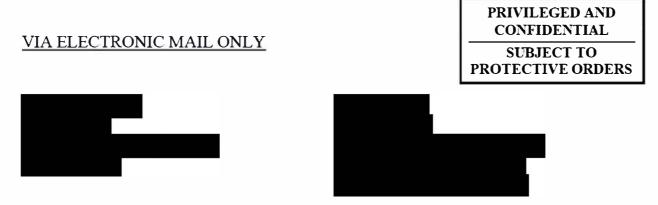


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February 10, 2025



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

Dear :

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

Plaintiffs have again found substantial evidence that CDCR's accountability system is failing. For this report, Plaintiffs analyzed half of all AIU cases for the six prisons in Q4 2024. 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.

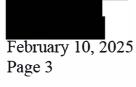
February 10, 2025 Page 2

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.

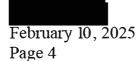
² See Additional Evidence of Accountability System Failures in Review of All Cases from KVSP Q3 2024 (December 10, 2024); Additional Evidence of Accountability System Failures in Review of All Cases from LAC Q4 2023 (April 24, 2024).



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.

///



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





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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%

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- - 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.) alleged that canteen supervisor 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 Mr. spoke with canteen supervisor Mr. 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. reintroduce an "ADA day" for people with disabilities to more efficiently pick up their canteen orders. Mr. alleges that Mr. 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. denied making these comments, though he did admit to "raising his voice at and telling Mr. 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. submitted his 602 on June 8, 2022. See 602 at 1. Although Sgt. Mr. was assigned this case on August 17, 2022, SATF did not receive her request for

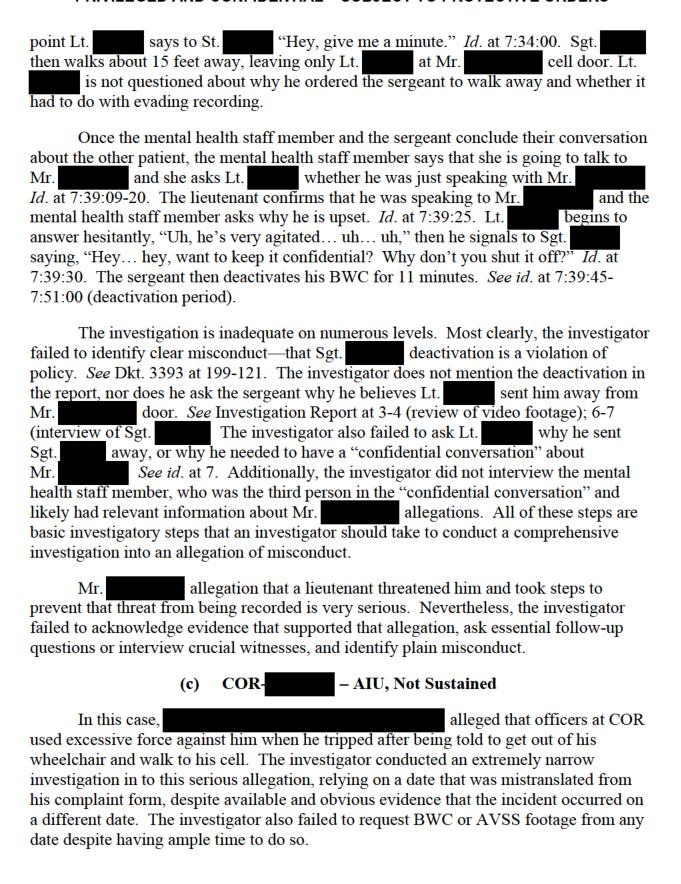
BWC and AVSS footage until September 12, 2022—one week after the footage was no longer available. *See* IR at 1; CDCR 1118: Body-Worn Camera Video Evidence Request. It is not clear why Sgt. did not request footage sooner. This case illustrates the importance of extending the video retention period to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

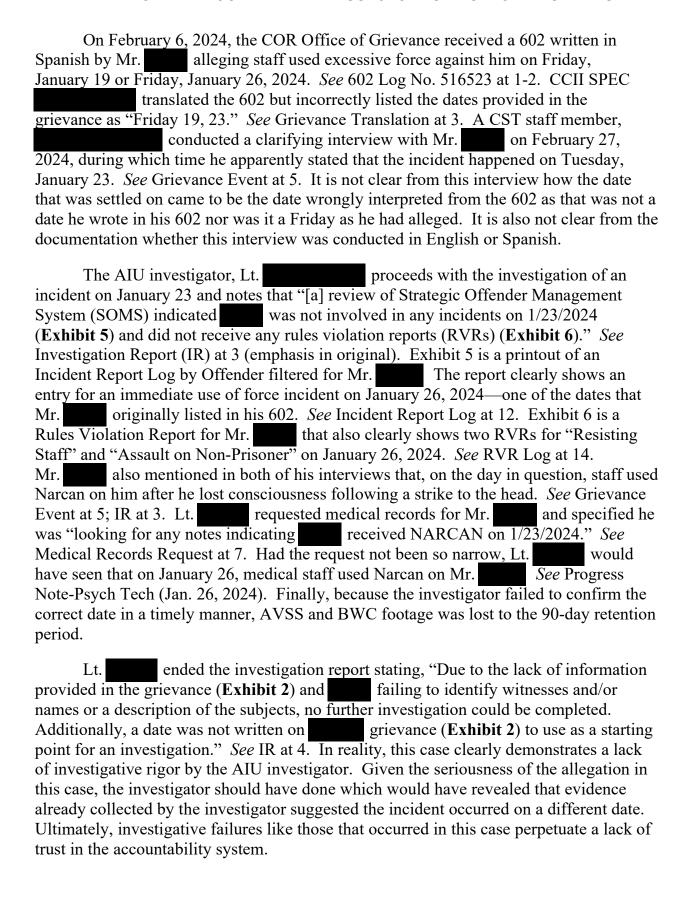
(b) COR- - AIU, Not Sustained

In this case, 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. 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. visited Mr. cell to persuade him to remove his window coverings but was unsuccessful in doing so. See id. at 2. Lt. then visited Mr. cell. Mr. 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. allegedly threatened Mr. with "death and violence," challenged him to a fight, and discussed planting knives in his cell. Id.

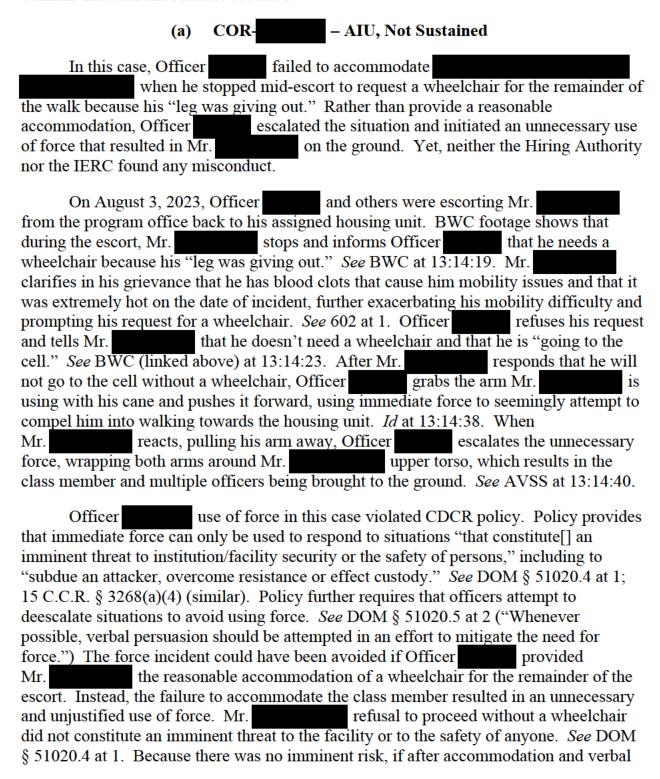
Sergeant BWC footage supports Mr. version of events. The BWC included in the file begins with he and Lt. clip of Sgt. discussing Mr. situation in the dayroom. See BWC 1 at 7:30:05. After about a minute of conversation, Sgt. and Lt. walk to Mr. cell door. *Id*. at 7:31:05. The sergeant walks outside to look through Mr. 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. 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. tries deescalating the situation by having a conversation with Mr. but after about 20 seconds, Lt. who is standing behind the sergeant, says to Mr. want us to go in and get you?" *Id.* at 7:33:30. This starts a back-and-forth between where he seems to be aggravating Mr. Mr. and Lt. instead of eventually threatens Lt. trying to deescalate the situation. Mr. at which





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.



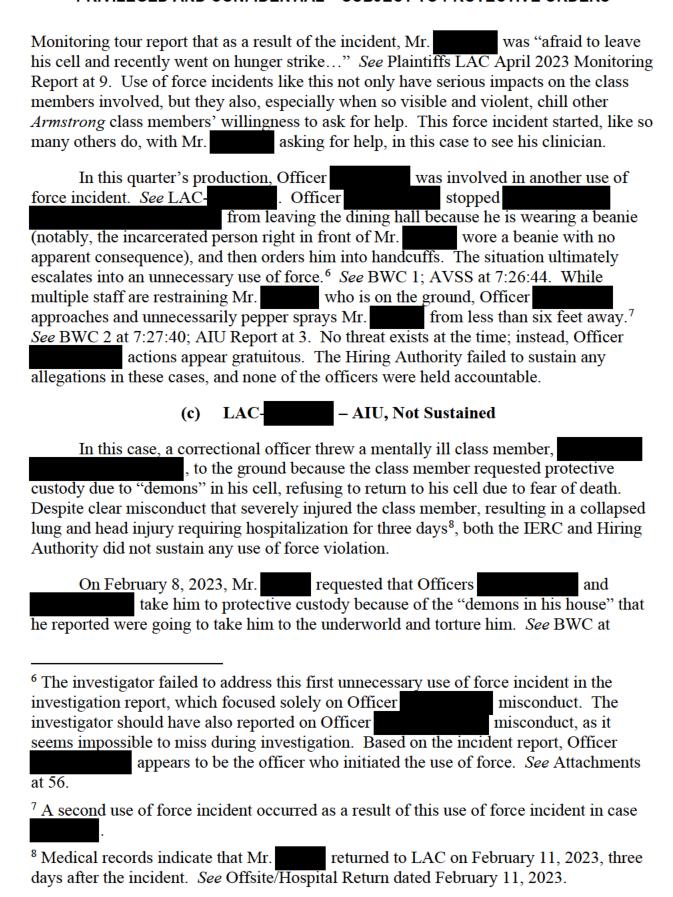
persuasion (including the threat of an RVR), Mr. still refused, controlled force and not immediate force would have been appropriate. Given custody staff's failure to provide a simple accommodation, the Hiring Authority should have, at minimum, sustained an allegation for failure to observe and perform within the scope of training (D26, 12345) and for unnecessary force (L1, 123). See Employee Disciplinary Matrix. LAC-- AIU, Not Sustained **(b)** In this case, Officer improperly used immediate force against an Armstrong class member with mobility disabilities, . In Plaintiffs' November 2024 Report, we outlined seven separate use of force incidents involving Officer 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 incident⁵ stated that "as usual, C/O P. was the lead in using the excessive force/unnecessary force." See 602 at 1-3 (written by another Armstrong class member, So far, the accountability system has failed *Armstrong* class members with respect to Officer Plaintiffs' counsel demand to know what, if any, action CDCR is taking to ensure that Officer 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. who is seated in his wheelchair in a mostly empty dayroom. Although not evident on video, the AIU report indicates that staff allowed Mr. to cool down in the dayroom for about an hour following a search of his cell. See AIU Report at 3-4. Mr. 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. needs to go to his cell, but staff will send the psychiatrist to him. See BWC (linked above) 11:50:53. Mr. refuses. After some discussion, to "take it in" and attempts to push Officer then orders Mr. in his wheelchair towards his cell. See BWC (linked above) at 11:53:26. Mr. When another officer grabs Mr. wheelchair, Mr. turns backwards and tells him to wait; Officer then grabs Mr. hand. See BWC (linked above) at 11:53:50. After several seconds, Mr. says he will go to the ⁵ A second use of force incident occurred as a result of this incident, and was investigated The BWC linked in this write-up is from case in case because it provides more context. The investigator in this case should have reviewed video starting

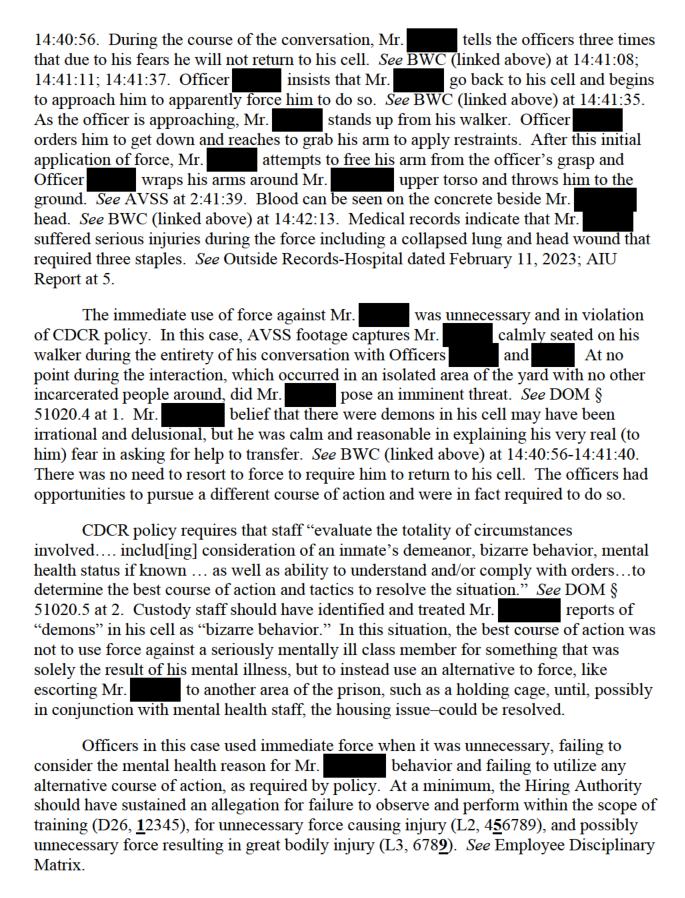
and staff.

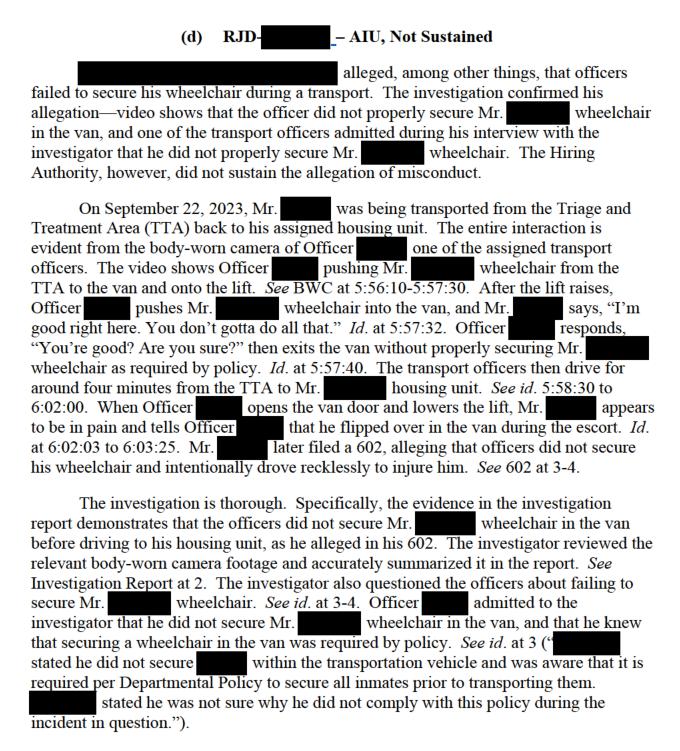
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at the beginning of the conversation between Mr.

cell on his own and repeatedly tells Officer to let go of his hand, which he does eventually. The officers follow as Mr. rolls to his cell. stands up from his wheelchair, surrounded by six At the cell, Mr. officers. He says multiple times "I need my doctor." See BWC (linked above) at adjusts his sleeves (in his AIU interview, Mr. 11:54:44. Mr. 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. asks why. The officer was "getting ready" (to fight). Several seconds later, Officer claims Mr. activates the alarm and grabs Mr. and pushes him into his cell. See BWC (linked above) at 11:54:52. Another officer sprays Mr. with pepper spray. Officers, including Officer rip off Mr. shirt and pull him into the dayroom. While officers are surrounding and grabbing Mr. Officer who is outside the circle of officers, strikes Mr. at least 10 times. See AVSS at 11:55:07; AIU Report at 9. Officer used immediate force – grabbing Mr. 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, was telling officers that he needed his doctor and presented no threat. wrote in his incident report that Mr. Officer "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. stance. Moreover, by the time Officer used force, the actions that allegedly justified the use of immediate force—Mr. standing up from his wheelchair and adjusting his sleeves—had passed. Officer omits that Mr. actively discussing with staff his need for mental health attention. Instead, as has occurred multiple times in other cases Plaintiffs have reported on, Officer rushed to use force when other officers were still using verbal persuasion to get to comply with the order. Mr. In addition to the unnecessary rush to use immediate force, Officer striking of Mr. 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. as they pull him out of his cell to effectuate custody. Officer ten strikes to Mr. head area appear gratuitous, punitive, excessively violent, and potentially dangerous to other staff as well as Mr. reported that he had "neck and Several days following the incident, Mr. 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







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

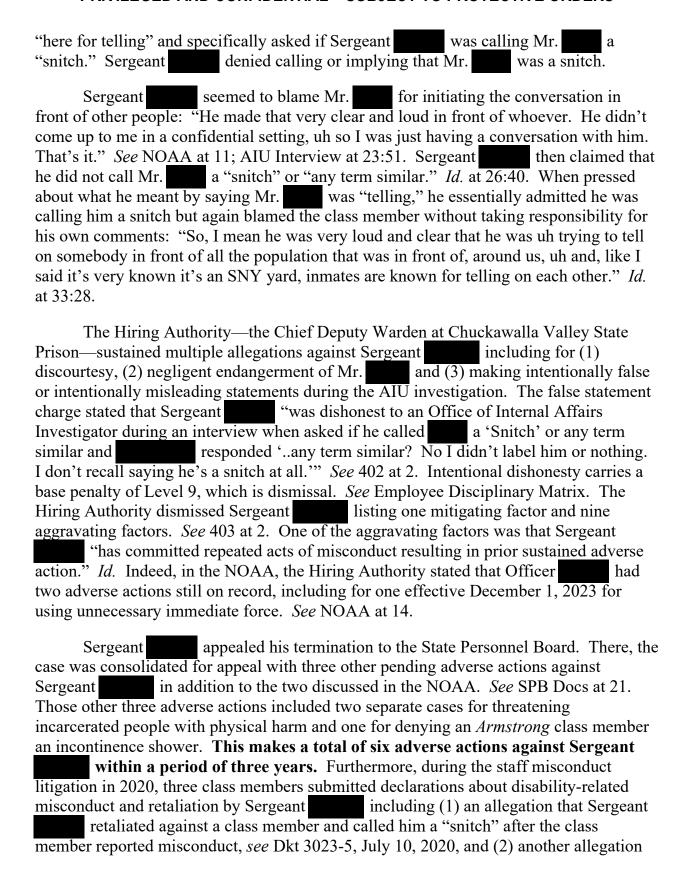
In this case, the Hiring Authority initially issued a Level 9 termination penalty to

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



for lying during an AIU investigation into an allegation that he endangered a class member. CDCR has found that Sergeant violated policy on multiple occasions. The Notice of Adverse Action in this case notes two prior adverse actions against him. Further, when Sergeant 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 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 approaches Sergeant 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. declines to provide names of people who remain there when Sergeant asks. *Id.* at 12:11:35. Sergeant 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. while walking past two incarcerated people, and with others in again. Sergeant 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. filed a 602 the same day, alleging that endangered him by suggesting in front of other incarcerated people that Sergeant he was a "snitch." See Grievance at 3. On December 1, 2023, the AIU investigator interviewed Sergeant See AIU Report at 4. Sergeant 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 multiple opportunities to explain what he meant when he said Mr.

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



that Sergeant 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. Statement to the investigator to be technically dishonest, the evidence does not support a preponderance." Id.

reviewed the BWC with his counsel beforehand, To the contrary, Sergeant and thus knew what the video shows: Sergeant telling Mr. 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 for snitching so openly, Sergeant blaming Mr. denied calling Mr. a "snitch" or "any term similar" when pressed by the investigator. Sergeant also failed to provide any alternative meaning behind his statement that Mr. "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 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-, KVSP-, KVSP-, KVSP-, KVSP-, LAC-, COR-, COR-, LAC-

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-, RJD-, KVSP-KVSP-, KVSP-, COR-, COR-, COR-COR-, COR-, COR-, COR-, LAC-LAC-2 LAC-LAC-. LAC-. LAC-. LAC-LAC-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. , the subject officer's footage contained four BWC For example, in LACviolations, 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-, COR-. COR-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.