in very few cases (6 cases) did the system work to hold staff accountable when evidence of misconduct existed. In other words, the true measure of any accountability system working is the number of cases where, when misconduct is evident, appropriate action was taken in response. This small number of cases in which CDCR's system worked stands in contrast to the 34 other cases where CDCR failed to sustain allegations or ensure appropriate discipline despite evidence of staff misconduct.

The parties continue to negotiate improvements to the system to ensure Defendants' compliance with the *Armstrong* Court orders and RJD and Five Prison Remedial Plans. As Defendants are on the cusp of implementing the Centralized Allegation Resolution Unit (CARU), Plaintiffs are hopeful that CARU will improve appropriate and consistent disciplinary decision-making, improve the timeliness of decisions, and improve the quality of investigations by identifying incomplete and biased investigations and sending those investigations back to investigators for further review. Plaintiffs' review continues to show that the largest category of accountability failures involve incomplete and biased investigations. Defendants must take steps along the way – before important video evidence is destroyed – to identify incomplete and biased investigations and to remedy problems before cases reach the CARU. Plaintiffs will continue to monitor CDCR's accountability system to determine whether remedies such as CARU are having a significant impact.

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Plaintiffs' counsel looks forward to discussing these cases with Defendants in second quarter 2025. We remain hopeful that the parties can continue to work on identifying and implementing remedies to the system to improve accountability for staff misconduct.

Sincerely,

ROSEN BIEN
GALVAN & GRUNFELD LLP

/s/ [redacted]

By: [redacted]

cc: [redacted]

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

The Remedial Plans and Court's orders require that Defendants' investigators conduct "comprehensive and unbiased investigations and ensure all relevant evidence is gathered and reviewed" and that Hiring Authorities impose appropriate and consistent discipline. RJD Remedial Plan, § II.B; Five Prisons Remedial Plan, § II.B; *see also* Dkt. 3060, ¶ 5.c; Dkt. 3218, ¶ 5.c.

To evaluate Defendants compliance, Plaintiffs reviewed half of all AIU cases produced for each prison, or 181 randomly selected AIU cases,[3] this quarter and found that Defendants' accountability system failed in 89 of 181 cases (49.2%). *See* AIU Table. Specifically, Plaintiffs reviewed each case and placed each into one of five categories:

Category	Description	%
Category 1	**No evidence of misconduct:** The investigator established that misconduct did not occur or exhausted reasonable investigative avenues or the complaint was so general that it likely should not have been treated as a staff complaint (e.g., allegations that "staff are generally disrespectful" resulting from the quarterly interview process).	**47.5%**
Category 2	**Incomplete investigations:** The incompleteness of the investigation (e.g., failing to obtain available video evidence or to interview relevant witnesses) made it impossible to determine whether the alleged staff misconduct occurred.	**30.4%**
Category 3	**Failure to sustain allegations:** The investigator provided enough evidence to the Hiring Authority to support sustaining an allegation of misconduct, but the Hiring Authority nevertheless failed to sustain the allegation.	**14.9%**

[3] Plaintiffs reviewed a total of 189 randomly selected AIU cases, approximately 50% of AIU cases from each prison. Out of that sample, five cases were duplicate allegations or otherwise were not intended to be staff misconduct complaints (see [redacted]; [redacted]; [redacted]; [redacted]; [redacted]) and three cases had essential documents missing at the time the review was conducted that prevented Plaintiffs from analyzing the case (see [redacted]; [redacted]; [redacted]). Thus, these eight cases were excluded from the sample.

Category	Description	%
Category 4	**Failure to impose appropriate discipline:** The Hiring Authority sustained at least one allegation of staff misconduct, but imposed a penalty that was not appropriate for the misconduct and/or that was inconsistent with CDCR's policies, including the Disciplinary Matrix.	**3.9%**
Category 5	**Staff properly held accountable:** The Hiring Authority sustained one or more allegations of misconduct and imposed appropriate and consistent discipline.	**3.3%**
	TOTAL	**100%**

As to each category, Plaintiffs' counsel identified 30.4% of cases with incomplete investigations (Category 2), 14.9% of cases revealed evidence of misconduct but no violation was sustained (Category 3), and 3.9% of cases where misconduct was sustained but the action taken in response was inappropriate (Category 4). In only 3.3% of cases did Plaintiffs agree that the accountability system worked to discover staff misconduct and to hold staff accountable (Category 5). Although 47.5% of cases were not staff misconduct (Category 1), this does not equate to Defendants' system necessarily working in half the cases, as the system has never appeared to be deficient in exonerating staff. Instead, breakdowns occur in discovering whether evidence of staff misconduct exists and, if so, taking appropriate action in response. The true measure of whether Defendants' system is working is whether, when there is evidence of staff misconduct, they hold staff accountable. Plaintiffs found evidence that staff misconduct occurred in 40 cases (categories 3, 4, and 5) and only six cases where the appropriate accountability action was taken (category 5).

Plaintiffs have provided in greater detail below examples of cases that demonstrate the primary types of failures—failures to conduct a comprehensive and unbiased investigation (Category 2), failure to sustain allegations when there is evidence of misconduct (Category 3), and failure to issue appropriate discipline (Category 4).[4]

[4] Most but not all of the cases referenced below were included in the review of 189 cases and therefore also appear on the AIU Table.

A. Incomplete Investigations and Inappropriate Disciplinary Decisions Remain a Significant Barrier to Accountability

1. Category 2 – Incomplete Investigations

The ongoing failure of CDCR to identify ADA violations and to take action in response—either through correcting staff by notifying them of the failure or through disciplinary action if it is an ongoing problem—is alarming after multiple court orders, since 2007, to get CDCR to respect the rights of people with disabilities in prison. *See* Dkt. 1045 at 7; *Armstrong v. Brown*, 768 F.3d 975, 979 (9th Cir. 2014); *see also* Order Modifying Permanent Injunction of August 2, 2012, Dkt. 2180; Order Modifying 2007 Injunction of December 29, 2014, Dkt. 2479; Dkt. 3059; Dkt. 3060; Dkt. 3217; Dkt 3218.

The cases highlighted in the OIG's report include the exact types of failures included in Plaintiffs' counsel's reports including the failure to retain and review relevant video footage, the failure to cite to and rely on the correct CDCR policy relevant to the alleged violation, omissions of important and relevant factual evidence from reports, and other significant problems. *See* OIG January 2025 Report; OIG December 2024 Report.

(a) SATF-[redacted] – AIU, Not Sustained

In this case, the investigator delayed in requesting pivotal body-worn camera ("BWC") and audio-video surveillance system ("AVSS") footage, making it impossible to determine whether the alleged misconduct occurred. [redacted] ([redacted]) alleged that canteen supervisor [redacted] made racially derogatory and disrespectful comments to him, threatening to limit his access to canteen following a verbal dispute after he requested an accommodation for his disability.

After obtaining permission from [redacted] Mr. [redacted] spoke with canteen supervisor Mr. [redacted] about concerns related to excessive wait times for canteen as he has a disability and takes medication that makes him sensitive to heat. *See* 602 at 3; Investigation Report (IR) at 3-4. He requested that Mr. [redacted] reintroduce an "ADA day" for people with disabilities to more efficiently pick up their canteen orders. Mr. [redacted] alleges that Mr. [redacted] became upset with him for requesting an accommodation and said, among other things, "From now on, you are only going to be able to shop once a month," and called him "just another Mexican" in front of other incarcerated people. *See* IR at 4. Mr. [redacted] denied making these comments, though he did admit to "raising his voice at [redacted] and telling Mr. [redacted] something to the effect of "go ahead and write me up." *Id*. at 9. Because this conversation took place in an area frequented by incarcerated people with at least one officer nearby, AVSS and BWC footage likely existed that could have shown what happened that day.

Mr. [redacted] submitted his 602 on June 8, 2022. *See* 602 at 1. Although Sgt. [redacted] was assigned this case on August 17, 2022, SATF did not receive her request for

BWC and AVSS footage until September 12, 2022—one week after the footage was no longer available. *See* IR at 1; CDCR 1118: Body-Worn Camera Video Evidence Request. It is not clear why Sgt. [redacted] did not request footage sooner. This case illustrates the importance of extending the video retention period to ensure access to relevant footage.

(b) COR-[redacted] – AIU, Not Sustained

In this case, [redacted] alleges—among other claims—that a lieutenant threatened him during a cell-front encounter while on suicide watch and ordered the sergeant to walk away so the threat would not be captured on camera. BWC footage from a nearby sergeant captures evidence suggesting the lieutenant took steps to circumvent his cell-front conversation from being recorded and that, when he later discussed that conversation with other staff, he improperly ordered a sergeant to deactivate his camera. The investigator should have done more to determine what happened here and whether the class member was threatened, as alleged. Yet, the investigation report makes no mention of the lieutenant's BWC camera violations, nor is there any effort to question him or other staff about it. The Hiring Authority did not sustain serious misconduct.

Mr. [redacted] alleged that, after mentally decompensating due to problems with CDCR not following his dietary requirements, he became upset and boarded up. *See* 602 at 1-2. The sergeant in the unit, Sgt. [redacted] visited Mr. [redacted] cell to persuade him to remove his window coverings but was unsuccessful in doing so. *See id*. at 2. Lt. [redacted] then visited Mr. [redacted] cell. Mr. [redacted] alleged that the lieutenant sent the sergeant away so that his conversation would not be recorded on a BWC. *See id*. (Lieutenants are not required to wear BWCs). During that unrecorded conversation, Lt. [redacted] allegedly threatened Mr. [redacted] with "death and violence," challenged him to a fight, and discussed planting knives in his cell. *Id*.

Sergeant [redacted] BWC footage supports Mr. [redacted] version of events. The clip of Sgt. [redacted] BWC included in the file begins with he and Lt. [redacted] discussing Mr. [redacted] situation in the dayroom. *See* BWC 1 at 7:30:05. After about a minute of conversation, Sgt. [redacted] and Lt. [redacted] walk to Mr. [redacted] cell door. *Id*. at 7:31:05. The sergeant walks outside to look through Mr. [redacted] back window; when he returns, several other officers have approached the cell door to open the food port. *Id*. at 7:32:30-7:32:45. Once they open the food port, Mr. [redacted] uncovers the cardboard blocking his cell window and begins talking to the sergeant and the lieutenant about his frustrations with his one-to-one observer. *Id*. at 7:32:47-7:33:30. Sgt. [redacted] tries deescalating the situation by having a conversation with Mr. [redacted] but after about 20 seconds, Lt. [redacted] who is standing behind the sergeant, says to Mr. [redacted] "You want us to go in and get you?" *Id*. at 7:33:30. This starts a back-and-forth between Mr. [redacted] and Lt. [redacted] where he seems to be aggravating Mr. [redacted] instead of trying to deescalate the situation. Mr. [redacted] eventually threatens Lt. [redacted] at which

point Lt. [redacted] says to St. [redacted] "Hey, give me a minute." *Id*. at 7:34:00. Sgt. [redacted] then walks about 15 feet away, leaving only Lt. [redacted] at Mr. [redacted] cell door. Lt. [redacted] is not questioned about why he ordered the sergeant to walk away and whether it had to do with evading recording.

Once the mental health staff member and the sergeant conclude their conversation about the other patient, the mental health staff member says that she is going to talk to Mr. [redacted] and she asks Lt. [redacted] whether he was just speaking with Mr. [redacted] *Id*. at 7:39:09-20. The lieutenant confirms that he was speaking to Mr. [redacted] and the mental health staff member asks why he is upset. *Id*. at 7:39:25. Lt. [redacted] begins to answer hesitantly, "Uh, he's very agitated… uh… uh," then he signals to Sgt. [redacted] saying, "Hey… hey, want to keep it confidential? Why don't you shut it off?" *Id*. at 7:39:30. The sergeant then deactivates his BWC for 11 minutes. *See id*. at 7:39:45-7:51:00 (deactivation period).

The investigation is inadequate on numerous levels. Most clearly, the investigator failed to identify clear misconduct—that Sgt. [redacted] deactivation is a violation of policy. *See* Dkt. 3393 at 199-121. The investigator does not mention the deactivation in the report, nor does he ask the sergeant why he believes Lt. [redacted] sent him away from Mr. [redacted] door. *See* Investigation Report at 3-4 (review of video footage); 6-7 (interview of Sgt. [redacted] The investigator also failed to ask Lt. [redacted] why he sent Sgt. [redacted] away, or why he needed to have a "confidential conversation" about Mr. [redacted] *See id*. at 7. Additionally, the investigator did not interview the mental health staff member, who was the third person in the "confidential conversation" and likely had relevant information about Mr. [redacted] allegations. All of these steps are basic investigatory steps that an investigator should take to conduct a comprehensive investigation into an allegation of misconduct.

Mr. [redacted] allegation that a lieutenant threatened him and took steps to prevent that threat from being recorded is very serious. Nevertheless, the investigator failed to acknowledge evidence that supported that allegation, ask essential follow-up questions or interview crucial witnesses, and identify plain misconduct.

(c) COR-[redacted] – AIU, Not Sustained

In this case, [redacted] alleged that officers at COR used excessive force against him when he tripped after being told to get out of his wheelchair and walk to his cell. The investigator conducted an extremely narrow investigation in to this serious allegation, relying on a date that was mistranslated from his complaint form, despite available and obvious evidence that the incident occurred on a different date. The investigator also failed to request BWC or AVSS footage from any date despite having ample time to do so.

On February 6, 2024, the COR Office of Grievance received a 602 written in Spanish by Mr. [redacted] alleging staff used excessive force against him on Friday, January 19 or Friday, January 26, 2024. *See* 602 Log No. 516523 at 1-2. CCII SPEC [redacted] translated the 602 but incorrectly listed the dates provided in the grievance as "Friday 19, 23." *See* Grievance Translation at 3. A CST staff member, [redacted] conducted a clarifying interview with Mr. [redacted] on February 27, 2024, during which time he apparently stated that the incident happened on Tuesday, January 23. *See* Grievance Event at 5. It is not clear from this interview how the date that was settled on came to be the date wrongly interpreted from the 602 as that was not a date he wrote in his 602 nor was it a Friday as he had alleged. It is also not clear from the documentation whether this interview was conducted in English or Spanish.

The AIU investigator, Lt. [redacted] proceeds with the investigation of an incident on January 23 and notes that "[a] review of Strategic Offender Management System (SOMS) indicated [redacted] was not involved in any incidents on 1/23/2024 (**Exhibit 5**) and did not receive any rules violation reports (RVRs) (**Exhibit 6**)." *See* Investigation Report (IR) at 3 (emphasis in original). Exhibit 5 is a printout of an Incident Report Log by Offender filtered for Mr. [redacted] The report clearly shows an entry for an immediate use of force incident on January 26, 2024—one of the dates that Mr. [redacted] originally listed in his 602. *See* Incident Report Log at 12. Exhibit 6 is a Rules Violation Report for Mr. [redacted] that also clearly shows two RVRs for "Resisting Staff" and "Assault on Non-Prisoner" on January 26, 2024. *See* RVR Log at 14. Mr. [redacted] also mentioned in both of his interviews that, on the day in question, staff used Narcan on him after he lost consciousness following a strike to the head. *See* Grievance Event at 5; IR at 3. Lt. [redacted] requested medical records for Mr. [redacted] and specified he was "looking for any notes indicating [redacted] received NARCAN on 1/23/2024." *See* Medical Records Request at 7. Had the request not been so narrow, Lt. [redacted] would have seen that on January 26, medical staff used Narcan on Mr. [redacted] *See* Progress Note-Psych Tech (Jan. 26, 2024). Finally, because the investigator failed to confirm the correct date in a timely manner, AVSS and BWC footage was lost to the 90-day retention period.

Lt. [redacted] ended the investigation report stating, "Due to the lack of information provided in the grievance (**Exhibit 2**) and [redacted] failing to identify witnesses and/or names or a description of the subjects, no further investigation could be completed. Additionally, a date was not written on [redacted] grievance (**Exhibit 2**) to use as a starting point for an investigation." *See* IR at 4. In reality, this case clearly demonstrates a lack of investigative rigor by the AIU investigator. Given the seriousness of the allegation in this case, the investigator should have done which would have revealed that evidence already collected by the investigator suggested the incident occurred on a different date. Ultimately, investigative failures like those that occurred in this case perpetuate a lack of trust in the accountability system.

2. Category 3 - Failure to Sustain Allegations

This category of cases includes examples where there is evidence of staff misconduct included in the investigation file, but CDCR Hiring Authorities failed to confirm that staff misconduct occurred.

(a) COR-[redacted] – AIU, Not Sustained

In this case, Officer [redacted] failed to accommodate [redacted] when he stopped mid-escort to request a wheelchair for the remainder of the walk because his "leg was giving out." Rather than provide a reasonable accommodation, Officer [redacted] escalated the situation and initiated an unnecessary use of force that resulted in Mr. [redacted] on the ground. Yet, neither the Hiring Authority nor the IERC found any misconduct.

On August 3, 2023, Officer [redacted] and others were escorting Mr. [redacted] from the program office back to his assigned housing unit. BWC footage shows that during the escort, Mr. [redacted] stops and informs Officer [redacted] that he needs a wheelchair because his "leg was giving out." *See* BWC at 13:14:19. Mr. [redacted] clarifies in his grievance that he has blood clots that cause him mobility issues and that it was extremely hot on the date of incident, further exacerbating his mobility difficulty and prompting his request for a wheelchair. *See* 602 at 1. Officer [redacted] refuses his request and tells Mr. [redacted] that he doesn't need a wheelchair and that he is "going to the cell." *See* BWC (linked above) at 13:14:23. After Mr. [redacted] responds that he will not go to the cell without a wheelchair, Officer [redacted] grabs the arm Mr. [redacted] is using with his cane and pushes it forward, using immediate force to seemingly attempt to compel him into walking towards the housing unit. *Id* at 13:14:38. When Mr. [redacted] reacts, pulling his arm away, Officer [redacted] escalates the unnecessary force, wrapping both arms around Mr. [redacted] upper torso, which results in the class member and multiple officers being brought to the ground. *See* AVSS at 13:14:40.

Officer [redacted] use of force in this case violated CDCR policy. Policy provides that immediate force can only be used to respond to situations "that constitute[] an imminent threat to institution/facility security or the safety of persons," including to "subdue an attacker, overcome resistance or effect custody." *See* DOM § 51020.4 at 1; 15 C.C.R. § 3268(a)(4) (similar). Policy further requires that officers attempt to deescalate situations to avoid using force. *See* DOM § 51020.5 at 2 ("Whenever possible, verbal persuasion should be attempted in an effort to mitigate the need for force.") The force incident could have been avoided if Officer [redacted] provided Mr. [redacted] the reasonable accommodation of a wheelchair for the remainder of the escort. Instead, the failure to accommodate the class member resulted in an unnecessary and unjustified use of force. Mr. [redacted] refusal to proceed without a wheelchair did not constitute an imminent threat to the facility or to the safety of anyone. *See* DOM § 51020.4 at 1. Because there was no imminent risk, if after accommodation and verbal

persuasion (including the threat of an RVR), Mr. [redacted] still refused, controlled force and not immediate force would have been appropriate.

Given custody staff's failure to provide a simple accommodation, the Hiring Authority should have, at minimum, sustained an allegation for failure to observe and perform within the scope of training (D26, **1**2345) and for unnecessary force (L1, 1**2**3). *See* Employee Disciplinary Matrix.

(b) LAC-[redacted] – AIU, Not Sustained

In this case, Officer [redacted] improperly used immediate force against an *Armstrong* class member with mobility disabilities, [redacted]. In Plaintiffs' November 2024 Report, we outlined seven separate use of force incidents involving Officer [redacted] including several instances where, as here, he used immediate force when none was warranted. *See* November 2024 Report at 15-19. This pattern of misconduct is well-known to class members: one of two grievances filed about this incident[5] stated that "as usual, C/O P. [redacted] was the lead in using the excessive force/unnecessary force." *See* 602 at 1-3 (written by another *Armstrong* class member, [redacted] So far, the accountability system has failed *Armstrong* class members with respect to Officer [redacted] Plaintiffs' counsel demand to know what, if any, action CDCR is taking to ensure that Officer [redacted] is held responsible for ongoing serious misconduct and to minimize his contact with incarcerated people.

This incident occurred on December 15, 2022 and is shown on video, which begins while five officers are talking to Mr. [redacted] who is seated in his wheelchair in a mostly empty dayroom. Although not evident on video, the AIU report indicates that staff allowed Mr. [redacted] to cool down in the dayroom for about an hour following a search of his cell. *See* AIU Report at 3-4. Mr. [redacted] tells the officers that he needs to go to his EOP group and to talk to his psychiatrist. *See* BWC at 11:50:23. An officer says that Mr. [redacted] needs to go to his cell, but staff will send the psychiatrist to him. *See* BWC (linked above) 11:50:53. Mr. [redacted] refuses. After some discussion, Officer [redacted] then orders Mr. [redacted] to "take it in" and attempts to push Mr. [redacted] in his wheelchair towards his cell. *See* BWC (linked above) at 11:53:26. When another officer grabs Mr. [redacted] wheelchair, Mr. [redacted] turns backwards and tells him to wait; Officer [redacted] then grabs Mr. [redacted] hand. *See* BWC (linked above) at 11:53:50. After several seconds, Mr. [redacted] says he will go to the

[5] A second use of force incident occurred as a result of this incident, and was investigated in case [redacted]. The BWC linked in this write-up is from case [redacted] because it provides more context. The investigator in this case should have reviewed video starting at the beginning of the conversation between Mr. [redacted] and staff.

cell on his own and repeatedly tells Officer [redacted] to let go of his hand, which he does eventually. The officers follow as Mr. [redacted] rolls to his cell.

At the cell, Mr. [redacted] stands up from his wheelchair, surrounded by six officers. He says multiple times "I need my doctor." *See* BWC (linked above) at 11:54:44. Mr. [redacted] adjusts his sleeves (in his AIU interview, Mr. [redacted] stated that "when he stood up and adjusted his sleeves, he stated it was a habit to fix himself, but he did not mean it in a fighting stance or threatening way.") *See* AIU Report at 13. One of the officers pulls out pepper spray, and Mr. [redacted] asks why. The officer claims Mr. [redacted] was "getting ready" (to fight). Several seconds later, Officer [redacted] activates the alarm and grabs Mr. [redacted] and pushes him into his cell. *See* BWC (linked above) at 11:54:52. Another officer sprays Mr. [redacted] with pepper spray. Officers, including Officer [redacted] rip off Mr. [redacted] shirt and pull him into the dayroom. While officers are surrounding and grabbing Mr. [redacted] Officer [redacted] who is outside the circle of officers, strikes Mr. [redacted] at least 10 times. *See* AVSS at 11:55:07; AIU Report at 9.

Officer [redacted] used immediate force – grabbing Mr. [redacted] and pushing him back into his cell – when such force was not warranted. Under CDCR's use of force policies, immediate force is only justified when there is an "imminent threat" to the safety and security of the institution or to staff. *See* DOM § 51020.4 at 1. At the time, Mr. [redacted] was telling officers that he needed his doctor and presented no threat. Officer [redacted] wrote in his incident report that Mr. [redacted] "violently stood up and pulled up his shorts, roll(sic) his sleeves and took a bladed stance towards building staff and I." *See* Incident Report at 55. However, at no time did Mr. [redacted] take a bladed stance. Moreover, by the time Officer [redacted] used force, the actions that allegedly justified the use of immediate force—Mr. [redacted] standing up from his wheelchair and adjusting his sleeves—had passed. Officer [redacted] omits that Mr. [redacted] was actively discussing with staff his need for mental health attention. Instead, as has occurred multiple times in other cases Plaintiffs have reported on, Officer [redacted] rushed to use force when other officers were still using verbal persuasion to get Mr. [redacted] to comply with the order.

In addition to the unnecessary rush to use immediate force, Officer [redacted] striking of Mr. [redacted] was excessive. "Excessive force is the use of more force than is objectively reasonable to accomplish a lawful purpose." *See* DOM 51020.4 at 1. Eight staff members surround Mr. [redacted] as they pull him out of his cell to effectuate custody. Officer [redacted] ten strikes to Mr. [redacted] head area appear gratuitous, punitive, excessively violent, and potentially dangerous to other staff as well as Mr. [redacted]

Several days following the incident, Mr. [redacted] reported that he had "neck and shoulder pain, and lower extremity pains." *See* Nursing Face-to-Face dated December 18, 2022 at 1. Additionally, Plaintiffs reported in the April 2023 LAC Armstrong

Monitoring tour report that as a result of the incident, Mr. [redacted] was "afraid to leave his cell and recently went on hunger strike…" *See* Plaintiffs LAC April 2023 Monitoring Report at 9. Use of force incidents like this not only have serious impacts on the class members involved, but they also, especially when so visible and violent, chill other *Armstrong* class members' willingness to ask for help. This force incident started, like so many others do, with Mr. [redacted] asking for help, in this case to see his clinician.

In this quarter's production, Officer [redacted] was involved in another use of force incident. *See* LAC-[redacted]. Officer [redacted] stopped [redacted] from leaving the dining hall because he is wearing a beanie (notably, the incarcerated person right in front of Mr. [redacted] wore a beanie with no apparent consequence), and then orders him into handcuffs. The situation ultimately escalates into an unnecessary use of force.[6] *See* BWC 1; AVSS at 7:26:44. While multiple staff are restraining Mr. [redacted] who is on the ground, Officer [redacted] approaches and unnecessarily pepper sprays Mr. [redacted] from less than six feet away.[7] *See* BWC 2 at 7:27:40; AIU Report at 3. No threat exists at the time; instead, Officer [redacted] actions appear gratuitous. The Hiring Authority failed to sustain any allegations in these cases, and none of the officers were held accountable.

(c) LAC-[redacted] – AIU, Not Sustained

In this case, a correctional officer threw a mentally ill class member, [redacted], to the ground because the class member requested protective custody due to "demons" in his cell, refusing to return to his cell due to fear of death. Despite clear misconduct that severely injured the class member, resulting in a collapsed lung and head injury requiring hospitalization for three days[8], both the IERC and Hiring Authority did not sustain any use of force violation.

On February 8, 2023, Mr. [redacted] requested that Officers [redacted] and [redacted] take him to protective custody because of the "demons in his house" that he reported were going to take him to the underworld and torture him. *See* BWC at

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[6] The investigator failed to address this first unnecessary use of force incident in the investigation report, which focused solely on Officer [redacted] misconduct. The investigator should have also reported on Officer [redacted] misconduct, as it seems impossible to miss during investigation. Based on the incident report, Officer [redacted] appears to be the officer who initiated the use of force. *See* Attachments at 56.

[7] A second use of force incident occurred as a result of this use of force incident in case [redacted].

[8] Medical records indicate that Mr. [redacted] returned to LAC on February 11, 2023, three days after the incident. *See* Offsite/Hospital Return dated February 11, 2023.

14:40:56. During the course of the conversation, Mr. [redacted] tells the officers three times that due to his fears he will not return to his cell. *See* BWC (linked above) at 14:41:08; 14:41:11; 14:41:37. Officer [redacted] insists that Mr. [redacted] go back to his cell and begins to approach him to apparently force him to do so. *See* BWC (linked above) at 14:41:35. As the officer is approaching, Mr. [redacted] stands up from his walker. Officer [redacted] orders him to get down and reaches to grab his arm to apply restraints. After this initial application of force, Mr. [redacted] attempts to free his arm from the officer's grasp and Officer [redacted] wraps his arms around Mr. [redacted] upper torso and throws him to the ground. *See* AVSS at 2:41:39. Blood can be seen on the concrete beside Mr. [redacted] head. *See* BWC (linked above) at 14:42:13. Medical records indicate that Mr. [redacted] suffered serious injuries during the force including a collapsed lung and head wound that required three staples. *See* Outside Records-Hospital dated February 11, 2023; AIU Report at 5.

The immediate use of force against Mr. [redacted] was unnecessary and in violation of CDCR policy. In this case, AVSS footage captures Mr. [redacted] calmly seated on his walker during the entirety of his conversation with Officers [redacted] and [redacted] At no point during the interaction, which occurred in an isolated area of the yard with no other incarcerated people around, did Mr. [redacted] pose an imminent threat. *See* DOM § 51020.4 at 1. Mr. [redacted] belief that there were demons in his cell may have been irrational and delusional, but he was calm and reasonable in explaining his very real (to him) fear in asking for help to transfer. *See* BWC (linked above) at 14:40:56-14:41:40. There was no need to resort to force to require him to return to his cell. The officers had opportunities to pursue a different course of action and were in fact required to do so.

CDCR policy requires that staff "evaluate the totality of circumstances involved…. includ[ing] consideration of an inmate's demeanor, bizarre behavior, mental health status if known … as well as ability to understand and/or comply with orders…to determine the best course of action and tactics to resolve the situation." *See* DOM § 51020.5 at 2. Custody staff should have identified and treated Mr. [redacted] reports of "demons" in his cell as "bizarre behavior." In this situation, the best course of action was not to use force against a seriously mentally ill class member for something that was solely the result of his mental illness, but to instead use an alternative to force, like escorting Mr. [redacted] to another area of the prison, such as a holding cage, until, possibly in conjunction with mental health staff, the housing issue–could be resolved.

Officers in this case used immediate force when it was unnecessary, failing to consider the mental health reason for Mr. [redacted] behavior and failing to utilize any alternative course of action, as required by policy. At a minimum, the Hiring Authority should have sustained an allegation for failure to observe and perform within the scope of training (D26, **1**2345), for unnecessary force causing injury (L2, 4**5**6789), and possibly unnecessary force resulting in great bodily injury (L3, 678**9**). *See* Employee Disciplinary Matrix.

(d) RJD-[redacted] – AIU, Not Sustained

[redacted] alleged, among other things, that officers failed to secure his wheelchair during a transport. The investigation confirmed his allegation—video shows that the officer did not properly secure Mr. [redacted] wheelchair in the van, and one of the transport officers admitted during his interview with the investigator that he did not properly secure Mr. [redacted] wheelchair. The Hiring Authority, however, did not sustain the allegation of misconduct.

On September 22, 2023, Mr. [redacted] was being transported from the Triage and Treatment Area (TTA) back to his assigned housing unit. The entire interaction is evident from the body-worn camera of Officer [redacted] one of the assigned transport officers. The video shows Officer [redacted] pushing Mr. [redacted] wheelchair from the TTA to the van and onto the lift. *See* BWC at 5:56:10-5:57:30. After the lift raises, Officer [redacted] pushes Mr. [redacted] wheelchair into the van, and Mr. [redacted] says, "I'm good right here. You don't gotta do all that." *Id*. at 5:57:32. Officer [redacted] responds, "You're good? Are you sure?" then exits the van without properly securing Mr. [redacted] wheelchair as required by policy. *Id*. at 5:57:40. The transport officers then drive for around four minutes from the TTA to Mr. [redacted] housing unit. *See id*. 5:58:30 to 6:02:00. When Officer [redacted] opens the van door and lowers the lift, Mr. [redacted] appears to be in pain and tells Officer [redacted] that he flipped over in the van during the escort. *Id*. at 6:02:03 to 6:03:25. Mr. [redacted] later filed a 602, alleging that officers did not secure his wheelchair and intentionally drove recklessly to injure him. *See* 602 at 3-4.

The investigation is thorough. Specifically, the evidence in the investigation report demonstrates that the officers did not secure Mr. [redacted] wheelchair in the van before driving to his housing unit, as he alleged in his 602. The investigator reviewed the relevant body-worn camera footage and accurately summarized it in the report. *See* Investigation Report at 2. The investigator also questioned the officers about failing to secure Mr. [redacted] wheelchair. *See id*. at 3-4. Officer [redacted] admitted to the investigator that he did not secure Mr. [redacted] wheelchair in the van, and that he knew that securing a wheelchair in the van was required by policy. *See id*. at 3 ("[redacted] stated he did not secure [redacted] within the transportation vehicle and was aware that it is required per Departmental Policy to secure all inmates prior to transporting them. [redacted] stated he was not sure why he did not comply with this policy during the incident in question.").

Despite video evidence demonstrating misconduct, the investigator highlighting the misconduct, and an officer admitting to the misconduct, the Hiring Authority did not sustain the allegation or impose any discipline or training.

3. Category 4 - Failure to Impose Appropriate Discipline

The section includes an egregious example of a case where misconduct was sustained but the discipline ultimately received was inappropriate.

(a) RJD-[redacted] – AIU, Sustained (Level 9 reduced to Level 8 by SPB)

In this case, the Hiring Authority initially issued a Level 9 termination penalty to Sergeant [redacted] for lying during an AIU investigation into an allegation that he endangered a class member. CDCR has found that Sergeant [redacted] violated policy on multiple occasions. The Notice of Adverse Action in this case notes two prior adverse actions against him. Further, when Sergeant [redacted] appealed his termination to the State Personnel Board ("SPB"), the action was consolidated with *three additional* pending adverse actions against him.[9] At the SPB, CDCR settled for a demotion rather than termination. CDCR's explanation for reducing the punishment is contradicted by the evidence. Unfortunately, this inappropriate settlement means that now, Officer [redacted] despite a long pattern of disability-related and other misconduct, is in a position that ensures more, not less, contact with *Armstrong* class members, increasing the risk of future harm to class members and other incarcerated people.

The underlying incident occurred on August 22, 2023. On BWC, class member [redacted] approaches Sergeant [redacted] to ask why he was moved to a different housing unit for being on C-Status, when other people on C-Status remained in his prior unit. *See* BWC at 12:11:15. Mr. [redacted] declines to provide names of people who remain there when Sergeant [redacted] asks. *Id.* at 12:11:35. Sergeant [redacted] then loudly says, with other incarcerated people looking at him and in earshot, "Let me know who's missing and I'll go get em." *Id.* at 12:11:47. Mr. [redacted] refuses again. Sergeant [redacted] while walking past two incarcerated people, and with others in the area, says, "It sounds like you're here for telling though. All you're, all you're missing is a name." *Id.* at 12:11:58. Mr. [redacted] filed a 602 the same day, alleging that Sergeant [redacted] endangered him by suggesting in front of other incarcerated people that he was a "snitch." *See* Grievance at 3.

On December 1, 2023, the AIU investigator interviewed Sergeant [redacted] *See* AIU Report at 4. Sergeant [redacted] reviewed the BWC footage with his counsel beforehand. *Id.* During the audio-recorded interview, as excerpted at length in the Notice of Adverse Action (*see* NOAA at 10-13), the AIU investigator gave Sergeant [redacted] multiple opportunities to explain what he meant when he said Mr. [redacted] was

[9] Sergeant [redacted] is a familiar name to Plaintiffs' counsel. Several class members filed credible declarations about Sergeant [redacted] misconduct during the staff misconduct litigation in 2020.

"here for telling" and specifically asked if Sergeant [redacted] was calling Mr. [redacted] a "snitch." Sergeant [redacted] denied calling or implying that Mr. [redacted] was a snitch.

Sergeant [redacted] seemed to blame Mr. [redacted] for initiating the conversation in front of other people: "He made that very clear and loud in front of whoever. He didn't come up to me in a confidential setting, uh so I was just having a conversation with him. That's it." *See* NOAA at 11; AIU Interview at 23:51. Sergeant [redacted] then claimed that he did not call Mr. [redacted] a "snitch" or "any term similar." *Id.* at 26:40. When pressed about what he meant by saying Mr. [redacted] was "telling," he essentially admitted he was calling him a snitch but again blamed the class member without taking responsibility for his own comments: "So, I mean he was very loud and clear that he was uh trying to tell on somebody in front of all the population that was in front of, around us, uh and, like I said it's very known it's an SNY yard, inmates are known for telling on each other." *Id.* at 33:28.

The Hiring Authority—the Chief Deputy Warden at Chuckawalla Valley State Prison—sustained multiple allegations against Sergeant [redacted] including for (1) discourtesy, (2) negligent endangerment of Mr. [redacted] and (3) making intentionally false or intentionally misleading statements during the AIU investigation. The false statement charge stated that Sergeant [redacted] "was dishonest to an Office of Internal Affairs Investigator during an interview when asked if he called [redacted] a 'Snitch' or any term similar and [redacted] responded '..any term similar? No I didn't label him or nothing. I don't recall saying he's a snitch at all.'" *See* 402 at 2. Intentional dishonesty carries a base penalty of Level 9, which is dismissal. *See* Employee Disciplinary Matrix. The Hiring Authority dismissed Sergeant [redacted] listing one mitigating factor and nine aggravating factors. *See* 403 at 2. One of the aggravating factors was that Sergeant [redacted] "has committed repeated acts of misconduct resulting in prior sustained adverse action." *Id.* Indeed, in the NOAA, the Hiring Authority stated that Officer [redacted] had two adverse actions still on record, including for one effective December 1, 2023 for using unnecessary immediate force. *See* NOAA at 14.

Sergeant [redacted] appealed his termination to the State Personnel Board. There, the case was consolidated for appeal with three other pending adverse actions against Sergeant [redacted] in addition to the two discussed in the NOAA. *See* SPB Docs at 21. Those other three adverse actions included two separate cases for threatening incarcerated people with physical harm and one for denying an *Armstrong* class member an incontinence shower. **This makes a total of six adverse actions against Sergeant [redacted] within a period of three years.** Furthermore, during the staff misconduct litigation in 2020, three class members submitted declarations about disability-related misconduct and retaliation by Sergeant [redacted] including (1) an allegation that Sergeant [redacted] retaliated against a class member and called him a "snitch" after the class member reported misconduct, *see* Dkt 3023-5, July 10, 2020, and (2) another allegation

that Sergeant [redacted] asked a class member "so you're going to snitch on him?" in front of multiple incarcerated people. *See* 3109-1, September 10, 2020.

In the SPB proceedings, CDCR settled for a "Permanent Demotion," which is a Level 8 penalty. In an explanation for the settlement, CDCR wrote of the dismissal that "the NOAA lacked substantiated evidence to have it sustained at SPB." *See* SPB Docs at 21. Specifically, an RJD official wrote: "To substantiate an allegation of dishonesty on the dismissal case, one must demonstrate clear evidence of dishonesty accompanied by an intent to deceive. Based on the information currently available to me, it appears that the requisite evidence to maintain such a charge was lacking. Even if one considers Mr. [redacted] statement to the investigator to be technically dishonest, the evidence does not support a preponderance." *Id.*

To the contrary, Sergeant [redacted] reviewed the BWC with his counsel beforehand, and thus knew what the video shows: Sergeant [redacted] telling Mr. [redacted] in front of numerous incarcerated people, "It sounds like you're here for telling though." Despite the clear implication of that statement, and his statements in the interview essentially blaming Mr. [redacted] for snitching so openly, Sergeant [redacted] denied calling Mr. [redacted] a "snitch" or "any term similar" when pressed by the investigator. Sergeant [redacted] also failed to provide any alternative meaning behind his statement that Mr. [redacted] was "telling." CDCR's disciplinary action resulting in settlement and demotion was inappropriate in this case. The evidence and prior sustained findings of misconduct clearly support the initial imposed penalties. Sergeant [redacted] should have been dismissed instead of being placed in a position with even greater contact with incarcerated people.

II. Investigations Reveal Continuing Problems with Video Evidence

A. Investigators Routinely Fail to Retain and Review Relevant Video Footage, Including Due to the 90-Day Retention Policy

As Plaintiffs have repeatedly reported, CDCR continues to fail to retain and review all footage necessary for investigating staff misconduct allegations. In multiple cases selected for review by Plaintiffs, footage was lost when investigators failed to act to preserve all relevant footage before the 90-day retention period ran out. *See, e.g.*, RJD-[redacted], KVSP-[redacted], KVSP-[redacted], KVSP-[redacted], KVSP-[redacted], COR-[redacted], COR-[redacted], COR-[redacted], LAC-[redacted].

Plaintiffs' findings are consistent with those of the OIG. In the October 2024 OIG report "Monitoring Internal Investigations and the Employee Disciplinary Process, January-June 2024" (henceforth, "Oct. 2024 OIG Report") the OIG recommends that CDCR "extend its body-worn camera video retention policy to secure important evidence." Report at 45. The OIG reported several examples of cases in which the 90-day retention deadline led to the destruction of relevant evidence. *Id.* at 46-48.

In numerous other cases, investigators failed, without justification, to obtain all footage necessary to investigate allegations. *See, e.g.*, SATF-[redacted], SATF-[redacted], RJD-[redacted], KVSP-[redacted], KVSP-[redacted], KVSP-[redacted], COR-[redacted], COR-[redacted], COR-[redacted], COR-[redacted], COR-[redacted], COR-[redacted], LAC-[redacted], LAC-2[redacted], LAC-[redacted], LAC-[redacted], LAC-[redacted], LAC-[redacted], LAC-[redacted]. These failures prevent CDCR from adequately investigating allegations, as the OIG confirmed: "failure to secure video evidence before investigations begin can hinder the thoroughness of an investigation and can negatively impact investigative and disciplinary determinations." Oct. 2024 OIG Report at 45.

The OIG specifically recommended that CDCR extend retention times to one year "because 90 days is not enough time given department time frames for referring misconduct and initiating investigations." *Id.* at 48. Plaintiffs agree. Defendants should retain footage for longer than 90 days, to ensure that all relevant footage is available to investigators, if the investigation is delayed or otherwise it is later determined that more footage is necessary to investigate the allegation.

B. Officers Are Not Complying with BWC Policies

The cases reviewed by Plaintiffs' counsel this quarter included multiple examples of BWC violations and potential violations where CDCR did not sustain any discipline. For example, in LAC-[redacted], the subject officer's footage contained four BWC violations, including one deactivation that stretched over four hours. In another instance, the officer deactivated his BWC while walking across the yard with another officer. The subject officer's conduct was consistent with the class member's allegation that the subject officer conducted a cell search without his BWC. Footage from another officer involved in the incident shows a fifth BWC violation. Yet, despite noting two of the deactivations, the investigator did not even interview the subject officer, nor did the Hiring Authority consider or sustain discipline against either officer. Other cases with BWC violations or potential violations include LAC-[redacted], COR-[redacted], COR-[redacted], COR-[redacted] These findings are corroborated by recent OIG reports showing clear-cut cases of officers who were not identified as being responsible for nor investigated for violating BWC policies until the OIG intervened. *See* Office of the Inspector General, "Monitoring the Use-of-Force Review Process of the California Department of Corrections and Rehabilitation," August 2024, at 36-40. CDCR must start taking accountability for BWC violations seriously.

III. 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.