ROSEN BIEN
GALVAN & GRUNFELD LLP

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

[redacted]
Email: [redacted]

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PRIVILEGED AND CONFIDENTIAL

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Re: *Armstrong v. Newsom*: Plaintiffs' Review of CDCR's Accountability System
Our File No. 0581-03

Dear [redacted]:

We write regarding our review of Defendants' system for investigating and holding staff accountable for misconduct. This 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").[1] As detailed below and

[1] For RJD and SATF, the production included documents for cases closed between June 1-August 31, 2022. For KVSP and COR, the production included documents for cases closed between July 2-October 1, 2022. For LAC and CIW, the production included documents for cases closed between May 2-August 1, 2022. We also included five cases from the prior quarterly production for LAC, which were not produced in full by Defendants until it was too late for Plaintiffs to include the cases in the September 2022 Report (the last report which included a review of LAC cases).

in the accompanying Table A[2] (which is a separate Excel file), Plaintiffs found that Defendants continue to fail to comply with the *Armstrong* Court Orders, which have now been affirmed in relevant part by the Ninth Circuit, and the RJD and Five Prisons Remedial Plans. *See* Dkts. 3059, 3060, 3217, 3218, 3393; *Armstrong v. Newsom*, No. 21-15614, 2023 WL 1468771, at *1 (9th Cir. Feb. 2, 2023).

Hiring Authorities continue to fail to sustain findings of misconduct supported by the preponderance of the evidence and to impose appropriate discipline in the rare cases in which they find misconduct. *See* **Section I.A**, *infra*. Investigators continue to conduct incomplete and biased investigations, routinely failing to retain and review available video footage and making other investigative decisions that suggest they are trying to sweep allegations under the rug rather than determine whether misconduct occurred. *See* **Section I.B** *infra*. And officers continue to violate BWC policies with impunity. *See* **Section II**, *infra*.

The cases suggest that Defendants have made little progress in complying with the Court's Orders or the Remedial Plans. In particular, Plaintiffs identified twelve cases—including eight from a single prison (LAC) and nine involving uses of force—in which Hiring Authorities failed to hold staff sufficiently accountable where the preponderance of the evidence showed serious misconduct occurred. As detailed below, the cases with inadequate accountability include instances of shocking and upsetting misconduct—assaulting a person simply because he got under the officer's skin; providing confidential commitment offense information to other incarcerated people with the intent to have those people assault individuals convicted of sex crimes; spraying a mentally ill person in crisis with a fire hose for nine minutes; throwing an unresponsive person from a top bunk to the concrete floor of a cell as part of an emergency cell extraction intended to help the person; kneeling with full body weight on a prone person's head and neck; unnecessarily pepper spraying multiple people; and other unnecessary and excessive uses of force. In each of these cases, Hiring Authorities imposed no discipline or inadequate discipline.

Plaintiffs also identified numerous cases in which investigators failed at basic investigative tasks, including obtaining relevant, available video footage that could definitively answer whether staff engaged in misconduct. *See* **Section I.B**. These

[2] This report contains links to external documents and internal sections within the report. External links are underlined; internal links are not underlined.

failures are inexcusable and infuriating. Defendants have spent millions of dollars to comply with the Court's orders to install and implement AVSS and BWC. Obtaining relevant video evidence should, in almost every investigation, be the first and most urgent task for the investigator. Yet Defendants' investigators routinely delay in requesting video, request the wrong video, or review inadequate periods of video. Viewed collectively, these video-related and other investigative failures give the appearance of investigators intentionally trying to avoid gathering video footage and other evidence so as to make it impossible to hold staff accountable.

Many of the problems identified in this Report involve actors—Hiring Authorities, Office of Internal Affairs/Allegation Inquiry Management Section investigators, locally-designated investigators—whose roles remain the same or very similar in Defendants' old and new investigation systems. It is discouraging that, more than two years after the Court's initial RJD Order, the analysis, decision-making, and outcome of investigations has not significantly changed. Defendants already have the tools for accountability, including AVSS and BWC at the Six Prisons, and yet are still failing to hold staff accountable when the evidence shows they engaged in misconduct. These cases reaffirm that the new staff misconduct complaint process is only as good as the actors making decisions in that process. Currently, those actors' decisions are inadequate.

At the end of each case write-up in **Section I**, Plaintiffs have asked questions of Defendants intended to determine if Defendants agree with Plaintiffs' analysis of the case. Based on Defendants' response to Plaintiffs' last report, which was essentially a wholesale denial of problems unsupported by evidence, these questions are necessary to determine if there is consensus on (1) whether staff misconduct has occurred and, if so, whether the discipline imposed was appropriate, and (2) whether investigations are complete and unbiased.

Unless Defendants demonstrate rapid improvement in the ways they investigate and discipline staff for serious misconduct, Plaintiffs will have little choice but to return to court.

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' counsel closely reviewed 78 cases: 15 cases from LAC, 14 cases from CIW, 12 cases from RJD; 14 cases from SATF; 13 cases from COR; and 10 cases from KVSP.[3] The complete findings from Plaintiffs' review are contained in Table A. Note that the findings for each prison appear in separate tabs of the Excel file.

Below, Plaintiffs describe 17 cases that illustrate serious, ongoing problems regarding Defendants' accountability system. There are cases where: (1) the Hiring Authority either failed to sustain misconduct or failed to impose appropriate discipline for sustained misconduct or (2) an incomplete and/or biased investigation interfered with the ability of a decision maker to determine whether misconduct occurred. Some cases evidence both types of problems.

A. Hiring Authorities Failed to Hold Staff Accountable When the Preponderance of Evidence Shows Misconduct

Plaintiffs' review of cases reveals two serious problems: Hiring Authorities failing to sustain serious allegations supported by a preponderance of the evidence and failing to

[3] Plaintiffs selected the cases using a variety of criteria, including, but not limited to, whether: CDCR referred the case to OIA for investigation or direct adverse action; AIU investigated the case; AIMS conducted an inquiry; the case involved an allegation related to use of force or disability; the Hiring Authority sustained an allegation; and the case included video evidence. These criteria are intended to identify cases with the most serious and credible allegations of misconduct, which we then review to determine whether Defendants are holding staff accountable when the evidence shows misconduct occurred.

impose appropriate discipline when they do sustain allegations. As discussed in more detail in Appendix A, the productions covered by this Report included 426 unique cases. Hiring Authorities imposed adverse action in only 2 cases (0.5%). And, as discussed below and in Table A, the discipline in those cases was inadequate. *See* LAC – [redacted]; COR – [redacted] (addressed in Table A). Meanwhile, Plaintiffs only reviewed a subset of the 426 cases, but identified 12 cases with serious problems in Hiring Authority decision making. In 10 of these cases, the Hiring Authority did not sustain one or more serious allegations of misconduct even though the preponderance of the evidence showed that the misconduct occurred. In 5 of these cases, the Hiring Authority sustained an allegation of misconduct, but did not impose appropriate discipline to punish the misconduct. And in one case, Defendants failed to refer an officer for criminal prosecution for committing battery on an incarcerated person despite indisputable video evidence of the crime, eyewitness testimony from a sergeant, and an admission by the officer. (Note that these numbers add up to more than 12 cases, as some cases contained multiple types of problems.)

Eight of the cases that reveal misconduct and problematic Hiring Authority decision making are from LAC. They involve very serious allegations of misconduct, nearly all of which are captured on video. And in each of the cases, Warden Johnson, who has now retired, failed to hold staff at the prison accountable. These cases from LAC include the following:

- [redacted] – Warden Johnson did not sustain an excessive use-of-force allegation against an officer who, as part of an emergency cell entry, threw an unresponsive disabled incarcerated person from the top bunk to the concrete floor of the cell.

- [redacted] – Warden Johnson did not sustain use-of-force or endangerment allegations against an officer who unnecessarily pepper sprayed two people, then nearly caused a riot by unnecessarily threatening approximately 20 incarcerated people who were attempting to decontaminate from the residual pepper spray.

- [redacted] – Warden Johnson did not sustain use-of-force allegations and only issued corrective action against a sergeant and an officer who, in a case that harkens back to the 1960s, used a fire hose to spray a seriously mentally ill person for nine minutes in an attempt to clean him of urine and feces and then did not report the incident as a use of force.

- [redacted] – Warden Johnson did not sustain relevant allegations (disclosure of confidential information with intent to harm and unauthorized access of information) against an officer who accessed, without any legitimate explanation, information about an incarcerated person's sex crime, and then shared that information with other incarcerated people who proceeded to assault the person minutes later. Moreover, OIA did not refer the case to a local prosecuting agency even though the evidence warranted such a referral.

- [redacted] – Neither Warden Johnson nor OIA even considered a criminal investigation into an officer who committed criminal battery on a person when he slammed the person's head and body into the back of a holding cell because, as the officer admitted, he was angry at the person. And Warden Johnson issued a Level 7 penalty to the officer, rather than terminating him (Level 9).

- [redacted] – Warden Johnson failed to discipline an officer who improperly used immediate force to pepper spray a person in his cell, failed to discipline two officers who used excessive force when they later slammed the same person to the floor head first, and then improperly issued only corrective action against an officer who used excessive force when he stomped on the person's legs.

- [redacted] – Warden Johnson did not discipline four officers who participated in or observed an unclothed body search conducted in the middle of a day room in plain view of other incarcerated people, and improperly issued only corrective action against the sergeant who oversaw the search.

- [redacted] – Warden Johnson did not discipline multiple officers, including the same officer from LAC – [redacted] (discussed above), who improperly used immediate force against an incarcerated person who was peacefully refusing to return to his housing unit because of safety concerns.

These eight cases, as well as previous cases from LAC with similar failures in Warden Johnson's decision-making, *see* September 2022 Report at 7-13, illustrate two significant problems. First, Warden Johnson, prior to his retirement in December 2022, was a significant barrier to staff accountability at LAC. Second, Defendants' accountability system failed to detect a Hiring Authority making poor decisions and to remedy that problem. *See* Injunction, Dkt. 1045, at 7 (Jan. 18, 2007) ("[D]efendants …

shall develop a system for holding wardens … accountable for compliance with the Armstrong Remedial Plan and the orders of this court.").

Please identify any mechanisms by which Defendants self-identify Hiring Authorities who are exercising poor discretion over accountability.

Please identify any steps you have taken with respect to specific Hiring Authorities who you have identified as exercising poor discretion over accountability.

The cases from LAC and the other prisons also reflect a serious problem with CDCR failing to appropriately discipline officers in use-of-force cases. Six of the LAC cases and three of the cases from the other prisons involved serious accountability problems in use-of-force cases.

- CIW – [redacted] – The Hiring Authority failed to sustain a use-of-force allegation against an officer who escalated, rather than deescalated, a situation, resulting in an immediate use of force.

- COR – [redacted] – The Hiring Authority failed to sustain an excessive use-of-force allegation against an officer who, once an incarcerated person was prone on the ground, dangerously placed his knee and full body weight on the person's head and/or neck.

- KVSP – [redacted] – The Hiring Authority failed to sustain allegations regarding BWC non-compliance against a sergeant and an officer whose BWCs were improperly deactivated in ways that made it impossible to determine whether the sergeant used excessive force after an incarcerated person kicked him.

These cases reflect a pattern that Plaintiffs have reported on in multiple prior reports: Hiring Authorities failing to find misconduct and hold staff accountable for violations of CDCR's use of force policies that are captured on video. Until Hiring Authorities begin to discipline staff for improper uses of force, Defendants will never fix their long-standing cultural problem. And until Defendants fix their cultural problems, they will continue to interfere with class members' ability to receive needed disability accommodations and will remain out of compliance with the Americans with Disabilities Act ("ADA"), the Remedial Plans, and the Court Orders.

1. LAC – [redacted]

In this case, during an emergency cell rescue, Officer [redacted] used unnecessary and excessive force when he threw a mentally ill and unresponsive class member, [redacted], off of the top bunk onto the concrete floor. Yet, after OIA authorized direct adverse action, the Hiring Authority failed to sustain a charge of excessive force.

According to incident reports, Mr. [redacted] had reportedly been completely unresponsive and motionless to verbal requests from medical and custody staff. *See* 989 at 22; 25.[4] Medical staff concluded that he needed a higher level of care and transfer to an outside hospital. This led to an emergency cell rescue. In the video, Mr. [redacted] can be seen lying unresponsive on the top bunk, with his arms hanging limply off the side. Staff enter the cell, but Mr. [redacted] still does not respond. Officer [redacted] who is the first officer into the cell, then firmly yanks Mr. [redacted] off of the top bunk. Officer [redacted] does very little, if anything, to brace Mr. [redacted] fall (he claims in his incident report that he held on to Mr. [redacted] clothing as he fell, though the video is unclear). Mr. [redacted] falls approximately 5 feet from the top bunk onto the concrete floor, landing on his side with almost the full force of his body weight.

Officer [redacted] actions could have seriously injured or even killed Mr. [redacted] and violated CDCR's use of force policy. Mr. [redacted] did not pose a threat to himself or officers that required such a dangerous and risky use of force. The officers all had protective gear and shields. They could have taken measures to attempt to awaken Mr. [redacted] (e.g., using their batons or shields to poke or shift Mr. [redacted] with their shields as protection) or, if unsuccessful, could have more safely removed him from the top bunk and lowered him to the ground. None of the officers warned Mr. [redacted] that they were going to use such force. Instead, Officer [redacted] used force that unnecessarily put Mr. [redacted] at risk and that was not commensurate to the risk, if any, that he posed to himself or others. Even the Letter of Instruction Officer [redacted] received for the unrelated policy violation of dropping his shield acknowledges that Mr. [redacted] "was not resistive when you grabbed him and pulled him from the top bunk to the ground." *See* LOI at 2. Despite this evidence that the force used was unnecessary

[4] In these case summaries, all citations to page numbers of documents refer to the page of the PDF, not to any internal pagination in the document.

and excessive given the circumstance, the Hiring Authority did not sustain excessive or unnecessary use of force allegations.

Questions for Defendants

1. Does the preponderance of evidence in this case show that Officer [redacted] used excessive and/or unnecessary force when he threw Mr. [redacted] from the top bunk to the ground? If no, why not?

2. LAC – [redacted]

In this case, video shows Officer [redacted] unnecessarily escalating a situation that another officer was deescalating, and then pepper spraying two incarcerated people who did not pose any immediate threat to safety and security. Over the next few minutes, Officer [redacted] antagonized dozens of other incarcerated people who were suffering from exposure to the pepper spray and gasping for breath, including by challenging the incarcerated people to fight him and threatening to pepper spray them when they tried to decontaminate. Officer [redacted] dangerous and unprofessional conduct so inflamed tensions that a sergeant ordered Officer [redacted] to leave the scene and staff had to call a Code 2 alarm to quell the situation.

As is discussed more fully below, the Hiring Authority improperly sustained only one charge for discourteous conduct based on Officer [redacted] saying "what is the problem … who has a fucking issue" to the three incarcerated people who were involved in the pepper spray incident. *See* 402 at 1. And the Hiring Authority issued only corrective action (Letter of Instruction). *See* LOI. The Hiring Authority failed to sustain a host of more serious allegations, including unnecessary use of force, and failed to impose commensurate adverse action.

The video evidence shows Officer [redacted] and [redacted] engaged in a dispute about Mr. [redacted] returning to his cell . *See* BWC.[5] Officer [redacted] escalated the encounter when another officer stepped in to deescalate. However, after that successful resolution and after Mr. [redacted] had returned to his cell front, Officer [redacted] began mocking Mr. [redacted] He stated, "you got up, huh? Good job. How about

[5] This link is to Officer [redacted] entire BWC video; the subsequent links are to excerpts from this video.

that? Good job. I'm proud of you. Proud of you. Go for it." He also mockingly held two thumbs up. Officer [redacted] then walked away. He then saw Mr. [redacted] and two other incarcerated people—[redacted], and [redacted]—talking to another officer. Officer [redacted] jogged over to the group. Along the way, Officer [redacted] muttered, "we still got a fucking problem, we still got issues, we still got fucking issues." Officer [redacted] then charged into the group and pushed the other officer out of the way. Officer [redacted] ordered Mr. [redacted] to "turn around and cuff up." At that same moment and without providing Mr. [redacted] with any time to comply, Officer [redacted] reached out aggressively to grab Mr. [redacted] wrist or arm. Mr. [redacted] pulled away, said "don't touch me," and squared up. Officer [redacted] then pepper sprayed Mr. [redacted] and Mr. [redacted]

Officer [redacted] immediate use of force was improper and unnecessary. At the time that Officer [redacted] charged into the group, the incarcerated people did not pose an immediate threat to safety or security. In fact, as the Hiring Authority recognized in the 989 form submitted to OIA, the other officer was, in accordance with policy, trying to deescalate the situation by verbally persuading the three incarcerated people to return to their cells. *See* 989 Request at 2. Officer [redacted] escalated the situation by demanding that Mr. [redacted] submit to handcuffs. And then, Officer [redacted] further escalated the situation by grabbing at Mr. [redacted] without giving him an opportunity to comply. CDCR does not authorize an immediate use of force when incarcerated people fail to comply with an order, which is ultimately what predicated the use of force in this case (Mr. [redacted] failure to immediately submit to handcuffs). DOM § 51020.4. Once Officer [redacted] escalated the situation and the incarcerated people took a defensive stance, Officer [redacted] may have been justified to use force. But Officer [redacted] action needlessly escalated the situation to that point and caused the use of force.

Officer [redacted] conduct following the use of force also was extremely problematic. He can be seen on BWC footage taunting and antagonizing people who are struggling to breathe after being exposed to the pepper spray. Officer [redacted] says to this group, "Take a seat…. It's not that bad. That's some good shit isn't it…. I did it, that was all me, you guys have a question, say something to me…. I sprayed all of it…. You damn right I did." When some of the incarcerated people attempt to access the nearby water fountain to decontaminate, Officer [redacted] screams "Take a seat! Sir, take a seat! You don't need water! … Don't make me do it [use pepper spray] again! … Take a seat!" When incarcerated people respond angrily to his aggression, Officer [redacted] further incites them and says "By all means, go ahead!" as if challenging them to a fight. A

sergeant then orders Officer [redacted] to leave the scene and provides the incarcerated people with permission to decontaminate. Officer [redacted] starts walking away, but then, hears an incarcerated person say something inaudible that further enrages him. In violation of the supervisor's order, he then starts jogging back to the group of incarcerated people, and yells "How dare you? Come on!" He further antagonized the incarcerate people, incited them to fight him, and jeopardized the safety and security of multiple staff and incarcerated people by creating a dangerous situation. . As he walks away, he mutters under his breath, "wish they would."[6]

Officer [redacted] had singlehandedly incited such a large group of incarcerated people—first by using unnecessary force and then by being discourteous and threatening about decontamination—that staff had to call in a Code 2 to quell what could have been a budding riot. *See* BWC at 13:15:33. The video shows eight officers with weapons running onto the yard). *See* BWC at 13:17:20. This weaponized response resulted from Officer [redacted] conduct and significantly increased the risk of harm to the officers and incarcerated people.

Based on this evidence, the Hiring Authority should have sustained charges for (1) unnecessary use of force (L1, 1**2**3), and (2) negligently endangering self or others by violation of "departmental policy … or training" (D2, 1**2**3). The Hiring Authority also should have sustained multiple charges of discourtesy (D1, **1**23456). Officer [redacted] behavior and complete lack of ability to control himself and act professionally in the face of adversity suggests that he requires significant additional training, oversight and corrective action, in addition to adverse action commensurate with the serious violations in this case.

[6] Plaintiffs reviewed another case—KVSP – [redacted]—in which an officer similarly incited incarcerated people. In that case, staff and incarcerated people were engaged in a heated verbal dispute about why the officers did not release some people for the dayroom. An officer appears to attempt to goad the incarcerated people into fighting staff when he says: "Everyone has a loud mouth, but you won't do nothing, bro. Everyone has a loud mouth, but you won't do nothing. Keep running your mouth, bro." An incarcerated person says, "Be professional please. You're on camera." The officer replies, "I don't care about the camera." *See* BWC.

The Hiring Authority did not consider these charges, let alone sustain them and punish Officer [redacted] accordingly. The Hiring Authority instead sustained a single charge—discourtesy—related to Officer [redacted] interaction with Mr. [redacted] Mr. [redacted] and Mr. [redacted] and imposed only corrective action.[7] Officer [redacted] violated policy by failing to deescalate a situation and using unnecessary force, unnecessarily exposed dozens of people to pepper spray, and then nearly caused a riot, but did not receive any adverse action. This case fits the deeply troubling pattern from LAC and elsewhere—serious, blatant misconduct captured on video for which the Hiring Authority imposes, at most, a slap on the wrist.

Questions for Defendants

1. Does the preponderance of evidence in this case show that Officer [redacted] failed to comply with CDCR policy to deescalate situations prior to using force? If no, why not?

2. Does the preponderance of evidence in this case show that Officer [redacted] use of pepper spray was an unnecessary use of force? If no, why not?

3. Does the preponderance of evidence in this case show that Officer [redacted] interactions with incarcerated people outside of the building after using pepper spray were discourteous and/or endangered incarcerated people? If no, why not?

4. Staff and incarcerated people alike appear to be suffering from the effects of the pepper spray in this unit and Mr. [redacted] can be heard audibly struggling to breath after being sprayed in the face. Plaintiffs' counsel has received multiple complaints from class members about a new form of pepper spray that is now in

[7] The 402 lists only a single charge for discourtesy related to the following allegation: "[O]n or about November 27, 2021, … Officer … [redacted] when he [sic] said to … [redacted] …, [redacted] …, and [redacted] …, '… what is the problem …who has a fucking issue …,' or words to that effect." *See* 402 at 1. This narrow charge contrasts with the much broader approval for direct adverse action from OIA, which covered allegations of unprofessionalism, disrespect, jeopardizing safety of staff and inmates, unnecessary/excessive force, and disobeying an order from a supervisor. *See* 989 at 2.

use. Has CDCR recently switched the pepper spray it is using and if so what is now being used?

3. LAC – [redacted]

This case involves the disturbing and highly inappropriate use of a fire hose to spray a gravely disabled, black, 52-year-old class member for over 9 minutes. At the time of the incident, [redacted] was so mentally ill as to be subject to a *Keyhea* forcible medication order. Although the Hiring Authority sustained two charges against the officers and issued corrective action (Letters of Instruction), that discipline was not commensurate with the misconduct here, which fall far outside of any type of behavior officers in CDCR should be engaged in when responding to people with such serious disabilities or otherwise.

On November 29, 2021, according to officer incident reports and the local investigation report in this case, Mr. [redacted] dumped a bag of his own urine and feces on his head. *See* Allegation Inquiry at 1. The video footage produced to Plaintiffs[8] begins about 45 minutes later with officers—including one in a hazmat suit—approaching Mr. [redacted] cell. *See* BWC. Mr. [redacted] cell has feces on the cell door, and Mr. [redacted] has feces on his head. Mr. [redacted] complies with the instruction to cuff up. Mr. [redacted] then exits the cell in his wheelchair and receives his court-ordered medication. Officers roll Mr. [redacted] into the shower and close the shower door. Mr. [redacted] states that he is not going to shower. Officer [redacted] immediately says, "Let's get the water hose." *See* BWC at 19:31:02. Sergeant [redacted] then approves Officer [redacted] using the fire hose because it is a "biohazard." *See* BWC at 19:31:36. A couple minutes later at 19:33:40, Officer [redacted] asks Sergeant [redacted] if using the water hose at low pressure is a use of force and Sergeant [redacted] states, "No, it's water."

Officer [redacted] begins spraying Mr. [redacted] at about 19:35:20 and continues to spray him, with a steady stream of water that appears strong enough to hurt a person, for the next nine minutes. *See* BWC. A voice off-camera says, "This is not 1960!" For parts of the incident, Officer [redacted] sprays Mr. [redacted] from as close as three feet away.

[8] This approximately 45 minutes of footage from Sergeant [redacted] BWC, which the local investigator stated he reviewed, was not produced to Plaintiffs *See* Allegation Inquiry at 1. The footage Plaintiffs received all begins no earlier than 19:27.

Officer [redacted] also sprays him directly in the face (19:42:19). At multiple points, Mr. [redacted] asks whether the officers are done, indicating that he wanted them to stop.

Mr. [redacted] filed a 602 about the incident on December 7, 2021, about a week later.[9] *See* Grievance at 3. In the 602, Mr. [redacted] complained of an injury to his left hand. Based on the report from the inquiry,[10] the Hiring Authority referred the incident to OIA for two allegations against Sergeant [redacted] and Officer [redacted] (1) inappropriate use of the fire hose; and (2) whether use of the fire hose was an unreported use of force. OIA authorized direct adverse action. *See* 989 at 2.

The Hiring Authority only sustained a charge of failure to perform within the scope of training (D26) against Sergeant [redacted] and Officer [redacted] The Form 402 for each officer implied that was the only charge, and ignores the more serious unreported-use-of-force allegation referred to OIA. *See* [redacted] 402/[redacted] 402 at 3.

The Hiring Authority should have considered such a charge and, at a minimum, sustained a charge for unreported use of force (L8, 234**5**6). The Hiring Authority should also have considered whether the officer's conduct constituted excessive or unnecessary unreported force (L9, 45678**9**), which carries a higher penalty.

The use of the hose on Mr. [redacted] was a use of force. The DOM states that use of force options "include but are not limited to" certain enumerated options. *See* DOM § 51020.5. The DOM also acknowledges the existence of non-conventional force, which "utilizes techniques or instruments that are not specifically authorized in policy,

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[9] The case file contains other statements about the genesis of the investigation, as the Letters of Instruction state that on or around February 4, 2022, "information was received alleging staff in Facility D, Building 5 engaged in misconduct on or about November 2021." *See* [redacted] LOI/[redacted] LOI at 1. The file contains no indication for how that "information was received." Plaintiffs did not receive the 602 until December 27, 2022, as part of the LAC Q4 2022 production produced by Defendants.

[10] The inquiry report was generally adequate, though omitted important information. The report makes no mention of Mr. [redacted] repeated "Are you good?" questions to Officer [redacted] and the fact that Officer [redacted] ignored them, as well as Mr. [redacted] request that officers "wrap it up." These omissions may have created the mistaken impression that Mr. [redacted] did not protest his treatment.

procedures, or training." *See* DOM § 51020.4. If a hand hold is a use of force, DOM § 51020.5, spraying the fire hose at someone for a prolonged period of time —and at a pressure that could cause injury—is certainly also a use of force. Neither Sergeant [redacted] nor Officer [redacted]—nor any of the other officers present[11]—reported the use of the hose as a use of force. The fact that, on his 602 Mr. [redacted] reported a left-hand injury as a result of this incident lends further credence to the fact that this was a force incident. Two days later, medical staff documented swelling on Mr. [redacted] left hand. *See* EHRS record dated December 1, 2021. However, the investigation report failed to assess whether the use of force injured Mr. [redacted] even though he reported the injury on his 602.

The evidence also supports a finding that the force was potentially unnecessary and excessive. Mr. [redacted] was experiencing a mental health crisis, and staff should have had a mental health professional evaluate Mr. [redacted]—as the Hiring Authority stated in the Letters of Instruction. *See* [redacted] LOI/[redacted] LOI at 2. That mental health professional could have encouraged Mr. [redacted] to shower and explored alternative ways to clean Mr. [redacted] including by having him transferred to a clinic. Staff could also have turned on the water in the shower for Mr. [redacted] The situation was certainly a difficult one, which underscores why a mental health professional should have been involved. Regardless, using the fire hose as a first resort is highly inappropriate, dangerous, inhumane, and discriminatory towards this gravely disabled person. "[E]xcessive force is the use of more force than is objectively reasonable to accomplish a lawful purpose." *See* DOM § 51020.4. The use of a fire hose in this situation exceeds what is objectively reasonable. The Hiring Authority agreed, stating in Letters of Instruction that "use of the fire hose to clean fecal matter from Inmate [redacted] was an inappropriate means to address the situation," and citing LAC's Local Operating Procedures for people in the mental health services delivery system. *See* [redacted] LOI/[redacted] LOI at 2. For unclear reasons, however, the Hiring Authority failed to sustain the correct charge for that wrongful conduct.

The Hiring Authority erred again when disciplining Sergeant [redacted] and Officer [redacted] for the sustained charge of failing to perform within the scope of training by

[11] The Hiring Authority did not refer any allegations against any other officers to OIA, but arguably, the other officers present for the spraying of Mr. [redacted] also failed to report a use of force that they observed (L10 or L11).

issuing only Letters of Instruction. That violation carries a base penalty of 1, with a range of 1-5. The list of aggravating factors on the officers' 403s—the inherent nature of the act, willful conduct, and the existence of written policies and post orders, among others—far outweigh the one mitigating factor, that the misconduct was "not premeditated." Yet the Hiring Authority concluded on the 403s that he was issuing corrective action rather than adverse action because, in part, "[m]itigating factors outweigh all aggravating factors considered." *See* [redacted] 402/[redacted] 402 at 3. The use of a fire hose to spray an incarcerated person hearkens back to the 1960s, when police officers in the South used hoses to hurt people protesting for racial equality. Then, as it is now, the use of a fire hose by any police officer to manage the population is considered brutal and a potential violation of civil rights. That is especially true when the hose is turned on an elderly and mentally ill person in a wheelchair and for a prolonged period of time. Despite the clear evidence of serious misconduct here warranting adverse action, the Hiring Authority issued only corrective action (Letter of Instruction).

Questions for Defendants

1. Does the preponderance of evidence in this case show that Officer [redacted] engaged in an unreported use of force? If no, why not?

2. Does the preponderance of evidence in this case show that Officer [redacted] engaged in an excessive/unnecessary use of force? If no, why not?

3. Should the Hiring Authority have imposed adverse action on Officer [redacted] and Sergeant [redacted] If no, why not? If so, at what level? Was the corrective action that was imposed inconsistent with the Employee Disciplinary Matrix? If no, why not?

4. LAC – [redacted]

In this case, a thorough local inquiry by ISU Lieutenant [redacted] uncovered substantial evidence that Officers [redacted] and [redacted] accessed confidential information regarding people's sex crime commitment offenses and shared that information with other incarcerated people, resulting in their being assaulted. Specifically, Lt. [redacted] found that incarcerated people attacked [redacted] minutes after Officer [redacted] accessed the part of his SOMS file that contains information about his sex crime conviction. Similarly, Lt. [redacted] found that

Officer [redacted] accessed information about [redacted] sex crime conviction in SOMS three days before a group of incarcerated people attacked Mr. [redacted] Lt. [redacted] also obtained witness testimony that the assailants gathered with the subject officers immediately prior to the attacks on Mr. [redacted] and Mr. [redacted] Lt. [redacted] also found additional similar incidents where Officers [redacted] and [redacted] accessed sex crime commitment offense information within days of when three other incarcerated people were attacked. The Hiring Authority referred the case to OIA, which opened a criminal investigation. Approximately nine months later, OIA converted the case into an administrative investigation "due to lack of evidence." *See* OIA Notifications at 4.

It is worth noting that Officer [redacted] has been the subject of multiple reports of serious staff misconduct by class members for years including in prior advocacy letters, declarations filed with the Court, and in other lawsuits, some of which also allege that he inappropriately shared information related to conviction offenses that resulted in attacks.[12] This fact is significant because, under Defendants' current iteration of their Early Warning System ("EWS"), officers with a repeated pattern of alleged staff misconduct will not be flagged by the system unless the allegation is sustained. Plaintiffs are not aware of any sustained allegations resulting in adverse action against Officer [redacted] And yet, looking only at the limited sources of information available to Plaintiffs, there is a concerning pattern of a serious staff misconduct allegations involving this officer. As identified recently in the Court Expert's Report on the Treatment of People with Disabilities at SATF, self-correction must be the goal. *See* Dkt. 3446 at 2-6; 62. Until and unless CDCR utilizes all information available to identify and correct

[12] Plaintiffs have submitted multiple declarations, advocacy letters, and tour reports about Officer [redacted] misconduct. *See* Dkt. 2947-5, Ex. 25 (declaration); *id.*, Ex. 31 (declaration); *id.*, Ex. 31 (declaration); *id.*, Ex. 42 (declaration); *id.*, Ex. 50 (declaration); Dkt. 2947-7, Ex. G., at 10-11, 15-16, 21-24 (letter); *id.*, Ex. I, at 13 (tour report); *id.*, Ex. K, at 24-25 (tour report); Dkt. 3108-1, Ex. 12 (declaration) . An incarcerated person who alleged that four officers at LAC, including Officer [redacted] shared confidential information about him to orchestrate an attack against him in September 2018, recently settled a civil suit on this claim. *See Branham v. Villa,* 20-cv-2090 (Sept. 26, 2022 C.D. Cal.).

problems, those problems will persist and the need for court-ordered oversight will continue. *Id*.

Incomplete and biased investigation

The OIA administrative investigation was so incomplete and biased it appears designed to dispose of the allegation by minimizing the severity of the officers' misconduct and to bury relevant evidence.

First, the interviews with Officers [redacted] and [redacted] which were critical to this investigation into incidents that occurred prior to AVSS and BWC—were extraordinarily problematic. During the interview, Officer [redacted] admitted to accessing the confidential commitment information for the five incarcerated people with sex crimes who were later assaulted. He stated that he accessed the information because "he likes to read the stories." *See* OIA Report at 18. The OIA investigator failed to ask <u>any</u> follow up questions to this unconvincing answer, most notably how it happened that he accessed that information right before multiple assaults. Moreover, the investigator did not appear to consider whether Officer [redacted] had violated DOM § 49020.10.5[13] by admittedly accessing information without a legitimate reason.

Second, the OIA investigator's report is one of the most poorly written, disorganized, and biased reports Plaintiffs have encountered, especially in light of the seriousness and complexity of the allegations. This case involved, *inter alia*, potential improper access to and dissemination of confidential information for five different incarcerated people by two different officers that may have resulted in those five incarcerated people being assaulted. The investigation report, which consists almost entirely of summaries of interviews, contains no summary of the evidence that would be necessary for a Hiring Authority to consider the case. The most significant and alarming piece of evidence—that Officer [redacted] accessed Mr. [redacted] Probation Report (which contained information about his sex crime) four minutes before incarcerated people attacked Mr. [redacted]—is buried on page 15 of the report. *See* OIA Report at 15. In a section entitled "Forensic Analysis," the investigator discusses the dates on which Officers [redacted] and [redacted] accessed the commitment offense information for four

[13] Section 49020.10.5 provides: "The use of all CDCR information assets including ... applications run on or accessed from CDCR computers is restricted to official CDCR business."

of the five victims. *See* OIA Report at 15 (no discussion of forensic evidence regarding access to Mr. [redacted] commitment offense information). But the dates on which each of these people were assaulted are scattered throughout the report, making it very difficult to know how much time passed between when the officers accessed the information and the victims were assaulted. The OIA report contrasts starkly with the inquiry report drafted by Lt. [redacted] which includes a clear and concise summary of the evidence. *See* Inquiry Report at 13-14. The report is so poorly organized that it seems intended to obfuscate whether misconduct occurred.

The report was biased in other respects. For example, in an apparent effort to bolster the credibility and professionalism of the officers in the report, the investigator included multiple, unsupported statements from incarcerated people and Officers [redacted] and [redacted] (the regular control booth officer in the building) that those officers always intervened when fighting occurred in the dayroom. *See* OIA Report at 6-7, 12, 16, 19, 21. These statements were, however, unrelated to whether the allegations in this case had occurred and were contradicted by documentary evidence gathered by Lt. [redacted] during his inquiry that at least four fights had happened in the dayroom of the building while these officers were working that were never reported by the officers, suggesting that they did not always intervene and comply with policy in reporting incidents when they occurred. *See* Inquiry Report at 9-12. Each of the fights was reported after the fact by medical staff or other correctional staff. The OIA investigator ignored this evidence.

Third, the OIA investigation report omits critical evidence. A witness, [redacted] in his inquiry interview with Lt. [redacted] indicated that prior to Mr. [redacted] being assaulted by a group of incarcerated people, Officer [redacted] gathered all of the porters and Inmate Advisory Council ("IAC") representatives for a meeting, during which Officer [redacted] said "Ain't no Chomo's [child molesters] going to be in his building." *See* Inquiry Report at 5-6. Mr. [redacted] who was an IAC rep, told Lt. [redacted] that Officer [redacted] then gathered the porters from the building, and that, after that gathering, one of the porters informed Mr. [redacted] that Mr. [redacted] had been convicted of rape—which implies that information was just learned during the meeting among porters with Officer [redacted] *Id.* Mr. [redacted] also indicated to Lt. [redacted] that, later that day, Officers [redacted] and [redacted] used excessive and unnecessary force when they kicked Mr. [redacted] in the legs and hit in him in the head while he was handcuffed

and face down on the ground.[14] *See* Inquiry Report at 6-7. The OIA investigator did not ask Mr. [redacted] about any of these facts and they were omitted from the investigation report. *Compare* Inquiry Report at 5-7 (local inquiry interview with Mr. [redacted] *with* OIA Report at 7 (OIA interview with Mr. [redacted]

The OIA investigator did not interview [redacted] who Lt. [redacted] identified as possessing relevant evidence about the following relevant facts: (1) Officer [redacted] disseminating confidential conviction offense information to incarcerated people; (2) Officers [redacted] and [redacted] failing to respond to the attack on Mr. [redacted]; and (3) Officer [redacted] staging fights among incarcerated people. *See* Inquiry Report at 9-10. The OIA investigator did not interview [redacted] who was interviewed by Lt. [redacted] and who indicated that he had "heard Officer [redacted] talking about not wanting any child molesters or rapists in Building C1." *See* Inquiry Report at 13. The OIA investigator did not interview Mr. [redacted] about his claims to Lt. [redacted] the Officer [redacted] set him up to be attacked by other incarcerated people, that Officer [redacted] disclosed other incarcerated people's sex crime commitment offense to him, and that Officer [redacted] brought his cell phone into the housing unit, played music on a Bluetooth speaker in the dayroom, and had incarcerated people engage in rap battles. *See* Inquiry Report at 1-5; OIA Report at 7. The OIA investigator did not conduct any investigation into the speaker allegation, even though the 989 specifically requested such an investigation and another officer issued a memorandum about Officer [redacted] having a cell phone within the secure perimeter, which lends credence to Mr. [redacted] allegations. *See* 989 at 4; Attachments 1-4 at 86.[15]

[14] According to Mr. [redacted] after Mr. [redacted] was assaulted by incarcerated people, he left the building. Upon his return to the building, he physically fought with Officers [redacted] and Mr. [redacted] He then stopped and submitted to handcuffs. At that point, Officer [redacted] assaulted him.

[15] The scope of the investigation that the Hiring Authority requested from OIA was also far too narrow. OIA did not investigate any of the following allegations, all of which were reported to Lt. [redacted] during the inquiry: (1) that Officers [redacted] and [redacted] used excessive and unnecessary force against Mr. [redacted] *see* Inquiry Report at 7; (2) that Officer [redacted] had previously threatened Mr. [redacted] after Mr. [redacted] returned from an interview with ISU about staff misconduct, *see* Inquiry Report at 5; and (3) that

Inappropriate Discipline

Even with the poor investigation and report produced by OIA, the Hiring Authority should have at least sustained a charge of accessing confidential information without a valid work purpose, a charge to which Officer [redacted] admitted. There is also a preponderance of evidence that Officer [redacted] disseminated confidential information to incarcerated people with the intent to harm other incarcerated people.[16] Instead of sustaining those allegations, the Hiring Authority sustained only a single, unrelated allegation against Officer [redacted] improper possession of a cell phone on prison grounds—and imposed corrective action—a Letter of Instruction.[17] *See* LOI; 402/403 at 1.

This case represents another, serious failure of accountability, with Officers [redacted] and [redacted] facing no punishment for their serious misconduct.

Officer [redacted] repeatedly and intentionally failed to intervene to stop incarcerated people from assaulting other incarcerated people.

[16] The evidence in the case includes: Officer [redacted] accessed Mr. [redacted] commitment offense four minutes before incarcerated people attacked him; Mr. [redacted] Mr. [redacted] and Mr. [redacted] reported that immediately before the attack, Officer [redacted] was talking with a group of incarcerated people, including the assailants, near the custody office in the building; the assailants attacked Mr. [redacted] immediately after speaking with Officer [redacted]; and Officer [redacted] could provide no legitimate reason for accessing Mr. [redacted] commitment offense information, instead stating only that he "likes to read the stories." *See* OIA Report at 18. This evidence was bolstered by Mr. [redacted] testimony that, on a different date, Officer [redacted] shared Mr. [redacted] commitment offense with incarcerated people prior to Mr. [redacted] being assaulted. Also, multiple people report Office [redacted] making disparaging statements about not wanting people with sex crimes in his unit.

[17] The applicable Matrix categories from the 2021 Matrix include endangering incarcerated people by violation of statutes, regulations, ordinances, or departmental policy, procedures, or training (D2, 1**2**3); Improper access to information (D8, 1**2**34); Improperly transmitting confidential information with malicious intent or for personal gain (D9, 456**7**89).

Questions for Defendants

1. Does the preponderance of evidence in this case show that Officer [redacted] accessed confidential information in SOMS about Mr. [redacted] commitment offense on March 11, 2020, and then shared the information with other incarcerated people, resulting in an attack on Mr. [redacted]? If no, why not?

2. Was the OIA investigation incomplete? If no, why not?

3. If Defendants agree the OIA investigation was incomplete, did the incompleteness interfere with the Hiring Authority's ability to determine whether misconduct occurred? If no, why not?

4. Was the OIA investigator's investigation report inadequate? If no, why not? If yes, did Defendants take any steps to improve the investigator's performance (identify the steps, if any, and when they were taken)?

5. Was the OIA investigator's investigation report biased? If no, why not? If yes, did Defendants take any steps to improve the investigator's performance (identify the steps, if any, and when they were taken)?

6. Does Officer [redacted] still work for CDCR? If yes, at what prison and in what role?

5. LAC – [redacted]

In this case, Officer [redacted] slammed the head of a naked, seriously mentally ill class member, [redacted], against the back of a cage because, as Officer [redacted] later admitted, he was angry at him. Mr. [redacted] has been diagnosed with antisocial personality disorder and schizoaffective disorder. Then, Officer [redacted] mischaracterized and minimized his conduct in a written incident report and a subsequent memorandum to his supervisor. The video shows Officer [redacted] battering Mr. [redacted], yet CDCR did not even open a criminal investigation, let alone refer the case to a local prosecuting agency. And though Officer [redacted] conduct calls into question whether he is suited to be working with people with disabilities who require accommodations, the Hiring Authority did not terminate him.

Before the assault, Mr. [redacted] was shaking pepper spray from his hair while Officer [redacted] escorted him to a holding cell in the gym; Mr. [redacted] was trying to get the pepper spray out of his eyes. *See* NOAA at 12. Officer [redacted] threatened multiple times that if Mr. [redacted] did not stop shaking his head, Officer [redacted] would use force to throw Mr. [redacted] to the ground.[18]

The BWC videos for Officer [redacted] and Sergeant [redacted], who witnessed the incident, show Mr. [redacted] being held in a cage. He is handing his clothes through the tray slot to Officer [redacted] in anticipation of an unclothed body search. Mr. [redacted] tosses a small bar of soap to Officer [redacted], who becomes visibly upset. Officer [redacted] then tells a nearby officer to turn around. Officer [redacted] then grabs Mr. [redacted] and slams his head against the back of the cage with enough force to make a loud, audible noise. Officer [redacted] then berates Mr. [redacted].[19] Officer [redacted] admitted that he had no lawful reason for harming Mr. [redacted] and that he did so because he was angry at Mr. [redacted] "defiance" and "disrespect[]." *See* Officer [redacted] Memo at 8 ("My actions were a result of briefly allowing inmate [redacted] to get under my skin…. [redacted] defiance coupled with his disrespectful actions caused me to become angry.").

Officer [redacted] actions constitute criminal battery. Cal. Penal Code § 242 ("A battery is any willful and unlawful use of force or violence upon the person of another."). Yet, neither the Hiring Authority nor OIA even considered investigating this incident for potential criminal referral or referring the case to a local prosecuting agency. The failure to treat this incident as a criminal matter is a serious failure of CDCR's system and a violation of the Remedial Plans. *See* Five Prisons Remedial Plan at 11 ("If probable cause of criminal conduct is discovered during the course of the investigation, OIA will refer the case to the district attorney for prosecution."); RJD Remedial Plan at 10 (same).

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[18] Officer [redacted] said "Watch out, you are going to get some fucking spray on me man, you might hit the ground" and "Man I'm telling you, you do that one more time you are going to hit the ground." *See* NOAA at 12.

[19] Officer [redacted] said "'I don't know who the fuck you think you are, G. Don't throw nothing at me. I told you this already, I told you this already. Don't be disrespectful. I can be disrespectful too. You're the one on a fucking EOP yard, can't fucking stay on a GP yard." *See* [redacted] BWC.

Making matters worse, the Hiring Authority likely did not impose a sufficient punishment against Officer [redacted] for committing battery against Mr. [redacted] The Hiring Authority correctly found that Officer [redacted] committed an intentional unnecessary use of force. *See* 402/403. Under the relevant version of the Matrix, intentional unnecessary use of force carries a baseline penalty of Level 9 (termination), with a range of 7 to 9. The Hiring Authority found a number of aggravating factors (subject was sworn staff, misconduct could result in harm to public service and could have resulted in serious consequences; length of service; intentionality) and mitigating factors (remorsefulness, acceptance of responsibility, being honest during the investigation). *See* 402/403. At best, these factors should have cancelled each other out, resulting in the imposition of the baseline penalty of termination. Instead, the Hiring Authority initially imposed the lower level of penalty, a 70-day suspension from work (Level 7). *See* 402/403 at 2. After Officer [redacted] appealed the penalty to the State Personnel Board, CDCR agreed to reduce the penalty even further to a 10% pay reduction for 36 months. *See* NOAA at 1.

The deliberateness and intentionality of the unnecessary force should also have weighed strongly in favor of the baseline penalty of termination. Officer [redacted] actions represent the worst type of misconduct: an intentional, violent abuse of authority. Although Officer [redacted] showed some remorse for his misconduct after the fact, officers who intentionally assault mentally-ill incarcerated people should not be working around any people with disabilities and should likely not be employed by CDCR. Being disrespected by incarcerated people, especially incarcerated people with mental illness, comes with the territory of being an officer.

Moreover, the Hiring Authority should not have given Officer [redacted] any credit for his remorse and cooperation. To begin with, as Plaintiffs have explained previously, it makes little sense to lessen a penalty because an officer was honest and cooperative with an investigation; officers are required to do so by law. Giving Officer [redacted] credit in this case makes even less sense. His misconduct was caught on camera and had been reported by a supervisor who directly observed it, so he had little choice but to be truthful and remorseful. Even so, Officer [redacted] misrepresented his conduct in his incident report, in which he wrote that he "grabbed [redacted] wrist with my hands forcing him to the back of the holding cell counselling him about his actions, to which he was receptive as he calmed down immediately." *See* Incident Report at 25. He similarly misrepresented his actions in a memorandum drafted to his captain, stating "I … took control of inmate [redacted] and pushed him towards the back of the holding cell." *See* Request for

Administrative Review at 8. What Officer [redacted] actually did was slam Mr. [redacted] head into the back of the cage.

Lastly, the evidence in this case was ironclad. There was no basis for settling for less than the penalty imposed by the Hiring Authority, which, as discussed above, was too low to begin with. In addition, knowing that many punishments are negotiated down at the SPB, it is essential for CDCR to take an aggressive position with the initial imposition of discipline.

Questions for Defendants

1. Does the evidence in this case show that Office [redacted] committed criminal battery on Mr. [redacted]

2. Should CDCR have opened a criminal investigation into Officer [redacted] misconduct? If no, why not?

3. Should OIA have referred this case to a local prosecuting agency to determine whether criminal charges should have been brought against Officer [redacted] If no, why not?

4. Should the Hiring Authority have imposed the baseline penalty of termination in this case? If no, why not?

5. Is Officer [redacted] still employed by CDCR? If so, what steps have been taken, beyond enforcing already required trainings that failed to prevent the misconduct in the first place, to prevent this from happening again (e.g., has he been moved to a location where he does not come in to contact with incarcerated people with disabilities and mental illness, has he received anger management classes, etc.)?

6. LAC – [redacted]

This case involves three separate and improper uses of force against [redacted], a class member with serious mental illness. First, Sergeant [redacted] initiated an improper immediate use of force when he pepper sprayed Mr. [redacted] through the food port of his cell after Mr. [redacted] had retreated and did not pose an imminent threat. Second, during a subsequent escort, a group of officers used excessive force when they flipped Mr. [redacted] upside-down and slammed him

headfirst into the concrete. Third, once Mr. [redacted] was on the ground, Officer [redacted] used excessive force when trying to control Mr. [redacted] legs. During the IERC review process, a captain flagged the first and third incidents as potentially violating policy. They were referred to OIA, which approved direct adverse action. Ultimately, the Hiring Authority sustained only the third allegation, but then failed to impose appropriate discipline.

First use of force (pepper spray)

The video shows Mr. [redacted] in his cell with the door closed and Sergeant [redacted] at the cell front. *See* BWC. Sergeant [redacted] was at Mr. [redacted] door to escort him to receive court-ordered psychiatric medication. *See* Req. for Admin Review at 19. Mr. [redacted] reaches his hands out of the tray slot in an apparent attempt to grab handcuffs from Sergeant [redacted] Sergeant [redacted] pulls away out of reach of Mr. [redacted] Mr. [redacted] then retreats inside the cell. Only then does Sergeant [redacted] pepper-spray Mr. [redacted] Mr. [redacted] then reaches out of the tray slot again, but quickly retreats. Sergeant [redacted] then closes the tray slot without incident.

Sergeant [redacted] use of pepper spray was an improper immediate use of force because, once he moved away from the door so that Mr. [redacted] could not reach him or the handcuffs, there was no imminent threat to safety and security. Mr. [redacted] was locked in his cell "in an area that c[ould] be controlled or isolated." *See* DOM § 51020.4 (definition of Controlled Use of Force). He did not pose an imminent threat to himself or anyone else. At most, Mr. [redacted] may have been momentarily refusing to permit staff to close and lock the tray slot. But CDCR policy makes clear that no force may be used if staff can close the tray slot (which Sergeant [redacted] did) and that, if they cannot close the slot, they can only initiate a controlled use of force. *See* DOM § 51020.11.3 ("If the inmate relinquishes control of the food/security port, it will be secured. In the event the inmate does not relinquish control of the food port, the officer shall back away from the cell and contact and advise the custody supervisor of the situation. Controlled force may be initiated …."). Staff cannot, as Sergeant [redacted] did, use immediate force. Despite the clear video evidence that Sergeant [redacted] use of pepper spray was an improper immediate use of force, the Central Intake Panel closed this and all other allegations against Sergeant [redacted] "due to lack of evidence." *See* Closure & OIA Notifications at 3. As a result, Sergeant [redacted] was not held accountable for unnecessarily pepper spraying Mr. [redacted]

Second use of force (slamming Mr. [redacted] to the ground)

The second improper use of force occurred about six minutes later. Officers are escorting Mr. [redacted] back from decontaminating outside the building. Mr. [redacted] is wiggling, and kicks his legs in the direction of a medical cart near a medical staff member. Officers [redacted][20] and Sergeant [redacted] who are escorting Mr. [redacted] are much larger than him. They easily turn Mr. [redacted] away from the cart and he stops kicking. Then, at 10:30:02, Sergeant [redacted] and Officer [redacted] lift Mr. [redacted] off his feet and slam him headfirst onto the concrete floor. *See* AVSS excerpt.

This use of force was excessive and possibly unnecessary. Mr. [redacted] posed little, if any, threat because he was handcuffed, secured by two very large officers, and surrounded by at least four other officers. At no point do the two officers who are escorting Mr. [redacted] appear to lose control of him. When Mr. [redacted] turns toward the medical cart and the medical staff member, the officers easily redirect him. It is therefore questionable whether the officers needed to use any force other than to pull him away. That said, even if some force was warranted, the officers had many, less dangerous force options available, including, but not limited to, forcing Mr. [redacted] into a wheelchair to complete the escort, bending him at the waist to control his erratic movements, or forcing him to sit down on the ground. Instead, the officers drove Mr. [redacted] into the ground headfirst with significant force. Mr. [redacted] could have been seriously injured during this incident. Neither the IERC nor the Hiring Authority identified any policy violations related to this use of force; the Hiring Authority therefore did not refer this allegation to OIA for investigation and potential adverse action.

Third use of force (stepping on Mr. [redacted] leg)

Regarding the third use of force, the Hiring Authority sustained the wrong charge for the misconduct, which resulted in less discipline than required by the Employee

[20] Officer [redacted] was also responsible for the excessive use of force in LAC-[redacted]. In his incident report, Officer [redacted] wrote that Sergeant [redacted] "pushed" Mr. [redacted] to the floor, which—like Officer [redacted] incident report in LAC-[redacted]—does not accurately convey the force with which Sergeant [redacted] and Officer [redacted] threw Mr. [redacted] to the ground.

Disciplinary Matrix. Right after officers throw Mr. [redacted] to the ground, Officer [redacted] stomps on Mr. [redacted] right leg multiple times and then remains with his full body weight pressing between his calf and knee for two minutes. *See* AVSS 2. During that time, Mr. [redacted] can be heard crying out in pain, and protesting that the officers are hurting him. Officer [redacted] does nothing to adjust his position to reduce the force, even though it does not appear that Mr. [redacted] is resisting.

The Hiring Authority sustained an allegation of "(L1) Unnecessary use of force without injury." *See* 402/403. This was wrong in two respects. First, Officer [redacted] use of force was excessive, not unnecessary, as the officers were authorized to use force at that moment, but Officer [redacted] used "more force than is objectively reasonable to accomplish a lawful purpose." *See* DOM § 51020.4. ("Excessive force is the use of more force than is objectively reasonable to accomplish a lawful purpose."). In fact, the Hiring Authority described the policy violation as an "excessive use of force" in the Letter of Instruction to Officer [redacted] *See* LOI at 1. Second, contrary to what the Hiring Authority found, the use of force caused injury. The 7219 form indicates bruising/discoloring on Mr. [redacted] left calf and ankle (in addition to the head injuries from being thrown to the ground). *See* Req. for Admin Review at 35. Such injuries are consistent with the video, which shows Officer [redacted] stomp on Mr. [redacted] legs at the beginning of the incident with his full body weight (10:30:09) and then put his body weight via his knee for about 2 minutes and 8 seconds.[21]

These two errors had significant consequences for the discipline imposed on Officer [redacted] Unnecessary use of force without injury (L1)—the misconduct found by the Hiring Authority—carries a Level 2 baseline and a range of 1 to 3. After finding such misconduct, the Hiring Authority in this case issued only corrective action (Letter of Instruction). In contrast, excessive use of force causing injury (L5) carries a Level 5 baseline and a range of 4 to 9. Accordingly, the erroneous findings and misapplication of the Matrix by the Hiring Authority resulted in the penalty being reduced from a

[21] The Hiring Authority and OIA both failed to mention another unnecessary use of force by Sergeant [redacted] While Mr. [redacted] was pinned to the ground by multiple officers, Sergeant [redacted] pressed his left forearm to Mr. [redacted] neck for about two minutes between 10:30:05 and 10:32:12. *See* AVSS 2. That use of force is excessive because Mr. [redacted] had stopped resisting and was secured by several officers.

presumptive 5% salary reduction for 25-36 qualifying pay periods or suspension without pay for 25-36 qualifying work days to corrective action.

Questions for Defendants

1. Does the preponderance of evidence in this case show that Sergeant [redacted] use of pepper spray against Mr. [redacted] was an inappropriate immediate use of force? If no, why not?

2. Does the preponderance of evidence in this case show that Officer [redacted] and Sergeant [redacted] used excessive force against Mr. [redacted] when they slammed him to the ground? If no, why not?

3. Does the preponderance of the evidence in this case show that Officer [redacted] used excessive force causing injury? If no, why not? If yes, did the Hiring Authority impose inappropriate discipline?

7. LAC – [redacted]

In this case, four officers and a sergeant strip searched [redacted], who had reported he was suicidal, in the dayroom of Building D5 in full view of many other incarcerated people. This search violated policy, which provides that "[u]nclothed body searches shall be conducted within the cell unless the physical design prevents visibility, at which point the inmate will be escorted to an alternate private/secure setting where the unclothed body search will be conducted." DOM § 52050.16.6; *see also* 15 C.C.R. § 3287 (strip searches "shall … be conducted in a professional manner which avoids embarrassment or indignity to the inmate"). And yet the Hiring Authority only disciplined the sergeant and did so with corrective action, as opposed to adverse action. *See* Counseling Chrono.

The video footage[22] shows officers forcing Mr. [redacted] to the ground during an escort. *See* BWC. At 19:11:45, officers take Mr. [redacted] to the front of his cell in a

[22] The video footage produced in this case was inappropriately short, a problem that Plaintiffs have documented in past reports. *See* Plaintiffs' November 2022 Report at 27. Here, the video footage ends in the middle of the officers stripping Mr. [redacted]. Moreover, the investigation report makes clear that the investigator reviewed video footage from a longer time range but Defendants did not produce that footage. The

wheelchair and order him to stand facing the wall. *See* BWC excerpt. Once the officers say they are going to remove his clothes, Mr. [redacted] protests. Notwithstanding his complaints, officers begin to remove Mr. [redacted] clothing with scissors. Mr. [redacted] notes that he had a documented suicide attempt and that officers were now stripping him "in front of all these inmates." A female officer, Officer [redacted], starts the removal. Officer [redacted] is present for over a minute until a supervisor instructs her to step away.[23] Several incarcerated people in holding cells in the dayroom, not far from Mr. [redacted], then begin to laugh and make statements. What they say is inaudible, but it is apparent they are yelling and laughing at Mr. [redacted], who yells back at them. *See* BWC at 19:14:40. Incarcerated people continue to yell at Mr. [redacted] and clap as officers strip him completely naked. Mr. [redacted] says "hey hey hey, this is hella illegal bro." The video ends with Mr. [redacted] standing naked outside the cell.

Despite the clear evidence of misconduct involving four officers and a sergeant, the Hiring Authority only imposed discipline against Sergeant [redacted]. The Hiring Authority should have disciplined all four officers for violating DOM § 52050.16.6 and should have disciplined Officer [redacted] for participating in a non-emergency strip search of an incarcerated person of the opposite sex. *See* DOM § 152050.16.5 ("Unclothed body searches of inmates by staff of the opposite biological sex shall only be conducted in emergency situations"). Furthermore, all of the officers violated BWC policies by failing to deactivate their BWCs. Per LAC policy, BWCs shall be deactivated during unclothed body searches, but none of the officers deactivated their cameras at any point during the search. *See* LAC BWC Local Operating Procedure at 4, attached to Five Prisons Remedial Plan. The search was clearly an unclothed body search, which consists of "removal of a portion of all of an individual's clothing so as to permit a visual inspection by staff of the body and body cavities for security reasons." *See* DOM § 54020.3.

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investigator stated that the footage shows Mr. [redacted] being "placed into his cell with no further incident." *See* Investigation Report at 3. None of the 13 videos produced to Plaintiffs show that occurring.

[23] Officer [redacted] makes a number of inappropriate and derogatory comments. She tells Sergeant [redacted] that officers used force on Mr. [redacted] because he was "fucking acting crazy." *See* BWC at 19:12:21. She also incites Mr. [redacted] by saying "spit at me, I swear to fuckin god." *See* BWC at 19:12:33.

Questions for Defendants

1. Does the preponderance of evidence in this case show that multiple officers, in addition to Sergeant [redacted], conducted or observed an unclothed body search of Mr. [redacted] that violated CDCR policy? If no, why not?

8. LAC – [redacted]

In this case, officers are shown on video improperly using immediate force while attempting to force [redacted] into a wheelchair after he failed to comply with orders to get into the wheelchair so the officers could return him to his cell. Despite the clear video evidence of misconduct, the Hiring Authority failed to hold the involved officers accountable.

Mr. [redacted] was in a medical wet tank in the clinic when staff decided to return him to Building D2, despite Mr. [redacted] alleging he had safety concerns, requesting to be on crisis bed status, and explaining he did not want to return to that unit. *See* BWC at 12:54:28. Nevertheless, at 12:59, Officer [redacted] and Officer [redacted] then begin escorting him from the clinic to D2, asserting that he had been cleared. When they have crossed about half of the yard, Mr. [redacted] states, "I've got enemy concerns, I'm not going" and drops to the ground. He proceeds to lie on the ground face down while protesting the return to his housing unit and stating that he has enemy concerns.[24] Officer [redacted] summons a wheelchair. Officer [redacted] and Sergeant [redacted] then lift Mr. [redacted] to his feet. Mr. [redacted] states, "I'm not getting in the chair … I'm not getting in the chair." Officers [redacted] and [redacted] then initiate an immediate use of force, attempting to force Mr. [redacted] into the wheelchair for the purpose of escorting him to the housing unit against his will and despite expressed safety concerns. Mr. [redacted] begins resisting, which requires the use of additional force and places him and staff at risk of injury. Mr. [redacted] can be heard stating that he will walk to segregation but he does

[24] Officer [redacted] BWC shows, at 1:00:53, Officer [redacted] appearing to reactivate his BWC without announcement. The events prior to the reactivation—Officer [redacted] escorting [redacted] across the yard—are not a permissible deactivation circumstance. The investigator failed to note this apparent violation of the BWC policy or refer it for further investigation or discipline. Officer [redacted] BWC footage was not produced to Plaintiffs, nor did the investigator appear to review it, but the violation is apparent from Officer [redacted] BWC.

not want to be forced back to the unit where he has safety concerns. Ultimately, the officers give up and escort Mr. [redacted] to a holding cell in the gymnasium. During the time they are escorting him to the gym they are taunting and mocking his safety concerns. *See* BWC at 12:58:38.

The officers' attempt to force Mr. [redacted] into the wheelchair was an improper immediate use of force. In their incident reports, the officers admit that they initiated the force. *See* [redacted] Incident Report at 26 ("[redacted] and I attempted to assist [redacted] to the wheelchair, but refused to go willingly."); [redacted] Incident Report at 27 ("We attempted to assist [redacted] to the wheelchair but he was refusing."). But Mr. [redacted] did not present an imminent threat at the moment he was standing but refusing to sit in the wheelchair. *See* DOM § 51020.4; 51020.10 (permitting the use of immediate force only when there is an imminent threat to institutional security or the safety of persons). He was failing to comply with an order, but order non-compliance is not sufficient grounds for using immediate force. *See* DOM § 51020.4. Moreover, the officers did little to try to deescalate the situation. Though the officers generally remain calm and respectful during the force, it is unclear why they disregard his request to be transferred to segregation and insist over and over again that he must return to D2. It is the officers' failure to deescalate, and not Mr. [redacted] conduct, that ultimately created any imminent threat even though they had full control of Mr. [redacted]. The officers should have addressed Mr. [redacted] safety concerns (because he appeared willing to comply with an escort to another location) or, if not, initiated a controlled use of force. Instead, they chose to use immediate force, in violation of policy.

The Hiring Authority, however, did not sustain any allegations and closed the case without referring it to OIA.

Finally, Officer [redacted] in this case is the same officer from LAC – [redacted], who was found to have used intentional unnecessary force—slamming a naked incarcerated person into the back of a holding cell because he was angry at the person—and punished with a 10% pay reduction for 36 months. Despite the AIMS inquiry report in the instant case being completed on March 25, 2022, after the Hiring Authority imposed a penalty in LAC – [redacted] on February 9, 2022, the inquiry report makes no mention that Officer [redacted] had recently been found to have engaged in very serious misconduct involving a different use of force violation. This use of force may have been prevented if more had been done following the first use of force policy violation by Officer [redacted]. This case thus represents a failure by Defendants to track serial allegations against an officer, to

take seriously the progressive discipline process, and to utilize all avenues of information regarding problematic staff behavior in order to effectively police themselves.

Questions for Defendants

1. Does the preponderance of evidence in this case show that multiple officers initiated an improper immediate use of force against Mr. [redacted]? If no, why not?

9. CIW – [redacted]

In this case, officers improperly used immediate force after [redacted] attempted to speak with them about an ongoing problem with the temperature in her cell that she had been attempting to address for a week. Despite clear video evidence and a finding by the IERC that the officer failed to deescalate the situation, the Hiring Authority did not sustain any allegation of misconduct.

As shown in the BWC video, Ms. [redacted] approaches the officers and states that she needs to speak to a sergeant about her unaddressed requests for the heat in her cell to be turned off. She is agitated and her voice is raised, but she does not present an imminent threat to safety or security. At one point, she smacks her hand on the counter. Officer [redacted] then escalates the situation by screaming back at Ms. [redacted] "Who the hell are you talking to like that?" Officer [redacted] steps in and tries to deescalate. Before Officer [redacted] has a chance to deescalate, however, Officer [redacted] orders Ms. [redacted] to turn around and cuff up. Ms. [redacted] refuses to comply and Officer [redacted] then initiates immediate force to try to restrain Ms. [redacted] against her will, which results in a scuffle. *See* 15 C.C.R. § 3268(c)(2) ("Any deliberate physical contact, using any part of the body to overcome active physical resistance, is considered physical force."); *cf.* 15 C.C.R. § 3268(b)(4) (unresisted application of restraints is not a use of force).

Officer [redacted] violated policy by failing to deescalate the situation and by using immediate force when no imminent threat was present. With respect to the failure to deescalate, the IERC found: "Officer responded to the inmate in an equally agitated and aggressive manner…. [S]taff should have intervened to de-escalate the situation sooner." IERC Review & Further Action Recommendation at 14; IERC Critique and Qualitative Evaluation at 16. This conclusion is consistent with the video, which shows

Officer [redacted] escalating the situation by screaming at Ms. [redacted] and then charging past Officer [redacted] who was trying to deescalate, and toward Ms. [redacted] very aggressively. *See* 15 C.C.R. § 3268(b)(1) ("Employees shall attempt to use verbal commands and verbal de-escalation, followed by a reasonable amount of time for compliance before resorting to use of force."); DOM § 51020.5 ("Whenever possible, verbal persuasion should be attempted in an effort to mitigate the need for force").

The video also shows that Ms. [redacted] did not pose an imminent threat and that the use of force therefore did not comply with policy. Officer [redacted] claimed that Ms. [redacted] posed an imminent threat because of her "aggressive and non-compliant behavior." *See* Inquiry Report Summary at 2. To be certain, Ms. [redacted] was quite agitated and upset. Her reasonable request—to have the heat in her cell addressed—had been ignored for a week. But she did not appear to be threatening the safety of officers or other incarcerated people. DOM § 51020.4 (an imminent threat is "any situation or circumstance that jeopardizes the safety of persons or compromises the security of the institution, requiring immediate force. Some examples include, but are not limited to: an attempt to escape, on-going physical harm or active physical resistance."). And Ms. [redacted] refusal to comply with the order to submit to restraints is not, standing alone, a sufficient basis for initiating an immediate use of force. DOM § 51020.4 ("If it is necessary to use force solely to gain compliance with a lawful order, controlled force shall be used.").

Ultimately, the Hiring Authority found no misconduct and did not sustain any of Ms. [redacted] allegations. The Hiring Authority should have found that Officer [redacted] used unnecessary force.

Plaintiffs acknowledge that this case, like the immediately preceding case (LAC – [redacted] does not present a shocking or horrific example of an improper use of force. Instead these cases represent a common scenario in prison and thus illustrate the importance of staff following policy, which requires them to take action to de-escalate such situations—the opposite of what occurred . The situation with Ms. [redacted] likely could have been resolved without the need for force through skilled conversation, verbal persuasion, issuing additional orders to get Ms. [redacted] to retreat from the office if necessary, or threatening to issue an RVR. The combination of the failure to deescalate and the improper immediate use of force are emblematic of the pattern seen throughout many of these cases in which officers are far too quick to resort to force, placing themselves and incarcerated people at risk. If CDCR takes seriously its policy that

officers should avoid force where possible, CDCR must hold officers accountable in situations like this case and the preceding case. *See* 15 C.C.R. § 3268(b).

Questions for Defendants

1. Does the preponderance of evidence in this case show that Officer [redacted] initiated an improper immediate use of force without first engaging in sufficient efforts to deescalate the situation? If no, why not?

10. COR – [redacted]

In this case, Sergeant [redacted] used excessive force against [redacted] when he placed his knee and body weight on Mr. [redacted] neck or head for 18 seconds. Sergeant [redacted] then made misleading or false statements about the force he used in his incident report. The Hiring Authority should have held Sergeant [redacted] accountable for his misconduct, but instead imposed no discipline against him.

The video shows Mr. [redacted] arriving on a bus outside receiving and release. *See* AVSS at 11:13.[25] From the moment Mr. [redacted] exits the bus, staff escalate the situation. Four very large officers immediately surround him and begin to remove his restraints and apply flex cuffs. The officers repeatedly instruct Mr. [redacted] to look up at the sky and not at them. Mr. [redacted] appears surprised and confused about the instructions, asking "What's going on man? What are you doing?" *See* BWC. Whenever he turns to look at the officers giving him instructions, a natural human reaction when being spoken to, officers grab his chin and neck to force him to look up. *See* AVSS. In his incident report, Sergeant [redacted] stated that officers forced Mr. [redacted] to look up because he had prior staff assaults and "to keep the Maximum Custody Inmate ([redacted] at a disadvantage and slightly disoriented while his restraints are being removed outside of a secure area." *See* Request for Admin. Review at 6. Even assuming Mr. [redacted] was a threat, the officers could have employed more conventional means of disorientation used by correctional staff such as escorting him backwards into receiving and release. Instead, the tactic the officers employed made the situation less safe by escalating the confusion and tension between Mr. [redacted] and the officers. The treatment of Mr. [redacted] once he exited the bus stands in stark contrast to his experience on the bus, where he was respectful to and compliant with staff and where a staff member

[25] The AVSS shows a time stamp that appears to be ahead by two hours.

assisted Mr. [redacted] to put on his face mask (since his hands were restrained) without the same apparent concerns for staff safety articulated in the incident reports. *See* BWC.

After staff escalated the situation and the officers secure Mr. [redacted] and begin the escort into receiving and release, Mr. [redacted] plants his feet and appears to lean toward Officer [redacted], who then puts his arm around the front of Mr. [redacted] neck before bringing Mr. [redacted] to the ground in a potentially dangerous manner. *See* AVSS at 11:14:09.

Once Mr. [redacted] is on the ground, Sergeant [redacted] places his left knee and body weight directly on Mr. [redacted] head or neck for approximately 18 seconds. *See* AVSS (knee on head or neck from 11:14:18 to 11:14:36). The Hiring Authority referred this use of force to OIA. However, the OIA Central Intake Panel ("CIP") returned the allegation and, without any explanation, determined that "the information reviewed does not warrant corrective or adverse action." *See* Request for Admin. Review at 4. The CIP's decision was in error. Placing a knee on someone's neck is an extremely dangerous and potentially life threatening use of force as it restricts a person's breathing. The same type of force, albeit for a longer period of time, resulted in the death of George Floyd. And CDCR policy prohibits any force "which prevents the person from swallowing or breathing … unless the use of deadly force would be authorized." *See* DOM § 51020.5; *see also* 15. C.C.R. § 3268(c)(2) (same). The video of the incident and the officers' own statements make clear that deadly force was not authorized in this situation. *See* 15 C.C.R. § 3268(d)(1) ("[D]eadly force shall only be used when the officer reasonably believes, based on the totality of the circumstances, that such force is necessary [to] … Defend … from an imminent threat of death or GBI"); DOM § 51020.7 (same). By the time Sergeant [redacted] dropped his knee onto Mr. [redacted] neck, Mr. [redacted] was on his face on the ground, and secured by two other officers. No circumstance justifying deadly force was present. As Sergeant [redacted] wrote in his incident report, the force was designed "solely to keep [redacted] from attempting to stand up," which does not justify the use of a physical restraint that prevented or could have prevented Mr. [redacted] from breathing. *See* Request for Admin Review at 6. The Hiring Authority therefore should have sustained a charge for excessive use of force (L4).

The Hiring Authority also should have disciplined Sergeant [redacted] for making a false statement in a clarifying response to his incident report. In his incident report, Sergeant [redacted] reported that he placed his knee on Mr. [redacted] "upper back shoulder area." *See* Request for Admin. Review at 34. Sergeant [redacted] was asked to clarify his

knee placement because on video, "it appears as though you placed your knee and applied downward pressure onto Inmate [redacted] neck." In response, Sergeant [redacted] wrote that "although it appears I am on [redacted] neck, I am not. My knee is angled across his upper shoulder blade area and any weight I was using was resting on [redacted] upper back." *See* Request for Admin. Review at 37. This statement is contradicted by the video footage, which shows Sergeant [redacted] knee and body weight clearly on Mr. [redacted] neck, or even his head, for 18 seconds. Based on that video, the Hiring Authority should have disciplined Sergeant [redacted] for an evasive statement to a supervisor (E4) and potentially for making intentionally false or misleading statements to a supervisor (E5) and for falsification of material facts in reports or official records (E10).

Questions for Defendants

1. Does the preponderance of evidence in this case show that Sergeant [redacted] used excessive force when he placed his knee and body weight on Mr. [redacted] neck and/or head? If no, why not?

2. Does the preponderance of evidence in this case show that Sergeant [redacted] was not truthful in his incident report and clarifying statement when he stated that his knee was not on Mr. [redacted] neck and/or head? If no, why not?

11. KVSP – [redacted]

In this case, the Hiring Authority failed to impose any discipline even though Sergeant [redacted] and Officer [redacted] both had their BWCs deactivated in ways that made it difficult to determine whether Sergeant [redacted] used excessive force (too much pepper spray) against [redacted]. Sergeant [redacted] BWC was not activated for the entire incident, while Officer [redacted] activated his BWC only when arriving at the site of the incident.

The AVSS footage and other evidence in the case indicate that Sergeant [redacted] was at the front of Mr. [redacted] cell, applying handcuffs in order to escort Mr. [redacted] to the shower. Suddenly, Mr. [redacted] kicks his right leg backward and strikes Sergeant [redacted] in the knee. Sergeant [redacted] backs up, while Mr. [redacted] retreats inside the cell and out of view of the AVSS camera. Sergeant [redacted] pulls out his pepper spray and proceeds to spray Mr. [redacted] for approximately seven seconds. It is possible

to see Sergeant [redacted] using the pepper spray on the AVSS and another officer's BWC footage; Mr. [redacted] is not visible during the incident because Sergeant [redacted], who had the only view into the cell, did not have his BWC activated.

Mr. [redacted] alleged in his 602 and in his video-taped interview following the use of force that it was excessive for Sergeant [redacted] to spray him for seven seconds. Whether the use of pepper spray was excessive depends on whether Sergeant [redacted] used more pepper spray than necessary to accomplish the lawful objective of subduing Mr. [redacted][26] That analysis is impossible to conduct without video of Mr. [redacted] reaction and confirmation of whether or not he was subdued. And no such video exists because Sergeant [redacted] had not activated his BWC.[27]

Rather than highlight the consequences of the BWC non-compliance, the investigator made improper excuses for the deactivations that were not supported by the evidence. The investigator claimed in the inquiry report that they were "unable to review the BWC footage … [for] Sergeant [redacted] as a result of the camera being deactivated for unclothed body searches while conducting showers. *See* Allegation Inquiry at 6. The AVSS footage, however, shows that Sergeant [redacted] was standing in the hallway of the housing unit at the time of the incident and that Mr. [redacted] was clothed. Even if he had been conducting unclothed body searches previously, he should have reactivated his camera. With respect to Officer [redacted], the investigator glossed over the fact that he did not turn on his BWC until he arrived at the incident by writing that Officer [redacted] BWC "d[id] not capture the incident on video." Allegation Inquiry at 6. This statement wrongly suggests that the camera was on but simply was not pointed at the incident, when, in fact, the camera was deactivated in violation of policy.[28]

Though the evidence in the case establishes that Sergeant [redacted] and Officer [redacted] both had improperly deactivated their BWCs and that Sergeant [redacted]

[26] It is unclear whether this incident occurred before or after Defendants disseminated their new pepper-spray policy, which only allows three-second bursts of spray. If it occurred after, then Sergeant [redacted] conduct violated policy. If it occurred before, it still could have violated policy if it was excessive.

[27] Even once Officer [redacted] activated his BWC, he did not have a clear view into the cell.

[28] From the inquiry report, it does not appear that the investigator asked Sergeant [redacted] or Officer [redacted] any questions about their BWCs being deactivated.

deactivation, in particular, obstructed the investigation into the use of force, the investigator concluded that no misconduct occurred. The Hiring Authority agreed, closing the investigation without any finding of misconduct.

Questions for Defendants

1. Does the preponderance of evidence in this case show that Sergeant [redacted] and Officer [redacted] both improperly deactivated their BWCs in violation of policy? If no, why not?

2. Did the deactivations of BWCs in this case result in an obstruction of the investigation into the use of force? If no, why not?

3. Did this incident occur before or after Defendants disseminated their new pepper-spray policy?

12. RJD – [redacted]

In this case, the Hiring Authority appropriately sustained allegations against Officer [redacted] for exposing details of [redacted], commitment offense, but then imposed only corrective action, which was not an appropriate punishment for the misconduct.

BWC footage shows Officer [redacted] state loudly, within earshot of multiple incarcerated people attending a class, that Mr. [redacted] was convicted of arson. *See* Allegation Inquiry at 2. BWC footage also shows, a few minutes later, Officer [redacted] disclosing the same information in a one-on-one conversation with another incarcerated person. *See* Allegation Inquiry at 3.

The Hiring Authority determined that Officer [redacted] had been discourteous (D1, base 1, range 1-6) and had improperly disclosed confidential information (D12, base 4, range 2-9). The Hiring Authority also found extensive aggravating factors and only one mitigating factor. *See* 402-403. Given these findings, the Hiring Authority should have, at a minimum imposed a Level 4 penalty. Such a penalty was appropriate here where Officer [redacted] conduct was intentional and there was no conceivable reason for him to mention Mr. [redacted] commitment offense. Because the Matrix only permits penalties within the range provided for a violation, the lowest possible penalty was a Level 2 penalty, which is at the bottom of the range for D12. *See* DOM §33030.18 ("aggravating

and mitigating factors … may increase or decrease the penalty *within the penalty range*" (emphasis added)). Instead, the Hiring Authority imposed a Letter of Reprimand on Officer [redacted] (Level 1), which is outside of the range for D12.

Further compounding these issues, at a *Skelly* hearing, the Hiring Authority rescinded the Letter of Reprimand and issued only corrective action (a Letter of Instruction). *See Skelly* Hearing Results at 2. Given the seriousness of Officer [redacted] conduct, and the prevalence of aggravating factors found against him, the corrective action imposed was inappropriate and inconsistent with the Matrix.

Questions for Defendants

1. Did the Hiring Authority improperly apply the Employee Disciplinary Matrix in this case? If no, why not?

B. Investigators Conducted Incomplete and Biased Investigations that Interfered with Determining If Allegations Were True

In many of the cases reviewed by Plaintiffs (discussed below and in Table A), investigators failed to conduct complete and unbiased investigations. These investigative failures, especially failures to retain and review relevant video evidence, often made it difficult or impossible to determine whether the alleged misconduct occurred. These cases demonstrate that Defendants are not complying with the Remedial Plans. Moreover, the cases strongly suggest that investigators are conducting investigations in a manner designed to prevent the discovery of misconduct. Investigators frequently delay in requesting video footage for so long it gets destroyed, even though such footage is often the most important evidence in a case. When they request video, it is often from the wrong date or time frame or is for too short of a period to capture the alleged misconduct. Investigators also routinely seize on any excuse—for example, the misspelling of an officer's name or the surprising and suspect recantation of the complainant—to shut down an investigation. Viewed collectively, these cases show that Defendants are still failing at the most basic investigative objective: gathering evidence to figure out what happened. Until Defendants take adequate steps to ensure their investigators take this objective seriously, Defendants will not come into compliance with the Remedial Plans and the Court's orders.

1. RJD – [redacted]

In this case, [redacted] alleged that Officer [redacted] forced him to climb stairs to access the showers, even though he had a no-stairs chrono. Mr. [redacted] further claimed that when he was descending the stairs, he slipped and fell, injuring himself. This case should have been open and shut. Video footage would have shown if Mr. [redacted] went upstairs to shower, if Officer [redacted] directed him to do so, and if Mr. [redacted] fell. But the local investigator failed to request the relevant video evidence.

Mr. [redacted] told the investigator that this incident occurred on December 28, 2021, during Second Watch (06:00 to 14:00). *See* OGT Notes at 1. Mr. [redacted] medical records, which it does not appear the investigator requested or reviewed, show that he was seen in the TTA at 10:33 on December 28, 2021, and complained that "while being escorted down the stairs in the housing unit he slipped and fell and landed on buttocks and now has low back pain with numbness and tingling to the right leg." *See* EHRS record dated December 28, 2021 at 1. This medical note strongly suggests that his allegation was true. It also establishes that the incident likely occurred before 10:33 AM on December 28.

The investigator, however, appears to have reviewed only AVSS footage from 12:50 to 14:09 on December 28, which showed five interactions between Officer [redacted] and Mr. [redacted] none of which consisted of Officer [redacted] forcing Mr. [redacted] to walk upstairs for a shower. *See* Grievance Package at 11. Based on this video, the investigator concluded that Mr. [redacted] allegation was unfounded.

The investigator failed to determine whether this incident occurred. The investigator should have reviewed AVSS footage from the entirety of Second Watch, and also should have requested and reviewed footage from Officer [redacted] BWC. The investigator should have asked Mr. [redacted] if he sought medical attention and, if he had, obtained those records. The investigator should have reviewed the building log book, which likely would have recorded that Mr. [redacted] had to be sent to the TTA on an emergent basis. And the investigator should have interviewed Officer [redacted] to ask if the incident occurred. Having done none of these things, the incomplete investigation by the investigator obstructed any effort to hold Officer [redacted] accountable for this serious allegation regarding a failure to provide a disability accommodation.

Questions for Defendants

1. Was the inquiry incomplete because the local investigator failed to obtain and review relevant video evidence? If no, why not?

2. If Defendants agree the inquiry was incomplete, did the incompleteness interfere with the Hiring Authority's ability to determine whether misconduct occurred? If no, why not?

2. RJD – [redacted]

In this case, [redacted], alleged that an officer lunged into his cell without reason, causing him to back up and injure his knee. Mr. [redacted] alleged that the officer involved in the incident's last name was "[redacted] but noted in his 602 that he was unsure if he had misspelled the officer's last name. *See* Grievance at 9 (noting "Last name not sure if spelled correctly").

After interviewing Mr. [redacted] the investigator pulled the work roster for the relevant day, which did not show any officer with a last name of [redacted] working in Mr. [redacted] unit. *See* Allegation Inquiry at 2. As a result, the investigator closed the investigation. *See* Allegation Inquiry at 2.

While there was no Officer [redacted] working on the date of the allegation, the roster that the investigator reviewed and attached to the inquiry report shows that an officer by the name of "[redacted]" did work that day. *See* Allegation Inquiry at 4. Given the similarity between the two names, it is almost certain that Officer [redacted] was the subject of Mr. [redacted] allegation. Yet, despite pulling the roster as evidence, the investigator failed to make this simple and obvious connection. In addition, the investigation was not assigned to an investigator for seven months, meaning that even if the investigator had been able to identify the subject, it would not have been possible to obtain AVSS or BWC footage of the incident. The investigator's incompetence and the delays in the investigation resulted in a complete failure to determine whether this allegation was true.

Questions for Defendants

1. Should the local investigator have figured out that the subject of the investigation likely was Officer [redacted]? If no, why not? If yes, did the failure to draw that connection result in an incomplete investigation?

3. RJD – [redacted]

Although there were a number of problems with the incomplete local investigation in this case, the most serious issue was that the investigator recommended that the allegation not be sustained and then issued the complainant an RVR for falsely reporting a criminal offense based on the investigator's review of video footage from the wrong date. [redacted] alleged, *inter alia*, that on December 5, 2021, Officer [redacted] touched him in a sexually inappropriate way. The investigator, however, reviewed BWC footage from December 6, 2021, which was the day after the incident date.[29] Based on the lack of evidence of staff misconduct in the footage from the wrong date, the investigator concluded that Mr. [redacted] allegation was false. The investigator then issued Mr. [redacted] a Rules Violation Report for falsely reporting a criminal offense. *See* PREA-21 at 17. The investigator's incompetence in this case—reviewing video from the wrong date—therefore resulted in a failure to determine whether the incident occurred as alleged and in the issuance of a false RVR. Moreover, as Plaintiffs have previously reported, by issuing an RVR for filing a staff misconduct complaint, investigators potentially chill class members' willingness to file grievances and participate in the investigation process.

Questions for Defendants

1. Did the investigator lack a basis for issuing an RVR to Mr. [redacted] If no, why not?

4. SATF - [redacted]

These three cases involve an incident about which Plaintiffs wrote in the November 2022 Report, in which Officers [redacted] and [redacted] at SATF initiated an improper immediate use of force against [redacted]. As shown on video and as found by the Hiring Authority, the officers should have initiated a

[29] Although CDCR initially reported that the incident occurred on December 6, 2021, the incident date was corrected within ten minutes to December 5, 2021. *See* PREA-21 at 10. Additionally, the investigator received an email with the correct incident date more than a week before the investigator requested the BWC footage. *See* PREA-21 at 13, 15.

controlled use of force to address Mr. [redacted] refusal to leave the building's sallyport, as he was in a controllable space and did not pose an immediate risk to anyone.

Three separate incarcerated people reported this incident during the quarterly interviews at SATF—two during the October 2021 quarterly interviews and one during the March 2022 quarterly interviews. Based on those reports, and apparently without connecting that the accounts each related to the same incident, SATF launched three separate investigations into the allegation—[redacted] (discussed in the November 2022 report), [redacted], and [redacted]. None of the investigation reports acknowledged any prior investigations into this incident. All three of the investigations were of terrible quality. And all three investigators recommended that the Hiring Authority not sustain the allegation, even though video evidence clearly showed that the use of force was improper. Collectively, these cases reflect deeply-rooted problems with investigator incompetence and bias, reflected in the haste with which they sought to close these cases as unfounded. These cases also evidence CDCR's ongoing inability to track and recognize related cases, resulting in wasted investigation resources.

In [redacted] the third-party complainant in the case alleged that the officer involved in the incident was named Officer "[redacted]." The investigator concluded that the allegation was unfounded because no Officer "[redacted] worked at SATF. *See* Allegation Inquiry at 2. But the investigator failed to take any action to discover that an officer with a similar last name "[redacted] worked at SATF. In addition, the investigator stopped the investigation when the complainant recanted the allegation during their interview, which occurred about eight months after they initially reported the misconduct. According to the investigator, when asked about the incident, the complainant stated: "This whole thing is a lie. I never made these allegations and the staff on this yard are awesome…. Yes, I remember being interviewed by the Ombudsman, but I never told them any of these allegations. They are lying about all of this. I cannot help you with any of this because I am not aware of any of these incidents occurring on this yard." Allegation Inquiry at 1. The investigator relied on this recantation to end the investigation. Instead, given widespread reports regarding fear of retaliation, especially surrounding the quarterly interview process as reported by Plaintiffs' counsel, this recantation should have been viewed as suspect and the investigator should have redoubled his efforts.

In [redacted] the investigator concluded "there is no reasonable suspicion staff misconduct may have occurred based on the information reported and gathered" after

learning that the third-party complainant did not actually witness the incident. *See* Allegation Inquiry at 2. The investigator did nothing to determine whether the assault had in fact occurred.

Lastly, in [redacted], the investigator conducted a deeply incomplete investigation in which he did not interview the victim or another officer present for the use of force. Most troublingly, the investigator in this case was the only one of the three investigators in the related cases to review the video of the incident, but concluded from the video that "staff acted appropriately in the use of force," and recommended that the Hiring Authority not sustain the allegation.[30] *See* Allegation Inquiry at 6.

Questions for Defendants

1. Should the local investigator in [redacted] have figured out that the subject of the investigation likely was Officer [redacted]? If no, why not? If yes, did the failure to draw that connection result in an incomplete investigation?

2. Was it inappropriate in [redacted] for the local investigator to stop the investigation simply because the third-party complainant was not a direct witness to the incident? If no, why not?

5. Investigators Routinely Fail to Retain and Review Relevant Video Footage of Incidents

A recurring problem with Defendants' investigations is the failure to retain and review appropriate video footage. Prior to the Court's Orders, the lack of video evidence at the Six Prisons meant that most investigations boiled down to an unresolvable conflict between incarcerated people's allegations and staff's denials. Video can provide objective evidence of what transpired between staff and incarcerated people, thereby

[30] Notwithstanding the investigator's poor investigation and unsupported recommendation, the Hiring Authority requested and was granted approval for direct adverse action and then issued the officers Letters of Instruction. As Plaintiffs discussed in the November 2022 Report, that penalty was inconsistent with the Employee Disciplinary Matrix, which mandated at least a Level 2 penalty. That said, the Hiring Authority should be commended for seeing through the incomplete and biased investigation and sustaining the allegation against the officers.

providing the evidence necessary to hold officers and other staff accountable when they violate policy and to exonerate them when they do not. It is therefore critical to effective investigations and accountability that investigators retain and review relevant video evidence, and then produce that video to Plaintiffs per the Remedial Plans. RJD Remedial Plan, § IV; Five Prisons Remedial Plan, § V; *see also* November 2022 Report at 25-31 (reporting on Defendants' failure to retain, review, and produce relevant video evidence).

Defendants continue to fall short at the first, basic step: retaining BWC and AVSS footage.[31] Several cases in the COR production for this quarter suffered from substantial delays affecting video retention. For example, in COR-[redacted], the claimant filed a 602 on November 12, 2021, about two officers improperly deactivating their BWCs during a conversation with the claimant on October 17, 2021. On November 30, 2021, COR identified the 602 as making an allegation of staff misconduct and referred the investigation to AIMS. The AIMS investigator did not appear to begin their investigation until February 14, 2022, when they attempted to conduct their first interview. By that time, video had been destroyed.[32] The 602 was identified as alleging staff misconduct—a triggering event—well within the 90-day retention period, but both COR and the AIMS investigator failed to take any steps to retain the footage. The allegation would have been easily resolved with BWC footage. In multiple other cases, COR referred an allegation of staff misconduct within the 90-day retention period, but video was not retained

[31] Under the Remedial Plans and Defendants' BWC policy, Defendants must retain video footage for all triggering events, including, but not limited to, any allegation of staff misconduct, any PREA allegation, any allegation of misconduct by an incarcerated person, any suspected felonious criminal activity, and any use of force incident. *See, e.g.*, RJD Remedial Plan, § I; Operational Plan No. 28, § VII.B; Five Prisons Remedial Plan, Attachment A ("Operational Plan No. 131"), § VI.B. Plaintiffs reported on Defendants' failures to retain video footage in our prior report. *See* November 2022 Report at 25.

[32] Defendants' form for requesting video footage—Form 1118—does not require the person requesting the video to indicate the date he or she made the request. The absence of this information on the form occasionally makes it difficult to determine whether the investigator made a timely request for video. As indicated in Defendants' response to the November 2022 Report, CDCR is evaluating whether to revise this form. Plaintiffs reiterate their request that CDCR revise the form to include a date that the requestor made their request.

because COR never took steps to preserve the video and the AIMS investigator did not initiate their investigation until after the retention period. *See* COR-[redacted]; COR-[redacted]; COR-[redacted].[33]

Delays also led to the destruction of video in several RJD cases. Specifically, in 8 out of 38 cases (21%), the investigator could not review video footage because the 90-day retention period had expired. For example, in RJD-[redacted], the claimant alleged that on March 1, 2022, an officer yelled and shined her flashlight in incarcerated people's faces. When the claimant asked the officer to stop because they have a history of seizures, the officer laughed and continued to shine the light. Although the case was referred to an LDI on March 21, 2022, the investigator did not start the investigation and attempt to conduct the first interview until June 13, 2022, after the 90-day retention period, and the video was not preserved. *See also* RJD-[redacted]; RJD-[redacted]; RJD-[redacted] Similar issues arose at other institutions. *See, e.g.*, KVSP-[redacted]

While the failure to retain the footage may be negligent, it is difficult to understand in multiple cases how and why Defendants continue to fail to review relevant video footage. There should be limited circumstances in which an investigator is not able to view the footage, and yet, in multiple cases, investigators reviewed video from abbreviated time windows or from the wrong time window altogether.[34] *See* November 2022 Report at 25-26 (reporting on same failures). For example, in RJD-[redacted] the claimant alleged that three custody officers delayed him from receiving medical care after paramedics arrived at 08:20. The investigator requested BWC footage beginning at

[33] Refer to Appendix B for more information about the video problems with these cases and other cases that are cited but not discussed in detail in this section of the Report.

[34] An investigator should only fail to review video if (1) the video was appropriately deleted (meaning the complaint was made more than 90 days after the incident and the incident was not a triggering event that should have automatically led to retention); (2) the investigator cannot locate video evidence, after exhausting reasonable efforts to identify the date, time, and location of the alleged incident; or (3) the investigator concludes that the incident occurred under circumstances where video does not exist (e.g., during a circumstance in which staff are required to deactivate their cameras or prior to implementation of video at an institution).

08:50, which excludes an entire half hour from the beginning of the allegation. *See also* SATF-[redacted] LAC-[redacted] KVSP-[redacted]

In other cases, investigators fail to review footage from relevant officers present for an event. For example, in RJD-[redacted] the claimant alleged that during an argument, an LVN threatened her, saying things like "Meet me outside. You don't know who my boyfriend is." The investigator reviewed AVSS capturing the argument. However, only the claimant's side of the argument is audible on the AVSS footage. The footage shows two officers standing near the medical window, but the investigator failed to identify those officers and request their BWC footage to try to determine what the LVN said to the claimant. In LAC-[redacted] although a critical question was whether the claimant refused medical attention after being pepper sprayed, the video footage the investigator reviewed and that was produced to Plaintiffs does not resolve that question. Fixed camera footage shows an officer and a medical staff member approaching the claimant's cell at 12:16, and again shows an officer approaching the cell between 12:28-12:38, but the investigator failed to obtain BWC footage from those officers for audio showing whether the claimant refused medical attention. *See also* SATF-[redacted] LAC-[redacted] COR-[redacted] These failures are significant because they render it impossible for the allegation to ever be substantiated.

Investigators also fail to make a sufficient effort to identify the time, date, and locations of incidents. For example, in SATF-[redacted] the claimant alleged and an incarcerated witness corroborated that a named officer harasses the claimant on a near-daily basis, including by searching him more often than others upon his return from work, searching his cell, and allowing him only limited showers. The investigator wrote that he did not preserve or review video footage because he was unable to determine specific dates of the allegations. But the investigator failed to take other steps to identify dates and times of the incidents, such as by identifying dates that the subject officer was working in the building the same day that the claimant was working. Similarly, in RJD-[redacted] the claimant made the serious allegation that staff gave incarcerated people a list of people who were going to transfer and possibly other confidential information. The 602 listed a date (May 24, 2022), location (B-10), and time (2nd watch) for the incident, and the claim summary the investigator received included those details. Yet the investigator failed to request video from that date and time and incorrectly stated that "the complainant did not give any specific date and times associated to any allegations, voiding the need and ability to pull AVSS recording."

For additional information about Defendants' failures to properly retain, review, and produce relevant video evidence in compliance with the Remedial Plans, see Appendix B.

II. OFFICERS ARE NOT COMPLYING WITH BWC POLICIES

Plaintiffs' review of BWC footage from the productions shows that staff continue to violate BWC policies and that investigators and the Hiring Authorities are often failing to take appropriate action when BWC videos reflect intentional noncompliance. *See* Nov. 4, 2022 Report at 31. The policies mandate that officers must keep their BWCs activated for the entirety of an officer's shift, except for specified deactivation events.[35] And officers must reactivate their cameras as soon as the deactivation event has concluded, and announce their reactivation. *Id.*, § VI.B.11; Local Operations Procedure § VI.B.11.

Plaintiffs reviewed each deactivation/reactivation for all unique BWC videos produced by Defendants to determine whether (1) a deactivation may have been an intentional effort by the officer to interfere with the camera capturing misconduct ("code of silence") (2) a deactivation appeared to be for an inappropriate deactivation event, and (3) the officer failed to announce the reason for the deactivation/reactivation. Plaintiffs discuss the first two noncompliance issues below, and the third in Appendix C.

A. Officers Appear to Be Intentionally Deactivating BWCs to Promote a Code of Silence

In at least two cases, both following use of force incidents, officers deactivated their BWCs in circumstances that suggest the deactivations may have been intended to advance a code of silence or to allow officers to collude in report writing without being captured on video.

[35] *See* Connie Gipson, Update to Body-Worn Camera Deactivation Events (Aug. 19, 2021); *see, e.g.*, Operational Plan No. 28 § VI.B.10; Five Prisons Remedial Plan, Attachment B (Local Operations Procedure 944) § VI.B.10. Before deactivating their cameras, officers must announce the reason for the deactivation so that it is recorded by the BWC. Operational Plan No. 28 § VI.B.10; Local Operations Procedure § VI.B.10.

In LAC-[redacted] an officer pepper sprayed a person inside his cell after the incarcerated person apparently pinned the officer's hand against the food port. Sergeant [redacted] BWC[36] shows him deactivating the alarm and re-entering the housing unit moments after the use of force. For the next ten minutes, he had multiple discussions with officers and staff about the incident and appropriate response, discussed initiating a cool-down period and options for decontamination, and prepared medical to place the incarcerated person on suicide watch. At 20:06:40, while still addressing the incident, Sergeant [redacted] deactivated his camera without announcement for about two minutes after he approached another officer and said, "Hey, so check it out." Later, at 20:14:30, Sergeant [redacted] walked over to a group of officers and gestured at the chest of another officer, who then placed his finger on the button of his own BWC—apparently telling the officer to deactivate. Sergeant [redacted] then deactivated his camera without announcement. The available information here—the deactivations followed a use-of-force incident and occurred in the middle of discussions about that incident, no permissible deactivation circumstances appear present, and Sergeant [redacted] used hand signals to ensure another officer deactivated his camera as well—suggests the deactivation may have been designed to advance a code of silence.

In LAC-[redacted], discussed above, officers attempted to force a class member into a wheelchair during an escort. Several minutes after the improper use of immediate force, Sergeant [redacted] spoke to two officers about the incident. He said, "We're all going to have to write now," because the incident involved "physical force." *See* BWC at 13:05:25 and 13:05:40. The officer proceeded to discuss the report with an officer who was not involved in the incident. At 1:09:00, the sergeant sighs, walks into the hallway, says, "We're all writing, let's go," and deactivates his camera as the officers gather. One visible officer appears to also deactivate his BWC. The deactivation is not justified, and the fact that it occurs once Sergeant [redacted] decides the officers are writing reports and has gathered other officers suggests it may be intended to advance a code of silence or to allow the officers to collude without being caught on camera. Collusion in report writing is against policy. *See* DOM § 51020.17.1.

[36] In some of the converted videos linked here, the video freezes upon deactivation. To view any section of the video Plaintiffs' describe upon reactivation, click to the relevant timestamp later in the video player.

B. Improper Circumstances Violations

In several cases, officers deactivated or reactivated their BWCs in improper circumstances. In case COR-[redacted] alone, officers deactivated their BWCs in improper circumstances 16 separate times, and the Hiring Authority failed to address 12 of those violations. In LAC-[redacted] the officer walked into a medical building, physically covered his camera with two hands, and said "My camera's off I promise, hold on, two seconds," before deactivating. *See* BWC. Being in a medical unit alone is not a permissible deactivation circumstance. *See also* LAC-[redacted] (indiscernible justification while sergeant is approaching other officers in housing unit, which is not a permissible deactivation circumstance). *See* BWC

Plaintiffs have previously reported on officers at LAC announcing that they were engaging in "training" and then deactivating their BWCs, even though the circumstances give no indication training was occurring. *See* September 2022 Report at 33. That improper practice continues. In LAC-[redacted] the officer walked into the sally port where two other officers were standing, and announced "training," but the video contains no indication training was taking place. Moreover, when the officer reactivated the BWC a little over two minutes later, he was cell-side on the second tier for a conversation with an incarcerated person. *See* BWC. In the same case, another video showed a group of officers discussing a pepper spray incident. The officers asked each other if they saw force. The sergeant announced "training" and then deactivated, but again the preceding conversation indicates it is not training. *See* BWC.

Several videos show officers instructing other officers to turn off their camera in impermissible circumstances. In LAC-[redacted] the officer ran to what ultimately was a false alarm, and then gathered outside the housing unit with a group of officers. An officer said, "Let's have a quick meeting real quick," and someone can be heard saying "Turn off the cameras." The officer then deactivated his camera without announcement, and there were no apparent appropriate deactivation circumstances. About ten minutes later at 8:55:00, the officer addressed an incarcerated person who was repeatedly yelling "Ow!," with his leg partially in his cell door. After the officers walked away and into the program office, one of the officers instructed the other two officers to turn off their cameras. The officer deactivated with no apparent justification at 8:57:34. *See* BWC. *See also* LAC-[redacted] BWC at 20:19:00 (the officer instructed another officer to deactivate with no audible justification, and then the officer reactivated about 22 minutes later while cell-side talking to an incarcerated person); CIW-[redacted] at 10:34:32

(instructed to turn off BWC during a discussion about an escort, with no apparent permissible deactivation circumstance). *See* BWC. Investigators generally did not flag and the Hiring Authorities rarely did anything to address these violations.[37]

Lastly, it is worth noting that Defendants' BWC audit system would not identify many, if any, of these instances of BWC noncompliance, as few, if any, of the videos contain deactivations exceeding 1.5 hours.

III. INFORMATION REQUESTS

- In the November 2022 Report, Plaintiffs asked "What steps have Defendants taken to ensure that the investigators and Hiring Authorities identified in reports as performing deficiently improve their performance, complete comprehensive and unbiased investigations, and impose appropriate discipline to address disability-related staff misconduct in the future?" Defendants responded, in relevant part "Concerns with staff performance will continue to be addressed via the report review process, training, and ultimately, CDCR's employee disciplinary process." That answer is not sufficiently specific. Accordingly, we reiterate and clarify our request: **Have Defendants taken any steps to ensure that investigators and Hiring Authorities identified in reports as performing deficiently improve their performance? If yes, identify the each investigator/Hiring Authority and the specific steps that Defendants have taken to improve their performance (training, disciplinary process, etc.).**

- In the November 2022 Report, Plaintiffs requested that Defendants "[p]lease provide proof that all of the LDIs conducting investigations have been trained by OIA." Defendants did not provide such proof, instead stating that "LDI training has been incorporated into the Sergeants Academy and Lieutenants Academy. OIA staff also provide training to other staff in the field on a regular basis." **Please provide proof that all individuals conducting local inquiries have received training from OIA.**

[37] In multiple cases, officers appear to wear BWCs incorrectly. In LAC-[redacted] the officer appears to have the camera away from her body for almost half an hour from 6:07:20, when the camera is activated, to 6:34:10. *See also* LAC-[redacted]

- In the November 2022 Report, Plaintiffs wrote "[t]he Remedial Plans state that 'CDCR will develop on-going training requirements for CST staff, locally designated investigator, OIA investigators, vertical advocates, and hiring authorities to ensure comprehensive and unbiased investigations.' RJD Remedial Plan at 7; Five Prisons Remedial Plan at 7-8. What are the ongoing training requirements that have been developed? Who has received training and when? Please produce to us the current version of the training(s)." In response, Defendants only provided information about ongoing training for CST staff. **Please provide the requested information for the other types of staff listed in the information request.**

- In the November 2022 Report, Plaintiffs asked whether training for Hiring Authorities that is mandated by the Remedial Plans had been delivered to the Hiring Authorities. Defendants responded that they had already provided Plaintiffs with the training. **We have been unable to locate the training and would appreciate if Defendants could produce it.** In addition, Defendants did not confirm whether the Hiring Authorities at the Six Prisons have received the training. **Please indicate whether and provide proof that the Hiring Authorities at the Six Prisons have received the training.**

- In the November 2022 Report, Plaintiffs made the following request: "Under the Remedial Plans and relevant AVSS and BWC policies, the filing of a staff complaint is a triggering event requiring retention of video footage beyond 90 days. What procedures do Defendants have in place to ensure that, even before a staff complaint is assigned to an investigator, the filing of a staff complaint results in the retention of video?" Defendants did not respond to this request. **Please answer this important question.**

- In the November 2022 Report, Plaintiffs asked "What training do investigators (local and OIA) receive about how quickly to request video and how much video to request?" Defendants indicated that they have instructed staff in the AIU to request video within 10 business days of the receipt of the case in the AIU. Defendants did not provide any information about local investigators and did not provide any documentation of the AIU policy or training. **Please provide this information and documentation.**

IV. CONCLUSION

Pursuant to the parties' agreement, we expect to receive a response to this report from Defendants by March 17, 2023. Plaintiffs will continue to work with Defendants to attempt to bring Defendants into compliance with the Court's Orders and the Remedial Plans. To avoid further litigation, however, Defendants must immediately begin demonstrating significant progress.

Sincerely,

ROSEN BIEN
GALVAN & GRUNFELD LLP

/s/ [redacted]

By: [redacted]

[redacted]

cc: [redacted]

APPENDIX A

The productions we reviewed included 426 unique and closed case files. In 33 of the cases (7.5%), Hiring Authorities sustained allegations against at least one staff member.[38] In those cases with a sustained allegation, Hiring Authorities imposed adverse action against at least one staff member in only 2 cases (0.5).[39] In the remaining 31 cases with a sustained allegation, Hiring Authorities imposed corrective action or took no action.[40] The chart below breaks down the cases by institution.

	Cases	Sustained	Corrective Action	Adverse Action	% Sustained	% Adverse
LAC	135	10	9	1	7%	1%
RJD	38	3	3	0	8%	0%
CIW	45	5	5	0	11%	0%
SATF	113	5	5	0	4%	0%
COR	45	2	1	1	2%	2%
KVSP	50	8	8	0	16%	0%
Total	426	32	31	2	8%	0.5%

[38] In 7 additional cases, a separate policy violation was discovered in the course of the investigation and sustained against at least one staff member: SATF [redacted]; SATF [redacted]; SATF [redacted] SATF [redacted]; COR [redacted]; COR [redacted]; COR [redacted]

[39] LAC [redacted]; COR [redacted]

[40] LAC [redacted]; LAC [redacted]; LAC [redacted]; LAC [redacted]; LAC [redacted]; LAC [redacted]; LAC [redacted]; LAC [redacted] LAC [redacted]; RJD [redacted]; RJD [redacted] RJD [redacted]; CIW [redacted]; CIW [redacted]; CIW [redacted]; CIW [redacted]; CIW [redacted]; SATF [redacted]; SATF [redacted]; SATF [redacted]; SATF [redacted]; SATF [redacted]; COR [redacted]; KVSP [redacted]; KVSP [redacted]; KVSP [redacted]; KVSP [redacted]; KVSP [redacted]; KVSP [redacted]; KVSP [redacted]; KVSP [redacted]

APPENDIX B

KVSP

[redacted]	The claimant reported misconduct on January 7, 2022, and stated that it occurred in the three weeks prior, including on January 2, 2022. The AIU investigator did not interview the subject staff members until six months later. On an unknown date, but presumably close in time to those interviews, the investigator requested AVSS and BWC footage for a 15-minute period on January 2, 2022. In response, KVSP staff issued an undated memorandum indicating that the footage was no longer available. The investigator's unreasonable delay in beginning the investigation appears to have led to the footage being destroyed.
[redacted]	The claimant alleged that the subject officer did not allow the claimant to decontaminate after being pepper sprayed and that the officer planted a weapon while the claimant was in a holding cell. However, the BWC footage reviewed and produced to Plaintiffs stops when the officer and claimant arrive at the holding cell.
[redacted]	The investigator failed to request sufficient BWC footage. Several files produced to Plaintiffs' counsel cut off too early in the relevant interactions to hear how officers responded to alerts that the claimant needed water. One BWC video cuts off as an officer is responding. The investigator also failed to request footage from 10:36, when the claimant alleged that another incarcerated person asked the tower officer for water for the claimant. Instead, they requested footage stopping at 10:30.

COR

[redacted]	See discussion above regarding **retaining BWC and AVSS footage**.
[redacted]	The investigation report references the investigator viewing BWC footage obtained from both officers to investigate the allegation. However, Defendants only produced the BWC footage from one officer. The BWC footage not produced is relevant to the claimant's allegation that he discovered a weapon in his cell after that officer's cell search.

LAC

[redacted]	The claimant alleged that on January 1, 2022, an officer ignored his request for medical attention. The claimant's 602 said the incident occurred at 20:00 and he reported in the interview that it occurred around 19:30-20:00. Even though the claimant promptly filed a grievance and LAC referred the allegation to AIMS on January 27, 2022, no one took

	steps to preserve video evidence at that point. The AIMS investigator did not appear to begin their investigation until May, at which point video was destroyed. The AIMS investigator was able to review BWC footage from a different case, beginning at 20:00, and concluded that the existing footage "did not reveal any mention of [claimant] having a medical issue or calling for help during the time frame that was reviewed," but acknowledged that earlier BWC footage had not been retained. Absent video, it is not possible to resolve what happened in this case.
[redacted]	See case writeup.
[redacted]	See discussion above.
[redacted]	The investigator failed to review sufficient video footage of two incidents, a cell extraction and a use of force outside the gym. Although several officers were on the scene, the investigator requested only a sergeant's BWC footage. However, that camera view is blocked for much of the cell extraction and provides only a limited view of the claimant's actions preceding the takedown outside of the gym. The investigator failed to request BWC footage from the other officers present for both incidents, which would have helped resolve whether the officers' actions were within policy.
[redacted]	The investigator stated that they reviewed BWC footage of the claimant's refusal to participate in the AIMS interview, but Defendants failed to produce that footage to Plaintiffs.

SATF

[redacted]	The claimant alleged the subject officer was not wearing his mask for the "first couple hours" of the morning. Instead of reviewing AVSS footage from multiple hours that morning—which could have been done quickly, by watching the video at high speed—the investigator requested only a 43-second clip that shows the claimant being pushed through the rotunda area. The investigator should have reviewed a longer stretch of video.
[redacted]	The investigator reviewed only the BWC footage from one officer participating in the cell search. That video shows another officer entering the cell during the search, but the other officer's actions are not all viewable in that BWC footage. The investigator should have identified that other officer and obtained their BWC footage.
[redacted]	See discussion above.

RJD

[redacted]	The claimant alleged that on June 19, 2021, two officers removed and deactivated their BWCs while being disrespectful and using offensive language to the claimant. BWC footage would have immediately resolved whether the officers impermissibly deactivated their BWCs. RJD referred

	the case to an LDI on July 14, 2021. The Warden left a handwritten note on the AAR memo, dated July 14, 2021, stating "Video footage required." The case was not assigned to an investigator until nearly a year later, on June 1, 2022. The inquiry report states that "There was no documentation or AVSS/BWC available in regards to this inquiry due to the 90 day time limitation has expired as this incident allegedly occurred on June of 2021"—despite the Warden's note.
[redacted]	See case writeup.
[redacted]	See case writeup.
[redacted]	See discussion in report.
[redacted]	Claimant alleged that on February 17, 2022, he told an officer that he was waiting for an ADA worker to finish cleaning his cell when staff issued an order to lock up, and the officer threatened the claimant, saying to other officers in the unit, "I'll remember his name, remember this one's name guys!" The case was referred to an LDI on March 15, 2022, but the investigator did not start the investigation and attempt to conduct the first interview until May 26, 2022, after the 90-day retention period. As a result, the inquiry report states that "AVSS and BWC Footage could not be reviewed." BWC footage would have conclusively resolved whether the officer made the threat.
[redacted]	See discussion above.
[redacted]	The investigator did not request or review any video footage associated with this allegation that officers failed to accommodate the claimant's disability during a transport. The investigator should have requested and reviewed BWC footage from both officers, as well as AVSS footage. The footage would have shown whether the claimant tried to explain their need for an ADA van, the officers' response, and if the claimant struggled to enter the van. The investigation report gives no indication the investigator attempted to identify the officers to obtain their BWC footage.
[redacted]	See case writeup.
[redacted]	See discussion in report.
[redacted]	See discussion above.

CIW

[redacted]	Even though a witness corroborated the claimant's allegation that the subject officer had told the claimant that she was "faking" her medical emergency, the investigator failed to ask that witness about the date of the incident, so as to identify relevant video footage.
[redacted]	The investigator stated they reviewed BWC and AVSS footage related to this PREA allegation, but that footage was not produced to Plaintiffs.

[redacted]	The investigator stated they did not review AVSS footage because those remedies were not activated until August 2021, but the grievance stated that the incidents occurred *during* 2021. The investigator failed to ask the claimant questions to identify whether the incidents occurred after August 2021 and, if so, to provide a date and time to identify relevant video footage.
[redacted]	Defendants failed to retain and produce video footage because the investigator reviewed the video footage "on a viewing station to expedite the completion of the LDI report." However, CIW should have preserved the video footage because the complaint was an allegation of staff misconduct, which is a triggering event.

APPENDIX C

Prison	Failure to Announce Violations[41]
COR	[redacted] 206621-AVSS-BWC.g64x; 11:37:10 (deactivation) [redacted] COR-BWC-21-011.g64x (2); 8:16:19 (reactivation) [redacted] COR-BWC-21-011.g64x (4); 8:16:31 (reactivation) [redacted] COR-BWC-21-011.g64x (5); 8:16:30 (reactivation) [redacted] COR-BWC-21-202.g64x (1); 9:25:49-9:29:07 (deactivation and reactivation) [redacted] COR-BWC-21-202.g64x (2); 8:25:28-8:27:55, 8:38:13-8:39:29 (deactivation and reactivation) [redacted] COR-BWC-21-202.g64x (3); 8:23:29-8:37:52, 8:38:01-8:48:08, 8:49:13-8:51:12 (deactivation and reactivation)
SATF	[redacted] Z FLR 1 291904.g64x; 6:49:25-6:51:29 (deactivation) [redacted] Z SEC PAT ASU 1 292906.g64x; 7:04:11 (reactivation) [redacted] E 1 FLR 1 351508.g64x; 8:43:02 (reactivation) [redacted] E 1 CNTRL 251504.g64x; 8:03:32 (reactivation)
RJD	[redacted] A YARD 2 C022021_12-8-21_1037-1046; 10:37:42 (reactivation) [redacted] S ISU SGT 1 C092002_12-6-21_1315-130.22; 1:15:18 (reactivation) [redacted] C 11 FLR 1 C042006-2022-03-08; 6:22:26 (reactivation) [redacted] C 11 FLR 2 C042007-2022-03-08; 6:22:23 (reactivation) [redacted] CENTRAL CONTROL SPARE 27 C010027-12-17-21_APP 209967; 8:50:04 (reactivation) [redacted] CENTRAL CONTROL SPARE 28 C010028-12-17-21_APP_209967; 8:51:31-8:51:37; 10:00:39-10:00:45; 10:04:46-10:04:59; 10:06:25-10:06:31 (deactivations and reactivations)
KVSP	[redacted] HCA Z ESCRT MH 2 274022; 1:14:10 (reactivation) [redacted] Z 1 PROGRAM SGT 270411; 1:15:18 (reactivation) [redacted] D SEC PAT 2 342303; 5:06:26 (reactivation) [redacted] C 7 FLR 2 332117; 1:49:49 (reactivation)

[41] For files with multiple videos, Plaintiffs' have specified the video file name and the location of the specific video in the video player. For files with one video, Plaintiffs' have listed the camera post number.

LAC	LAC-[redacted] Incident 30052 11.3.2021 ADMIN REVIEW.g64x (top right); 3:13:45 (deactivation) LAC-[redacted] Incident 30052 11.3.2021 ADMIN REVIEW.g64x (bottom left); 4:13:45 (deactivation) LAC-[redacted] Incident 31183 11.27.2021_1.g64x - top right; 1:17:21 (reactivation) LAC-[redacted] Incident 34367 2.11.2022.g64x - middle right; 22:02:00 (deactivation) LAC-[redacted] Incident 34367 2.11.2022.g64x - bottom left; 22:01:57 (deactivation) LAC-[redacted] 1/12/2022 FDB5 Incident 33139.g64x - top left; 10:04:07 (reactivation) LAC-[redacted] Hospital Kit 01 A 000000; 10:11:05 (reactivation) LAC-[redacted] HCA D 2 ESCRT EOP 1 344221; 6:05:27 (reactivation) LAC-[redacted] Appeal 206663 12.6.2021 BWC g64x - top; 1:09:18 (deactivation) LAC-[redacted] Incident 31691 12.8.2021.g64x - top center; 8:06:45-8:09:07 (deactivation and reactivation); 8:14:30-8:18:03 (deactivation and reactivation); 8:18:15-8:18:54 (reactivation) LAC-[redacted] Incident 31691 12.8.2021.g64x - top right; 7:53:12 (reactivation) LAC-[redacted] Incident 31691 12021.g64x - middle center; 7:54:56 (reactivation) LAC-[redacted] Incident 31691 12021.g64x - bottom center; 7:53:11 (reactivation) LAC-[redacted] Incident 31691 12021.g64x - bottom center; 7:54:26-7:55:04 (deactivation and reactivation) LAC-[redacted] Incident 31691 12021.g64x - bottom right; 7:56:06-7:56:25 (deactivation and reactivation) LAC-[redacted] B 4 CNTRL 321731; 8:01:02-8:08:57 (deactivation and reactivation) LAC-[redacted] Incident 32108 12.18.2021.g64x - top left; 5:30:47 (reactivation) LAC-[redacted] Incident 32108 12.18.2021.g64x - 3rd row 2nd right; 5:30:14 (reactivation) LAC-[redacted] 1.28.2022 FAC.D5 AIMS Inquiry.219400.g64x - top left; 12:23:08 (reactivation) and 12:28:11 (deactivation) LAC-[redacted] 1.28.2022 FAC.D5 AIMS Inquiry.219400.g64x - top right; 11:48:03 (reactivation) and12:00:47 (deactivation) LAC-[redacted] 1.28.2022 FAC.D5 AIMS Inquiry.219400.g64x - bottom left; 11:34:27 (reactivation)

Prison	Failure to Announce Violations[41]
	LAC-[redacted] 1.28.2022 FAC.D5 AIMS Inquiry.219400.g64x - bottom center; 12:30:22 (reactivation) LAC-[redacted] Incident 33587 1.24.2021.g64x - top; 2:42:59 (reactivation) LAC-[redacted] Incident 33587 1.24.2021.g64x - 4th row middle; 2:43:42 (reactivation) LAC-[redacted] AIMS 228889 01/28.22 BWC.g64x - left; 6:38:39 (deactivation) LAC-[redacted] AIMS 228889 01/28.22 BWC.g64x - left; 8:08:59-8:09:26 (deactivation and reactivation) LAC-[redacted] Appeal 227159 02.18.2022.g64x; 2:09:53 (reactivation) LAC-[redacted] D 4 Flr 2 242052; 10:06:02 (deactivation) LAC-[redacted] AIMS 228889 02.28.2022 BWC 1.g64x - left; 6:07:20 (reactivation) LAC-[redacted] Incident 34156 2.8.2022_1.g64x - middle left; 7:29:01 (reactivation) LAC-[redacted] Incident 34156 2.8.2022_1.g64x - middle right; 7:29:25 (reactivation) LAC-[redacted] Aims 234352 1.31.22 2.1.22 2.2.22; 8:41:29 (reactivation) LAC-[redacted] B 4 Flr 2 321733; 2:02:43 (deactivation) LAC-[redacted] Appeal 19760 11.29.21.g64x; 7:31:28 (reactivation)
CIW	[redacted] CIW2022.05.10.002.ADA.g64x; 7:04:57 (reactivation) [redacted] CIW2022.04.22.005.ADA.B.g64x