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PRIVILEGED AND CONFIDENTIAL

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[redacted]

[redacted]

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

Dear [redacted], [redacted], and [redacted]:

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

Plaintiffs have again found substantial evidence that CDCR's accountability system is failing. The cases discussed below reflect a number of serious problems with CDCR's accountability system. In COR-[redacted] CDCR failed to conduct a thorough investigation into a very serious allegation, supported by some evidence, that an officer orchestrated an attack on an incarcerated person. In the cases discussed in Section I.B, CDCR failed to conduct comprehensive investigations (mostly local inquiries) into, and failed to hold staff accountable for, disability-related misconduct, including instances

where staff were disrespectful and dismissive of incarcerated people's requests for help. In the cases in Section I.C, CDCR failed to hold staff accountable for widespread violations of its use-of-force policies. In the cases in Section I.D, CDCR failed repeatedly to retain and review video evidence that likely would have resolved whether misconduct occurred. In the cases in Section I.E, Hiring Authorities failed to hold staff sufficiently accountable, even when the evidence showed staff engaged in misconduct. And, as discussed in Section II, data shows that the AIU is failing to timely complete investigations in the vast majority of cases. Finally, in Section III, the Office of the Inspector General ("OIG"), in a series of recent reports, has identified the same types of problems with CDCR's staff misconduct accountability system.

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

Sincerely,

ROSEN BIEN
GALVAN & GRUNFELD LLP

/s/ [redacted]

By: [redacted]

[redacted]

cc: [redacted]

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

In the cases discussed below, Defendants' investigators failed to conduct "comprehensive and unbiased investigations and ensure all relevant evidence is gathered and reviewed" and Defendants' Hiring Authorities failed to 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.

A. Failure to Comprehensively Investigate Serious Allegations of Misconduct

Plaintiffs recognize that CDCR cannot devote unlimited resources to every allegation of misconduct. What is crucial, however, is that CDCR marshals those investigative resources when it is possible staff engaged in serious and possibly criminal misconduct that endangers the safety of incarcerated people. In the following case, despite substantial evidence that an officer may have orchestrated an attack on an incarcerated person, the investigator failed to pursue all available leads.

1. COR-[redacted] – AIU, Not Sustained (bribe to assault another incarcerated person and intentionally failing to secure handcuffs)

In this case, the investigator failed to conduct a comprehensive investigation into a very serious allegation of potentially criminal misconduct—that Officer [redacted] offered to pay [redacted], to assault another incarcerated person (Mr. [redacted] then facilitated the assault by providing Mr. [redacted] with a weapon and intentionally failing to properly secure Mr. [redacted] in handcuffs for an escort. The allegation, which was supported by substantial evidence (discussed below), should have resulted in an investigation that pursued every available avenue of relevant evidence. Instead, CDCR conducted a perfunctory investigation that failed to determine whether Officer [redacted] orchestrated the assault.

The circumstances of the attack are suspicious. On March 27, 2023, Officer [redacted] escorted Mr. [redacted] from his cell (245) to a medical appointment outside of [redacted]. *See* AVSS at 8:41:40. Mr. [redacted] broke Officer [redacted] control and then attacked Mr. [redacted] in the middle of the dayroom. *See* AVSS (linked above) at 8:42:07. Evidence in the case—including BWC footage and incident reports from the involved officers—confirmed two critical facts: (1) that Mr. [redacted] right arm was not restrained in the waist-chains that Officer [redacted] applied at Mr. [redacted] cell AND (2) that Mr. [redacted] was in possession of a weapon (a 5.5 inch sharpened piece of

plastic), even though Officer [redacted] had strip searched Mr. [redacted] prior to starting the escort. *See* IR at 13 and Incident Report at 175.

Mr. [redacted] alleged that, while Officer [redacted] BWC was deactivated for the unclothed search, Officer [redacted] offered to provide Mr. [redacted] with contraband and $17,000 if he would attack Mr. [redacted] Mr. [redacted] further asserted that Officer [redacted] told Mr. [redacted] that he wanted Mr. [redacted] attacked because Mr. [redacted] had previously assaulted Officer [redacted] partner. Mr. [redacted] reported that he told Officer [redacted] that he did not have a weapon; Officer [redacted] reportedly then provided Mr. [redacted] with a weapon. Mr. [redacted] initially made some of these allegations to a mental health clinician, then repeated the allegation to the investigator. *See* IR at 8-10.

Officer [redacted] BWC footage includes a 45-second deactivation from 8:37:56 to 8:38:41. *See* BWC at 8:37:55. This gap is consistent with Mr. [redacted] allegation, but obviously does not show that Officer [redacted] engaged in the alleged misconduct. Other evidence uncovered by the investigator was conflicting. An incarcerated witness who was in the cell next to Mr. [redacted] corroborated the allegations. He stated that "he heard [redacted] tell [redacted] he had a problem with [redacted] and that he would give [redacted] drugs, a phone, and money to assault [redacted] and that he saw "through his cell window [redacted] not handcuff one of [redacted] hands." *See* AIU Report at 9.[1] Meanwhile, Officer [redacted] denied that he asked Mr. [redacted] to attack Mr. [redacted] and that he provided Mr. [redacted] with a weapon and stated he did not "know why [redacted] right hand cuff was not properly secured." *See* AIU Report at 12.

Given the seriousness of the allegation and the suspicious circumstances surrounding the attack, the investigator should have taken all reasonable steps to determine whether Officer [redacted] was involved in the attack on Mr. [redacted] The investigator, however, left a number of stones unturned.

First, the investigator should have obtained all available angles of AVSS footage to see whether, when Officer [redacted] BWC was turned off, he passed Mr. [redacted] a weapon or intentionally failed to properly secure Mr. [redacted] Instead, the investigator reviewed only a single angle of AVSS footage that includes only a partial view of the

[1] The incarcerated witness's testimony during his interview appears credible in a number of respects, especially considering that he stated that he never spoke to Mr. [redacted] after the incident. And the witness provided one other piece of information that corroborated Mr. [redacted] allegation. Mr. [redacted] alleged in his investigation interview that Officer [redacted] offered to pay him $17,000. The incarcerated witness stated that he heard Officer [redacted] offer to pay Mr. [redacted] $13,000 or $16,000, but he could not remember exactly. The similarity of this information further supports the allegation.

front of cell 245 and Officer [redacted] *See* AVSS 2 at 8:37:56 to 8:38:41. A better angle likely exists that the investigator should have reviewed.

Second, the investigator failed to conduct any investigation into whether Mr. [redacted] had previously assaulted Officer [redacted] partner—which Mr. [redacted] claimed was Officer [redacted] motive for arranging the attack on Mr. [redacted] CDCR could easily use its records to determine whether that prior assault occurred. The absence of such an assault would have been exculpatory evidence, while the existence of an assault would have partially corroborated Mr. [redacted] allegation.

Third, the investigator should have determined whether Mr. [redacted] and the incarcerated witness were able to speak with each other (*i.e.*, were ever in close proximity to each other) during the time period between the assault and the incarcerated witness's interview with the investigator. Mr. [redacted] allegation and the reports from the incarcerated person are very similar. *Compare* AIU Report at 8 with AIU Report at 9 and [redacted] Interview.[2] If those similarities occurred without any opportunity for them to discuss the incident, that supports Mr. [redacted] allegation.

Fourth, the investigator also failed to perform any forensic analysis of the weapon and other items found in Mr. [redacted] cell to determine if they had Officer [redacted] fingerprints on them or were otherwise connected to Officer [redacted]

Lastly, the investigator conducted a poor interview of Officer [redacted] The investigator focused on technical policy violations—the failure to properly secure, search, and escort Mr. [redacted] and the fact that Officer [redacted] partially obstructed his BWC with his jacket. Though these issues were appropriate to address in the investigation, the investigator missed the forest for the trees. The investigator never directly asked Officer [redacted] to explain the suspicious coincidence at the center of this case—that Mr. [redacted] possessed a weapon AND was not properly secured. *See* AIU Report at 11-12. Why would Mr. [redacted] know to bring the weapon if he did not also know he would be uncuffed? And how could he know that he would not be secured properly unless Officer [redacted] agreed to leave his hand free? While it is conceivable that Mr. [redacted] took a chance in bringing the weapon with him, and benefitted from Officer [redacted] coincidentally both negligently failing to conduct an adequate body search and negligently failing to properly secure him, the investigator never forced Officer [redacted] to go on the record on the pivotal issue in the case.

In addition, the investigator drafted a biased report. In particular, the investigator emphasized as exculpatory evidence that the BWC footage did not include any statements by Officer [redacted] consistent with Mr. [redacted] allegations. *See* AIU Report at 13. But

[2] The recorded interviews do not play in Sharefile, but can be downloaded and played from the link at the top of this case.

Mr. [redacted] alleged that Officer [redacted] made the offer to pay him to attack Mr. [redacted] while the camera was off; the fact that the footage did not include the incriminating statements is close to meaningless. The investigator also does not explain the failure to obtain AVSS footage that better captured Officer [redacted] and Mr. [redacted] cell-front interaction.

It is possible, perhaps even likely, that even if the investigator engaged in these additional investigative efforts, there still would not be enough evidence to establish that Officer [redacted] engaged in the alleged misconduct. Nevertheless, it was inexcusable for the investigator not to have tried. The allegations here were serious and supported by some credible direct evidence (the reports from the incarcerated witness and Mr. [redacted] and circumstantial evidence (the fact that Mr. [redacted] had a weapon despite a strip search and was not secured properly). Under such circumstances, the investigator needed to exhaust all reasonable investigative avenues. His failure to do so extinguished any possibility of determining whether Officer [redacted] facilitated the attack on Mr. [redacted]

Two other issues related to the criminal nature of the allegation in this case bear noting. First, the investigator did not appear, in any way, to treat this as a potential investigation into criminal misconduct by staff. The Remedial Plans state that:

> OIA will open an investigation and proceed as if criminal prosecution is possible. If during the course of the investigation CDCR makes a determination that it must interview the subject(s) of the investigation, OIA will engage in a case conference with EAPT for legal analysis before proceeding. If OIA and EAPT determine that the conduct violated a criminal law, CDCR will classify the investigation as criminal and proceed accordingly. If the conduct does not violate a criminal law, the investigation will proceed as administrative.

Five Prisons Remedial Plan at 11. There is no evidence that any such conferences occurred. And the fact that investigator conducted an interview with the subject, which could have spoiled any criminal investigation or prosecution, suggests that the investigator did not even contemplate approaching this case as a criminal investigation.

Second, given the seriousness and complexity of the investigation, the AIU should have assigned this case to a Special Agent, rather than a Lieutenant. If any case warrants the assignment of a Special Agent, it would be this one, involving a credible allegation that an officer orchestrated one incarcerated person to attack another. These two procedural failures by the AIU provide further evidence that CDCR failed to approach this case in a sufficiently serious manner.

B. Inadequate Investigations and Discipline in Cases Involving Disability Discrimination and Disrespect Toward People with Disabilities

In the following cases, Defendants' accountability system failed to adequately address serious allegations of disability-related staff misconduct. Two points warrant emphasis.

First, the first two cases involved officers being disrespectful and dismissive toward people with disabilities. In the first case, an ADA sergeant at SATF was disrespectful to an incarcerated person who was asking him for help. In the second case, KVSP staff laughed about their intentional failure to follow reporting and safety policies after a person reported to them that he was suicidal. In both cases, CDCR failed to make clear to staff that such behavior is not tolerated by the Department; the Hiring Authority did not sustain the first allegation and the Hiring Authority only imposed corrective action in the second case, despite the serious risk of harm that could have resulted. These cases show serious problems with CDCR's culture. Until CDCR takes these types of misconduct seriously—conducting adequate investigations and imposing appropriate discipline—CDCR will never come into compliance with the Remedial Plans.

Second, many of these cases involved inadequate local inquiries conducted by locally-designated investigators ("LDIs"). These cases are especially concerning given that these types of allegations, which are not on the Allegation Decision Index, are now going to be investigated through the routine grievance process. The routine grievance process has fewer safeguards than the local inquiry process to ensure that investigations are comprehensive and unbiased. Plaintiffs will be closely monitoring Defendants' implementation of this change.

1. SATF-[redacted] – Local, Not Sustained

This case represents a very recent example of an ADA sergeant at SATF dismissing someone with disabilities. This interaction did not occur in a vacuum, it came after a Court-ordered investigation of and significant litigation regarding access to ADA accommodations at SATF. It illustrates how class members continue to face significant [redacted] when requesting help from staff—including ADA staff—the very staff they are supposed to be most able to turn to for help.

As shown on video, on November 1, 2024, [redacted] approaches ADA Sergeant [redacted] who is in his office with the door closed, to, according to Mr. [redacted] follow up on an earlier conversation. *See* Inquiry Report at 2. Sergeant [redacted] asks, "What is this coming to me for?" *See* BWC at 10:54:42. After some discussion, Sergeant [redacted] says, "An ADA sergeant is not doing problems for every ADA inmate, that's not my job. My job is to make sure you guys have your appliances and everyone in the building is trained. That is it." *See* BWC (linked above)

at 10:55:23. Later, he states, "Dude, I'm getting irritated with you because you whine about everything." *See* BWC (linked above) at 10:55:49. Mr. [redacted] attempts to explain that ADA sergeants should be helping people with disabilities assert their rights under the ADA. Sergeant [redacted] cuts off Mr. [redacted] and says "we're done" as he points to the door. *See* BWC (linked above) at 10:56:18. Mr. [redacted] requests an ADA worker to push him out of the office, and Sergeant [redacted] responds, "Dude, you're DPO, you're not DPW. You can walk, I've seen you walk." *See* BWC (linked above) at 10:56:24. Mr. [redacted] retorts saying he exercises because he is supposed to, and Sergeant [redacted] says, "Ah, whatever, dude. Can you get him out of here?" as the ADA worker approaches to push Mr. [redacted] wheelchair. *See* BWC (linked above) at 10:56:34. As Mr. [redacted] is leaving, they continue to argue.

The interaction between the Sergeant [redacted] one of the ADA sergeants at SATF, and the class member is problematic. The job of the ADA sergeants is not strictly limited to making sure class members have their devices and training staff, as he asserts. The attitude of Sergeant [redacted]—"that is not my job," "I bid my job," *see* BWC (linked above) at 10:55:39—undermines the purpose of that position, which is to ensure that ADA class members have a staff member to turn to and, even if that person cannot directly assist them, can point them in the direction of someone who can without disrespecting their disabilities. The Hiring Authority should have found that Sergeant [redacted] did not perform his duties and that he was disrespectful to Mr. [redacted] and, at a minimum, ordered corrective action. And so long as the ADA-specific staff at SATF, like Sergeant [redacted] maintain a dismissive and disrespectful attitude toward incarcerated people with disabilities, SATF will never come into compliance with the ADA and the Court's prior orders.

2. KVSP-[redacted] – AIU, Sustained – Corrective Action

In this case, video showed and the three subject officers admitted that they violated CDCR's suicide prevention policy by failing to act when [redacted] reported suicidality. The Hiring Authority did not, however, impose appropriate discipline. He should have found that the officers negligently or intentionally endangered Mr. [redacted] but instead found only that the officers failed to perform consistent with training and policy. And he should have imposed adverse action for the officers' dangerous misconduct, but instead imposed only corrective action.

As shown on BWC footage, Officers [redacted] and [redacted] approach Mr. [redacted], who is standing outside the mental health clinic. *See* BWC 1 at 11:27:18. Officer [redacted] asks if Mr. [redacted] has group at that time. Officer [redacted] opens the door to the mental health clinic and asks staff if Mr. [redacted] has a scheduled one-on-one with his clinician, and Officer [redacted] steps outside and tells him that the clinician will see him in his housing unit. Mr. [redacted] responds, "Well, I'm suicidal." *See* BWC (linked above) at 11:27:44. Officer [redacted] responds, "Okay, I'll tell him." All three officers then enter the Mental

Health Clinic, leaving Mr. [redacted] alone outside. Officer [redacted] then laughs as she says to Officers [redacted] and [redacted] and two other officers, "You see how he said I'm suicidal and we just turned and walked away from him … no one cares," while the other officers laugh. *See* BWC (linked above) at 11:29:20.

Later, Officer [redacted] recounts the situation with Mr. [redacted] to another officer, saying in a mocking tone that Mr. [redacted] reported, "'I'm fucking suicidal.' And everybody just turned around and walked away," followed by a laugh. *See* BWC 2 at 11:38:45. Approximately eight minutes later, Officers [redacted] and [redacted] walk back outside, observe Mr. [redacted] sitting down against the wall of the mental health clinic, and tell him to return to his housing unit. *See* BWC 2 (linked above) at 11:46:40. Mr. [redacted] responds, "I am having a mental breakdown and I need to see somebody." The officers walk away from him toward Housing Unit 7. Mr. [redacted] reported to the investigator that it was not until 30 minutes to an hour later that Sergeant [redacted] arrived and the Crisis Intervention Team protocol was initiated. *See* IR at 5.

The investigator confirmed that Officers [redacted] [redacted] and [redacted] violated suicide prevention policy by ignoring Mr. [redacted] reports of suicidality. *See* IR at 4, 6, 7, 9. The Hiring Authority sustained D26 (failure to perform within the scope of training and policy), which carries a base level penalty of 1, and imposed corrective action (letter of instruction). *See* 403 at 2-5, 10-14, 29-32.

The Hiring Authority failed to identify all applicable Matrix categories. The Hiring Authority should have found violations of D2 (negligent endangerment, 1**2**3) or, arguably D3 (intentional endangerment, 45**6**789), given that the officers admitted that they knew they were supposed to follow the required safety protocols but intentionally ignored Mr. [redacted] report that he was suicidal. *See* IR at 6-10. A finding of intentional endangerment is further supported by the officers' comments mocking Mr. [redacted] which show they were aware of his need for help but consciously decided not to provide it. Had the Hiring Authority correctly applied the Matrix, it is likely that the officers would have faced more serious consequences, including adverse action, for their admitted misconduct.

Even based on the sustained violations for failure to perform, it was improper for the Hiring Authority to impose only corrective action. The three officers admitted to intentionally walking away from an individual who had reported being suicidal, even though they knew that the suicide prevention policy required them to act immediately to protect his safety, and then laughed about their violation of that policy. The lack of seriousness with which the Hiring Authority approached these violations sends a message that the safety of incarcerated people is not a priority.

3. RJD-[redacted] – Local, Not Sustained

In this case, an investigator conducted an inadequate investigation into an allegation that officers at RJD confiscated [redacted] talking books and personal property during a cell search. Mr. [redacted] 602 stated that the search occurred on August 17, 2023. *See* 602 at 2. The initial investigator, without conducting any interviews, inexplicably requested and reviewed only BWC footage from August 16, 2023, the day *before* the date listed on Mr. [redacted] grievance. *See* BWC. Before the AIU completed the investigation, it reassigned the investigation to a second investigator. The second investigator attempted to request footage from August 17. *See* Investigation Report (IR) at 2; NICE Request Report at 12-18. But, because the reassignment occurred after the 90-day video retention period, that video from the correct date was not available. *Id*.

Further compounding the problem, the second investigator then relied solely on the August 16 video in drafting an inquiry report in which he concluded that no misconduct occurred. *See* IR at 2-3. Nowhere in the report did the investigator acknowledge that the August 16 video he reviewed—which does show a search of Mr. [redacted] cell—was from a different day than Mr. [redacted] allegation. Nor did the investigator do anything to determine if staff also searched Mr. [redacted] cell on August 17. The investigator also did not indicate whether the video (from the wrong day) shows officers confiscating a talking book player or other property. These failures resulted in an incomplete and biased investigation that did not determine whether staff engaged in the conduct alleged by Mr. [redacted]

4. SATF-[redacted] – Local, Not Sustained

[redacted] alleged that he was denied an incontinence shower, but the investigator failed to conduct a complete investigation to determine the veracity of the allegation. Mr. [redacted] alleged that on September 12, 2024, between 0900 and 1200, while Officer [redacted] (the floor officer) was performing security rounds, Mr. [redacted] informed him that he needed a shower following an incontinence accident. *See* 602 at 1-2. According to Mr. [redacted] Officer [redacted] then requested that Officer [redacted] the control booth officer, let Mr. [redacted] have his shower, but Officer [redacted] did not permit him to shower for 1-2 hours. *Id.* He claims that he developed a rash on his genitals as a result of not being able to timely shower. *Id.* at 2.

The LDI requested footage from Officer [redacted] body-worn camera and AVSS from the building cameras, but failed to request footage for Officer [redacted] *See* NICE Request Report at 10-12. The case file only includes five very short videos (3 BWC, 2

AVSS);[3] it is unclear from the inquiry report whether those videos were the only videos that the investigator reviewed or whether the investigator reviewed larger periods of video but only included in the case file the portions of the video the investigator deemed relevant. In any event, the footage included in the case file does not show any interaction among Officer [redacted] Officer [redacted] and Mr. [redacted] nor when Mr. [redacted] received a shower. It shows only (1) Mr. [redacted] carrying a yellow bag outside of the building at 9:57 am; (2) Officer [redacted] passing Mr. [redacted] cell for a security check at 11:46 without Mr. [redacted] saying anything to Officer [redacted] and (3) Mr. [redacted] exiting his cell, getting a drink of water from the water fountain, and then exiting the building at 11:56. *See* AVSS 1 at 9:57:16; BWC 1; AVSS 2 at 11:55:04 and BWC 2 at 11:56:25. The investigator did not interview either officer. Based on these videos, the investigator concludes that the officers did not deny Mr. [redacted] an incontinence shower.

This investigation was incomplete. The investigator should have requested and reviewed video for a longer period (9-12), and should have reviewed Officer [redacted] BWC and determined when/if Mr. [redacted] received a shower. The investigator should have also attempted to determine which of the hourly security checks was the one where a shower was requested from Office [redacted] rather than including footage from only a single check that occurred at 11:46. The investigator should have interviewed Officer [redacted] and, especially, Officer [redacted]

Finally, in one of the very short BWC videos that are part of the case file, Officer [redacted] made inappropriate and dismissive statements about incarcerated people who require accommodations relating to using the bathroom. The footage captures Officer [redacted] talking on the phone to an unidentified person. Officer [redacted] states, "[l]ast time some inmate was like [in a mocking voice] 'can I get toilet paper? can I get toilet paper? can I get toilet paper?' You know what I did? I went over to the closet, I got a whole box, and I threw it over the tier, and toilet paper went everywhere." *See* BWC 3 at 09:57:06-09:57:19. These comments are significant in the context of a case file about a class member requesting an accommodation for a toileting accident. Though they do not appear directly related to the case at hand, they are relevant to overall compliance with providing accommodations to people with incontinence and show a level of disregard for people who request supplies. The investigator should have asked Officer [redacted] why he made those comments and whether they were related to a request for an incontinence shower by Mr. [redacted] That Officer [redacted] made such comments suggests problems regarding his attitude toward people with disabilities and the accommodations they require that should have been addressed.

[3] The BWC videos are 15 seconds, 16 seconds, and 1 minute and 35 seconds long, while the two AVSS videos are 1 minute and 38 seconds and 1 minute and 36 seconds long.

5. LAC-[redacted] – Local, Not Sustained

In this case, the investigator failed to conduct a comprehensive investigation to determine which staff members were responsible for a class member being housed in violation of his lower bunk restriction for three weeks. The local investigator confirmed that CDCR issued Mr. [redacted] a temporary lower bunk chrono on August 1, 2024, but that Mr. [redacted] remained assigned to an upper bunk. *See* Inquiry Report (IR) at 1-2. Mr. [redacted] filed a 602 on August 21. *See* 602 at 2-3. That same day, CDCR removed his temporary lower bunk chrono. *See* IR at 3. Then, on August 22, CDCR gave him a permanent lower bunk/lower tier chrono and moved Mr. [redacted] to a lower bunk. *Id.*

The investigator failed to identify who was responsible for this serious and potentially dangerous disability-related staff misconduct. In his 602, Mr. [redacted] indicated that the "floor officers" had failed to move Mr. [redacted] despite his chrono because they "are too lazy to move anyone or to write anyone up for refusing to move," indicating that he raised the issue to floor officers. *See* 602 at 2. Mr. [redacted] also alleged in the 602 that officers were now attributing the failure to move him to a lower bunk to a lockdown. *Id.* In his inquiry interview, Mr. [redacted] also reported telling an officer or officers about his chrono, although he did not remember the names of any officers or the date of any conversations. *See* IR at 4. On the face of the inquiry report, the investigator did not do anything else to identify the staff member(s), such as asking the Mr. [redacted] about the time of day the conversations took place, or the appearance of the floor officers involved (male/female, race, tall/short, etc.). It also is not clear whether the investigator asked if Mr. [redacted] raised the housing issue with staff only once or multiple times, when the 602 suggests that Mr. [redacted] raised it multiple times. Even without additional information from Mr. [redacted] the investigator could have done more to identify the involved floor officers. For example, the investigator could have interviewed one or more floor officers who worked regularly in Mr. [redacted] building during the relevant time period, including the date of Mr. [redacted] grievance. The investigator also could have obtained pictures of the officers who worked in the building during that time period and asked Mr. [redacted] to identify any with whom he spoke. Because the investigator failed to take any additional steps, CDCR did not hold any staff accountable for this ADA violation.

6. LAC-[redacted] – Local, Not Sustained

In this case, an investigator obtained only 13 seconds of video footage, which was insufficient to resolve [redacted] allegation that Officer [redacted] denied him an incontinence shower on August 3, 2024.

Mr. [redacted] stated in his interview with the investigator that Officer [redacted] the tower officer, denied him an incontinence shower sometime after 5:00 p.m. on August 3. *See* Inquiry Report (IR) at 4. For unclear reasons, the investigator requested only thirteen seconds of video from that date, ranging from 5:19:08-5:19-20, and requested video only

from Officer [redacted] *See* NICE Request Report at 13-15. The footage shows only that someone states "141, incontinent," (referring to Mr. [redacted] cell number at the time) and then Officer [redacted] responds, "Why is all of a sudden everybody incontinent? It's crazy." *See* BWC. The limited footage was inadequate to prove whether or not Officer [redacted] violated policy. It does not show whether Officer [redacted] ever released Mr. [redacted] for a shower. And the investigator never gathered any other information (such as AVSS footage, additional BWC footage from Officer [redacted] or BWC footage from other officers) to determine whether and at what time Mr. [redacted] received a shower. Further compounding the problem, the investigator omitted Officer [redacted] incriminating statement from his report and did not appear to ask him about it in the interview.

7. LAC-[redacted] – Local, Not Sustained

In this case, [redacted] alleged that LAC staff were returning appeal responses without providing him a sign language interpreter ("SLI"), which violates policy. Despite two staff members admitting that they delivered appeal responses to Mr. [redacted] without providing an SLI and also admitting they did not know policy required an SLI, the Hiring Authority failed to sustain misconduct and did not even impose corrective action to educate the officers on the policy. *See* Inquiry Report at 5, 6; Exhibits at 3, 20, 21.

Additional interviews conducted by the investigator indicated more broadly that staff at LAC did not know of the policy and the staff SLI had never been requested to be present for the delivery of a grievance or RAP response for Mr. [redacted] *See* Inquiry Report at 4-5. The case file does not indicate that CDCR provided any of these or other staff members with training to ensure they understood the effective communication policy.

8. SATF-[redacted] – Local, Not Sustained

In this case, despite clear video evidence and a thorough investigation report, the Hiring Authority failed to sustain an allegation that Officer [redacted] violated policy by throwing away [redacted] durable medical equipment (medically-prescribed wipes). The body-worn camera footage confirms that Officer [redacted] one of the officers who packed Mr. [redacted] belongings, disposed of the wipes. *See* BWC 1 at 09:50:01 (Officer [redacted] taking the wipes from Mr. [redacted] cell) and BWC 2 at 10:15:05 (Officer [redacted] throwing the wipes in a trash bin). In his interview with the LDI, Officer [redacted] stated that it was his understanding that supplies, such as cream, wipes, and lotions, do not need to be packed up with a person's property. The LDI noted in the report that "[redacted] was unaware the baby wipes and creams are/were a part of the Durable Medical Equipment (DME's) and needed to go with [redacted] and cited SATF Operating Procedure 467 that defines

disposable/flushable wipes as DME and medical supplies. *See* AIR at 3. The LDI further noted that his review of Officer [redacted] body-worn camera shows the officer finding the wipes and throwing them in the trash. *Id.*

Nevertheless, the Hiring Authority did not sustain the allegation. Though adverse action likely was not appropriate here, the case presents a paradigmatic opportunity for corrective action, as Officer [redacted] violated policy and admitted to not understanding the policy. The failure to sustain the allegation and impose corrective action increases the likelihood that Officer [redacted] will engage in the same misconduct in the future and undermines the progressive discipline policy.

C. Problems With Investigations and Discipline in Use-of-Force Cases

The following cases all involve failures to hold officers accountable for uses of force that violate CDCR's policies. In each case, video shows officers engaging in misconduct—escalating, rather than deescalating situations; using immediate force without any imminent threat; using force when not authorized under the policy; or using excessive force. In all but the first case, the Hiring Authority failed to sustain any allegations of misconduct. And in the first case, though the Hiring Authority sustained the allegation, he ultimately inappropriately imposed only corrective action. The cases reflect a disturbing pattern of officers resorting to force quickly, without adequate justification and without engaging in sufficient attempts to avoid using force. This pattern was especially pronounced in the five cases discussed below in which officers used force to throw incarcerated people to the ground for very slight (if any) resistance during escorts. Taken together, the cases show the need for CDCR to make clearer the expectation that staff attempt to avoid force and to update its use-of-force policies, practices, and training to ensure that expectation is made crystal clear.

1. Failure to Impose Appropriate Penalty for Violations of Use-of-Force Policies

(a) LAC-[redacted] – AIU, Sustained – Level 4 Adverse Action Stipulated to Corrective Action

In this case, the Hiring Authority initially imposed an appropriate Level 4 penalty on Officer [redacted] who unnecessarily pepper sprayed a class member on his head from a very close distance, but then failed to hold him accountable when CDCR agreed to impose only corrective action.

The investigation revealed clear evidence of multiple policy violations by Officer [redacted].[4] On January 22, 2023, he ordered [redacted] to move to a new table in the dining hall. *See* BWC 1 at 9:30:03. At first, Mr. [redacted] indicates he will not move. Officer [redacted] then grabs Mr. [redacted] arm and says he will "put him down." Mr. [redacted] then agrees to move. Officer [redacted] digs in and says he will "dump" him off the stool. *See* BWC 1 (linked above) at 9:30:10. Officer [redacted] and Officer [redacted] then pull Mr. [redacted] onto the floor. *See* BWC 2 at 9:30:30. Officer [redacted] removes Mr. [redacted] sunglasses, sprays Mr. [redacted] in in the head from less than a foot away, and then sprays him in the head again from the same distance. *See* BWC 3 at 9:31:24; AIU Report at 5-6 (includes freeze frames of the BWC). At all levels of the IERC review, LAC staff determined that the use of force was within policy. *See* IERC at 61-64.

During the AIU investigation, Officer [redacted] demonstrated a serious lack of understanding of CDCR's force policies. In his OIA interview, Officer [redacted] stated that placing incarcerated people in handcuffs is a form of de-escalation, did not know that controlled use of force could be used outside of a cell, and did not know that he was required to use pepper spray at a distance of at least six feet. *See* AIU Report at 13, 14, 16. The investigator also found that Officer [redacted] incident report omitted the crucial fact that Mr. [redacted] said he would comply with Officer [redacted] instructions.[5] Officer [redacted] incident report also incorrectly stated that he sprayed Mr. [redacted] once, when he in fact sprayed him twice. *See* AIU Report at 6, 7. In addition, the investigator noted that the lieutenant conducting the local use of force review at LAC included statements that were inconsistent with the video, including that "numerous orders were issued for the combatants to cease their actions prior to each application of force"—when there were no combatants at all. *See* AIU Report at 7, 9.

The Hiring Authority sustained findings against Officer [redacted] for several charges, including excessive force and a failure to de-escalate.[6] *See* 402/403 at 1-2. Those

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[4] The investigation report in this case is an excellent example of how the investigator can present Hiring Authorities with the information necessary to determine discipline. The report includes screenshots of relevant video and offers relevant commentary on interview responses, rather than uncritically presenting the subject's version of events. The quality of the investigation makes CDCR's decision to reduce the discipline in this case that much more inexcusable.

[5] The other officers involved omitted this information as well. *See* Incident Report at 23, 25, 26, 27, 28.

[6] The Hiring Authority also found a failure to initiate controlled force protocols and a failure to perform within the scope of training for using pepper spray at less than 6 feet away. *See* 402/403 at 2.

violations carried a base penalty of Level 3 for the most significant charge, excessive use of force without injury (L4, 12**3**). The Hiring Authority imposed a Level 4 penalty due to multiple aggravating factors, including that "the employee does not accept responsibility." *See* 402/403 at 3-4.[7] As the Hiring Authority set forth in the NOAA, had Officer [redacted] just allowed Mr. [redacted] to move to another table there would have been no need to use force. *See* NOAA at 21-24. As the Hiring Authority further noted, Officer [redacted] failure to follow policy was especially problematic because he was working in a position that requires knowledge of how to engage with class members with mental illness. *See* NOAA at 21-22.

Ultimately, however, CDCR failed to hold Officer [redacted] accountable for his misconduct. After Officer [redacted] appealed to the State Personnel Board, CDCR stipulated to reduce Officer [redacted] discipline from a Level 4 penalty to corrective action. *See* Stipulation at 1; LOI; Training. Given the clear evidence of his violations of the use-of-force policies and his refusal to take responsibility for his actions, CDCR's decision to impose only corrective action was inexcusable.[8]

2. Failure to Hold Staff Accountable for Non-Compliance with De-escalation Policy

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

In this case, Officer [redacted] escalated a dispute with Mr. [redacted] over whether a TV in the dayroom should be on, resulting in a potentially unnecessary use of force, yet the Hiring Authority did not sustain any policy violations. As shown on BWC, Mr. [redacted] is yelling at Officer [redacted] after Officer [redacted] turned off the dayroom television. Officer [redacted] then starts yelling back at Mr. [redacted] saying, "You want to get out with me! .... It's not getting turned on, it's not getting turned on! Turn it on or what? Or what? It's not going on, it's not going on, it's not going on!" He then orders Mr. [redacted] to turn around and cuff up. *See* BWC (linked above) at 15:44:40. Though it is difficult to see, Officer [redacted] statements on BWC suggest that Mr. [redacted] resists the application of the restraints. Mr. [redacted] ultimately alleged that Officer [redacted] used excessive

[7] Officer [redacted] was also issued corrective action for using improper force to attempt to gain compliance with a lawful order. *See* 402/403 at 7.

[8] Officer [redacted] also appears to be a repeat offender, underscoring the need for accountability. During the litigation leading to the staff misconduct orders, several class members submitted declarations describing unnecessary uses of force by Officer [redacted] including via pepper spray.

force when he twisted his hands while applying the restraints. *See* Investigation Report at 1.

Though the use of force in this case was relatively minor, Officer [redacted] conduct violated the policies requiring de-escalation and verbal persuasion and efforts to avoid force. Rather than follow those policies, Officer [redacted] escalated the situation, which led to the need for force to apply the restraints and the alleged injury to Mr. [redacted] Two levels of the IERC review were completed before the AIU investigation, and at both levels, COR staff failed to note Officer [redacted] failure to deescalate (though the first-level review indicated that Officer [redacted] received professionalism training). *See* IERC at 1-7.

This case also includes a good example of how staff can de-escalate situations to avoid force. As shown on the video, Officer [redacted] responds to the commotion caused by Officer [redacted] and Mr. [redacted] *See* BWC (linked above) at 15:45:45. He immediately seeks to de-escalate the situation by taking custody of Mr. [redacted] and escorting him away from housing unit to a holding cell. Officer [redacted] calmness and efforts at de-escalation contrast markedly with Officer [redacted] anger and excitability.

3. Failures to Hold Staff Accountable for Improper Uses of Force During Escorts

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

These two uses-of-force occur when [redacted] is being escorted from a holding cell in a restrictive housing unit to another housing unit. Mr. [redacted] level of mental health care had changed from [redacted], and as a result, he was being moved to an [redacted] housing unit. *See* Investigation Report at 2. Prior to this escort, custody staff had packed up Mr. [redacted] belongings and put them on a cart, which would then transport Mr. [redacted] to the EOP unit. *Id*. The BWC footage begins with Mr. [redacted] being escorted out of the restrictive housing building and onto the transportation cart. *See* BWC 1 at 1:15:57. He is cuffed behind his back and being escorted by at least five custody officers, in an area of the prison with no other incarcerated people. While being placed in the backseat of the cart, Mr. [redacted] notices his belongings in the front seat and starts looking at them while standing on the back of the cart. *See* BWC 1 (linked above) at 1:16:05. An officer hands Mr. [redacted] a bag of his belongings, and he sits down, but he continues to peer over the seat of the cart at his legal work, which is still in the front seat of the cart. *See* BWC 1 (linked above) at 1:16:27. One of the officers tells him to "face forward," and Mr. [redacted] becomes angry and begins screaming and cursing at the officer. The officers decide to escort him by foot instead of on the cart. *See* BWC 1 (linked above) at 1:16:45. About five steps into the escort, he says to the escort officer, "Get your fucking hands off me." *See* BWC 2 at

1:16:40. Mr. [redacted] turns towards the escort officer as he makes that statement, but he does not appear to physically resist the escort. In response to Mr. [redacted] comment, the officer immediately throws him to the ground. It is unclear from the body-worn camera footage or the fixed camera footage what threat Mr. [redacted] presented that justified any force, let alone this degree of force. *See* BWC 2 (linked above) at 1:16:42; AVSS at 1:16:42. Accordingly, the force is both unnecessary and excessive.

After piling on top of Mr. [redacted] the officers apply leg restraints. The officers bring Mr. [redacted] to his feet and begin escorting him back into the restrictive housing building to conduct a medical evaluation and complete a CDCR 7219 form. During the escort, an officer tells Mr. [redacted] to face forward, and he responds to the officer, "Man, fuck you!" *See* BWC 2 (linked above) at 1:17:39. The officer immediately grabs him by the back of the neck and throws him down again. *See* AVSS 2 at 1:17:38. At the moment of the second use-of force, seven officers are escorting Mr. [redacted] and he is cuffed behind his back and wearing leg restraints. As with the first use of force, no imminent threat was apparent on video, and the force was both unnecessary and excessive.

Neither of the two officers who initiated force had a convincing explanation for their decision to use force. Officer [redacted], who threw Mr. [redacted] to the ground the first time, told the investigator that he used immediate force "due to [redacted] [sic] disregarding orders, his aggressive behavior, tensing his body and turning around and not knowing [redacted] intensions [sic]." *See* Investigation Report at 9. Officer [redacted] who threw Mr. [redacted] to the ground the second time, had an almost identical reason for using force, claiming Mr. [redacted] "became resistive by tensing up his body and turning towards his direction," and the officer, "not knowing [redacted] [sic] intensions [sic], fearing for his and staff's safety" decided to use force. *See* Investigation Report at 7. Neither of the generic and non-specific justifications are adequate under CDCR policy. Yet the allegations of excessive and unnecessary force were not sustained. *See* 402/403.

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

These two uses-of-force occur when [redacted] is being escorted out of the program office after expressing safety concerns during a classification committee. The short body-worn camera footage captures the first incident. Mr. [redacted] explains that his life is in danger in his current unit, stating "I'm scared for my life, and you guys are just going to ignore it?" *See* BWC 1 at 10:10:22. An officer gives him a "direct order" to go back to his cell. *See* BWC 1 (linked above) at 10:10:15. Mr. [redacted] is seated while two escort officers are standing on either side of him, and the officers guide him up and out of the chair by his arms. *See* BWC 1 (linked above) at 10:10:25 (The AVSS provides an overhead angle of the incident; *see* AVSS 1). Mr. [redacted] is in waist chains, uses a cane to ambulate, and has a vision disability. He stands up at the officers' direction, and turns around to begin to walk out of the program

office. While continuing to walk, he slightly moves his left arm forward to shrug off one of the escort officers. *See* BWC 1 (linked above) at 10:10:32. The other escort officers reacts by immediately pulling Mr. [redacted] to the ground. *See* BWC 1 (linked above) at 10:10:32. The force is dangerous for numerous reasons: Mr. [redacted] is secured in waist chains and cannot brace himself while falling; he has a mobility disability and is being pulled to the ground with the officer's full weight; he is in a small space and is thrown to the ground near the corner of the room and close to a small table and a refrigerator, and he almost hits his head while being taken down. The force is also excessive, for those reasons, and because Mr. [redacted] only slightly moved his arm prior to the force, he is cuffed in a controlled space surrounded by five custody officers, and no other incarcerated people are in the room. The reaction is disproportionate, and the degree of force used is objectively unreasonable. The officer who used force, Officer [redacted], is the same officer who threw Mr. [redacted] to the ground in a similar manner in a separate case described above (COR-[redacted] As was the case when he used unnecessary and excessive force against Mr. [redacted] Officer [redacted] provided an inadequate justification for using force against Mr. [redacted] Specifically, he explained that he used force because Mr. [redacted] "was resistive by shrugging his shoulder, pulling away and breaking his grasp," and that Officer [redacted] "felt a threat due to [redacted] actions and not knowing his intentions." *See* Investigation Report at 8. In the officer's view, the force was reasonable "because after the force the inmate complied." *Id*.

While on the ground, officers apply leg restraints to Mr. [redacted], and they continue escorting him out of the program office. *See* BWC 2 at 10:12:10 (Another AVSS camera and BWC show also show the second UOF; *see* BWC 3 and AVSS 2). During the escort, Officer [redacted], who is holding Mr. [redacted] left bicep, tells him, "Do not be tensing up like that." *See* BWC 3 (linked above) at 10:12:32. The officer says it two times, then immediately grabs Mr. [redacted] by the back of the head and brings him to the ground. *See* BWC 3 (linked above) at 10:12:25. Officer [redacted] told the investigator that he brought down Mr. [redacted] —who, again, is a man with mobility and vision disabilities who was secured in waist chains and leg restraints—to the ground because "he felt a threat because he did not know [redacted] intentions and didn't know if he was trying to spit or headbutt staff." *See* Investigation Report at 9. The Hiring Authority did not sustain the allegations against Officer [redacted] and Officer [redacted] *See* 402/403.

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

This use of force occurs when a class member, [redacted] is being escorted from his cell in the [redacted] to a medical evaluation after he reported that he was experiencing chest pains. *See* Investigation Report at 6-7. The escorting officer, Officer [redacted] applies handcuffs to Mr. [redacted] through the food port and

signals for the tower officer to open Mr. [redacted] cell door. *See* BWC at 3:45:15.[9] Upon exiting his cell, Mr. [redacted] takes a few steps forward into the empty dayroom and calls out to a person in another cell. *See* BWC (linked above) at 3:45:35. Mr. [redacted] briefly stops to show a box of toothpaste that he is holding to that person in the other cell, and he asks to see that person's deodorant. *See* BWC (linked above) at 3:45:40. Officer [redacted] tells Mr. [redacted] not to stop the escort and "we aren't doing that right now," then begins to walk forward while pulling on Mr. [redacted] arm. *See* BWC (linked above at 3:45:45. Mr. [redacted] turns back to Officer [redacted] and says, "Don't fucking pull on me." *See* BWC (linked above) at 3:45:51. Mr. [redacted] then keeps walking, and as he starts walking, he says again, "Don't fucking pull on me." In response, Officer [redacted] immediately tackles Mr. [redacted] to the ground. *See* BWC (linked above) at 3:45:54. According to the investigation report, Officer [redacted] "feared being elbowed by the claimant" so he tackled him. *See* Investigation Report at 7. The force was disproportionate to the situation; Mr. [redacted] was walking in the direction of the escort, cuffed behind his back, and only slightly moved his arm away from the officer before the officer brought Mr. [redacted] to the ground. The officer had no reason to tackle him to the ground, and the force did not comply with policy. But the allegation was not sustained. *See* 402/403 at 2.

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

In this case, Officer [redacted] used excessive force against [redacted], but the Hiring Authority did not sustain any force policy violations. Officer [redacted] puts Mr. [redacted] in handcuffs behind his back while he is in cell 110 in [redacted], which is the [redacted]. *See* BWC at 17:23:48. Officer [redacted] then escorts Mr. [redacted] to the shower. *See* BWC (linked above) and AVSS at 17:24. Officer [redacted] is using his left hand to hold Mr. [redacted] right bicep and to guide the escort. Mr. [redacted] asks to go speak with another incarcerated person in cell 115. Officer [redacted] declines to let Mr. [redacted] walk in that direction, claiming that Mr. [redacted] and the person in that cell had been arguing earlier in the day. After Mr. [redacted] takes a few steps in the direction of the cell, Officer [redacted] pulls on Mr. [redacted] arm to keep him from continuing to toward cell 115. Mr. [redacted] verbally protests and continues to pull, albeit without much force. Officer [redacted] says "Don't do this." *See* BWC (linked above) at 17:24:09. About one second later and without giving Mr. [redacted] a clear order and an opportunity to comply, Officer [redacted] grabs Mr. [redacted] throat with his right hand and forcefully pushes backward, while using his left leg take Mr. [redacted] legs out from under him, causing Mr. [redacted] to temporarily be airborne. *See* BWC and AVSS (linked above) at 17:24:10. Mr. [redacted] lands extremely hard on his back and head,

[9] The clearest view of the entire situation is from the BWC of a secondary escort officer, Officer [redacted], linked above. But the fixed camera footage also provides a clear view of the use-of-force. *See* AVSS.

unable to brace his fall. Officer [redacted] then says, "You don't fucking guide this. You don't fucking guide this. I'm letting you know." *See* BWC (linked above) at 17:24:17.

Regardless of the whether a threat existed to justify a use of force,[10] the force used by Officer [redacted] was excessive because it was unreasonable given the circumstances. Officer [redacted] lawful objective was to keep Mr. [redacted] away from cell 115. He could have done so using much less dangerous force than he employed. Specifically, Officer [redacted] could have continued to pull Mr. [redacted] away from cell 115 and asked other officers in the unit, of which there were many, for assistance. Body-slamming him backward while cuffed was not a reasonable way to accomplish his lawful objective. Moreover, Officer [redacted] statements that he used force to "let [Mr. [redacted] know" that he had to follow his orders suggests that Officer [redacted] used the force to send a message, not to accomplish a lawful objective.[11] The Hiring Authority therefore erred by not sustaining any use-of-force violations.[12]

In addition, Officer [redacted] in his investigation interview stated that "he ... chose to de-escalate the situation by using Physical Force to subdue [redacted] *See* Investigation

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[10] It is unclear whether any imminent threat existed to justify a use of force under these circumstances. Though Officer [redacted] was worried about interaction between Mr. [redacted] and the occupant of cell 115, the occupant of cell 115 was locked in his cell; Mr. [redacted] therefore could not do anything to harm him. In his investigation interview, Officer [redacted] said he was concerned for his own safety. The video, however, does not suggest that Mr. [redacted] posed any threat to Officer [redacted] Though Mr. [redacted] was not complying with Officer [redacted] order to not walk toward cell 115, Mr. [redacted] did not appear to display any type of physical threat toward Officer [redacted]

[11] The investigation report is also biased in a number of respects. Most egregiously, the report fails to accurately describe the forcefulness and dangerousness of the body slam. The investigator wrote "[redacted] is then observed Using Physical Force 'Strengths and Holds' to force [redacted] to the floor on his back without further incident." *See* Investigation Report at 3. In addition, the investigator did not even bother to interview Mr. [redacted] which may have been relevant to determining whether he posed an imminent threat to Officer [redacted] and did not include any information about injuries sustained by Mr. [redacted] which required taking him to an outside hospital. *See* Outside Records dated January 23, 2023 at 42 (he reported serious neck pain and had to be moved out of the unit on a gurney and in a neck brace). The absence of this information sends a signal to the Hiring Authority reviewing the report that Officer [redacted] did not violate policy by using excessive force, even though the video shows that he did.

[12] Two levels of the IERC review were completed before the AIU investigation, and at both levels, COR staff failed to note Officer [redacted] failure to deescalate. *See* IERC at 4-5.

Report at 3. To state the obvious, using force is not a method for de-escalating a situation to avoid using force. Officer [redacted] actions and statement reflects the all-too-common attitude of officers to immediately resort to using force, endangering incarcerated people and themselves.

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

This use-of-force against [redacted] occurs when Officer [redacted][13] escorts Mr. [redacted] from a holding cell for his mental health group back to his cell. Mr. [redacted] is wearing a green disability vest and waist chains. Throughout the escort, Mr. [redacted] makes bizarre, inappropriate, and racist comments. Officer [redacted] warns Mr. [redacted] about a puddle, and Mr. [redacted] stomps through in the puddle. *See* BWC at 12:17:55. Officer [redacted] says, "Don't be doing that shit," and Mr. [redacted] responds, "It's a puddle. I love puddles of rain. I can mess with it all I want; you can't tell me what the fuck I'm doing!" *See* BWC (linked above) at 12:17:58. He turns to Officer [redacted] as he makes that comment, and Officer [redacted] says, "No, you look forward." *See* BWC at 12:18:04. Mr. [redacted] tells him to "get your fucking hand off of me." The two have a back-and-forth while taking a few more steps, and then Officer [redacted] throws Mr. [redacted] to the ground and says, "Get on the fucking ground!" *See* BWC (linked above); AVSS at 12:18:10. The force was unnecessary and/or excessive, as Mr. [redacted] either did not pose a threat at all or did not pose a threat that warranted throwing him to the ground. Similar to the other unnecessary uses-of-force at Corcoran, Officer [redacted] provided a canned justification for throwing Mr. [redacted] to the ground. He told the investigator that he used force because "he them [sic] felt [redacted] body tense up, pull, turning towards him, and yelling at [redacted] to let him go. [redacted] stated he feared [redacted] intention was to batter him…" *See* Investigation Report at 6. Mr. [redacted] was in waist chains and in a secure area of the prison, yet he was tossed to the ground after he slightly turned towards the escort officer.

[13] Plaintiffs' counsel has reported concerns with Officer [redacted] numerous times over the years. In our November 2024 quarterly report, we described a case in which Officer [redacted] used unnecessary and excessive force against an *Armstrong* class member who used a walker to ambulate and was in waist chains at the time of the incident. *See* Plaintiffs' November 2024 Review of CDCR's Accountability System (Nov. 15, 2024) at 13-15. In that case (COR–[redacted]), Officer [redacted] grabbed the back of the class member's neck and tried to pull him over his walker when the class member refused to be escorted. In 2021, we wrote a letter to Defendants about how Officer [redacted] reported, in an RVR that he authored, that he entered a [redacted] class member's cell with a riot shield and used the shield to violently knock the class member out of his walker. *See* Letter from [redacted], Plaintiffs' Counsel, to CDCR Office of Legal Affairs, Advocacy Letter on behalf of [redacted], COR (Jan. 5, 2021).

The use-of-force in this case did not comply with policy, but the allegation was not sustained. *See* 402/403.

4. Failures to Hold Staff Accountable for Improperly Using Immediate Force

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

In this case, officers improperly used immediate force against [redacted]. As shown on BWC, Mr. [redacted] is not complying with an order for him to leave the MHCB and transfer back to SVSP. One way in which he is resisting the transfer is by spreading his own feces on his body. *See* Investigation Report at 3. At the start of the video, he is outside of a shower, sitting in his wheelchair and in waist restraints. *See* BWC at 12:36:05. He makes clear to staff that he will not agree to shower. Out of his presence, a captain provides a sergeant with authorization to force Mr. [redacted] to take a shower. *See* Investigation Report at 3. The sergeant returns to Mr. [redacted] who is sitting peacefully but still indicates that he will not taking a shower. The sergeant says, "Per the Captain, don't resist, you're taking a shower." *See* BWC (linked above) at 12:36:21. The officers and sergeant then pick him up and force him into the shower. A difficult-to-watch use of force ensues, with officers forcing him into a shower chair and cutting off his soiled clothing. They then place him in a transport vehicle to take him to SVSP. *See* Investigation Report at 6.

Policy required that staff use controlled force in this case. Mr. [redacted] did not pose an imminent threat when he was sitting in his wheelchair. *See* DOM 51020.4. And given Mr. [redacted] obvious serious mental illness, the safeguards of a controlled use of force—including a cool-off period and meeting with a mental health clinician—could have resulted in the avoidance of force.

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

In this case, officers improperly used immediate force against [redacted], but the Hiring Authority did not find any use-of-force policy violations. As shown on BWC, staff order Mr. [redacted] to move cells. *See* BWC at 18:44:38. He makes clear he is not going to move because he claims to need medical attention. He is standing at his door with his arms crossed, surrounded by 3-4 officers. A sergeant then tells Mr. [redacted] to put his arms behind his back, but Mr. [redacted] does not comply. The officers ask him if he will sit in the dayroom for medical, which he agrees to, but then he makes a few threatening statements to the officers ("I don't give a fuck about CDC, I don't give a fuck about you. I'll kill all of you motherfuckers."). As the video shows, notwithstanding the words he uses, Mr. [redacted] does not appear to present any actual threat at that moment; his words appear to be bluster and he does not make any move toward the officers. Still, the officers grab him and take him to the

ground. *See* BWC (linked above) at 18:46:00. The officers' use of immediate force was not consistent with CDCR's policy because, at the point force was used Mr. [redacted] did not present an imminent threat. *See* DOM 51020.4. If staff needed to move Mr. [redacted] to a different cell, staff should have initiated a controlled use of force. The Hiring Authority should have found that officers violated the use-of-force policy.[14]

D. Failures to Obtain Relevant Video Evidence

In the following cases, CDCR failed, for various reasons, to obtain video evidence. In some cases (including the first case which Plaintiffs discuss at length), CDCR failed to retain video because it delayed in assigning cases to investigators or the investigators delayed in requesting video once assigned to the case. In others, investigators initially requested video but then determined they had requested the wrong video, by which time the 90-day retention period had expired. And in others, video was inexplicably unavailable or investigators reviewed inappropriately narrow video footage (including two cases discussed above, SATF-[redacted] LAC-[redacted] As a result, in each of these cases, CDCR was unable to review video that likely would have resolved whether the alleged staff misconduct occurred. These investigative failures further underscore the need for CDCR to increase the video retention period to ensure the availability of video evidence for all investigations.

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

In this case, [redacted], who is hard of hearing, made a serious disability-related allegation: that an officer used force when Mr. [redacted]—who was wearing his disability vest—did not hear the officer's orders, and then failed to report that force. Although video would have conclusively resolved whether misconduct occurred, CDCR failed to preserve video from the incident and the investigator failed to timely request video.

On September 27, 2023, Mr. [redacted] filed a 602 about an incident that occurred that morning. Mr. [redacted] wrote that at 8:27 that morning, Officer [redacted] grabbed him by his shirt to get his attention because Mr. [redacted] did not hear him. *See* 602 at 4. Mr. [redacted] alleged Officer [redacted] pulled him backwards. *Id.* Mr. [redacted] claimed that he asked Officer [redacted] to report the incident, but was sent back to his building, and that the use of force was not documented. *Id.* Mr. [redacted] suggested that the incident may have been retaliatory because he had previously filed a 602 against the same officer. *Id.* at 5.

[14] The IERC, which completed its review before the AIU investigation, also failed to find any policy violations. *See* IERC at 3, 5, 6, 9, 11.

CDCR failed in two separate respects to preserve the video of this incident. First, the AIU investigator failed to timely request video, even though he was assigned to the case on October 11, 2023—76 days before the video would no longer be retained. *See* Investigation Report (IR) at 1. The investigator did not request video until January 11, 2024, well beyond the retention date. *Id.* at 3. Second, CDCR failed to retain the video as part of a use-of-force review. On October 2, 2023, five days after the incident, LAC conducted a use-of-force interview with Mr. [redacted] *Id.* at 2. Nevertheless, no one requested preservation of the video.

With no video, the investigator interviewed three incarcerated witnesses and three officers. Two incarcerated witnesses recalled an interaction between Officer [redacted] and Mr. [redacted] with one person reporting hearing Mr. [redacted] say, "Yeah, but you don't have to grab me" and the other witnessing the end of an interaction with Officer [redacted] holding Mr. [redacted] ADA vest. *See* IR at 5-6. Officer [redacted] and two other officers claimed not to remember any interaction with Mr. [redacted] that day.[15] *Id.* at 7-11. CDCR's failure to preserve video of the interaction made it impossible to determine the veracity of Mr. [redacted] allegation.[16]

2. Failures to Preserve or Obtain Any Video Within the 90-day Retention Period

- **KVSP-[redacted]**: The class member alleged that on June 17, 2024, an officer refused to allow him to shower because he is Black and deaf, and told him he "is not giving his black ass a shower, die and smell black." The class member reported this on an 1824 on the same day. The CST forwarded the grievance for an AIU investigation on June 18, and an investigator was assigned on June 19, 2024, only two days after the misconduct allegedly occurred. *See* Investigation Report at 1. Yet the investigator did not begin the investigation for more than four months, conducting the first interview on October 28, 2024. *Id.* at 3. The investigator offered no justification for failing to request the footage. *Id.* at 5.

- **RJD-[redacted]**: Plaintiffs' counsel submitted a third-party allegation that on December 2, 2021 and May 24, 2022, RJD staff did not allow a class member to

[15] Officer [redacted] claimed that he did not know Mr. [redacted] disability, even though he had been the housing unit officer in Mr. [redacted] building for one year. *See* Investigation Report at 10-11.

[16] The investigator also failed to inquire into the retaliation allegation by confirming Mr. [redacted] prior 602s against Officer [redacted] and their status (*e.g.*, if Officer [redacted] had been interviewed about a 602 close in time to the September 27, 2023 incident), or even by asking Officer [redacted] about prior staff complaints filed by Mr. [redacted]

attend an interview during an *Armstrong* monitoring tour. Plaintiffs' counsel submitted the allegation on August 12, 2022, within the 90-day retention period for the May allegation. *See* Investigation Report at 1. The CST forwarded the grievance for an AIU investigation on September 6, 2022, 13 days after the 90-day retention period expired for the second incident. *Id.* As a result, there was no video available of the incident.

- **SATF-[redacted]**: The class member alleged that the chaplain sexually assaulted him on February 22, 2024. The class member submitted his 602 on April 26, 2024. *See* Investigation Report at 1. CDCR assigned an investigator to the case on May 7, 2024 (75 days after the incident), but the investigator failed to preserve or request AVSS footage within the 90-day retention period. *Id.* at 2.

- **KVSP-[redacted]**: The class member alleged that on January 31, 2024, officers told other incarcerated people to "kill his life" and "get him," and then told the class member that he would be released to the yard. The class member filed a 602 on February 23, 2024, and the CST forwarded the grievance for an AIU investigation on March 5, 2024, well within the 90-day video retention period. *See* Investigation Report at 1. OIA failed to assign an investigator until June 4, 2024, after the retention period expired, and took no steps to preserve video footage in the interim. *Id.*

- **RJD-[redacted]**: The class member alleged that on August 9, 2024, a Recreational Therapist (RT) issued a false and retaliatory RVR for disrespect when the class member became upset after she requested and was denied mental health attention. The class member reported the misconduct on August 30, 2024. *See* 602 at 2-3. The CST referred the grievance to an LDI on September 9, 2024. *See* CST Memo at 1. The investigator conducted his first interview on November 1, 2024, within the retention period. *See* Inquiry Report at 3. But, the investigator, without any explanation for his delay, stated that he did not request any video footage because the 90-day retention period had elapsed. *Id.* at 4.

- **LAC-[redacted]**: A class member filed a 602 alleging, among other issues, that officers were targeting the class member for their gender identity and disability and confiscated the class member's wheelchair on May 15, 2024. The investigator, who misgendered the class member throughout the report, failed to request video footage before the retention period expired. According to the investigator, they waited until after the interview with the class member to request footage. *See* Investigation Report at 9. Due to no fault of the class member, the interview was delayed three times. *Id.* The first interview attempt was canceled because the class member transferred from LAC to SVSP. The second interview was canceled because the class member was in a mental health crisis bed. For the third, CDCR's videoconference technology was "inoperable." *Id.* As a result, the

interview did not occur until August 21, 2024, after the 90-day retention period expired. *Id.* at 6. The investigator should have acted to retain footage from at least May 15, 2024 once it became clear that the interview would not occur before the retention period expired.

- **SATF-[redacted]**: The class member alleged that on April 16, 2024, a sergeant falsely identified him as a "sexual predator" within earshot of other staff and incarcerated people and attempted to intimidate the class member by showing him a photo of a grim reaper to indicate that the sergeant could "take [his] life at any time." *See* 602 at 2-3. The class member filed a 602 on May 13, 2024 and the case was assigned to an investigator on June 3, 2024. *See* Investigation Report at 1. However, the investigator waited until September 6, 2024 to submit the AVSS/BWC request, by which time all footage had been destroyed. *See* BWC Request and Response.

- **LAC-[redacted]**: The class member alleged that on April 5, 2024, two officers placed the class member in a group with his known enemy, and one officer made a comment that endangered the class member. The class member filed his 602 on April 10, 2024 and the investigator interviewed him on May 6, 2024. *See* Investigation Report at 1, 4. According to the investigator, they did not obtain BWC footage because the class member's 602 named the wrong two officers and the two officers in question "was [sic] not identified until later during the interview with [redacted] when [redacted] clarified, the officers were not assigned to [redacted]" and "[a]t this time, the 90 day retention period had expired." *Id.* at 6. This justification does not make sense because the investigator interviewed the class member on May 6, 2024, well within the retention period.

- **RJD-[redacted]**: The class member alleged that on June 3, 2024, an officer discriminated against him by asking for his ID before and after chow and pill line, and that the officer told him he is "white trash" and that no one loves him because he does not have any appliances. The class member reported the incident on June 4, 2024. *See* 602 at 2-3. The CST referred the grievance to an LDI on June 12, 2024, but the investigator did not commence the investigation until September 20, 2024, by which time the 90-day retention period had expired. *See* CST Memo at 1; Inquiry Report (IR) at 2, 4.

3. Failures to Obtain the Correct Video Footage

- **LAC-[redacted]**: A class member who uses a wheelchair alleged that on October 1, 2023, officers failed to secure the class member's wheelchair in a van during a transport. He alleged that the officers drove aggressively, such that he fell back in his wheelchair and struck his head. The class member filed his 602 on

October 9, 2023 and an investigator was assigned on October 19, 2023. *See* Investigation Report at 1. Although the class member did not participate in an interview, the investigator determined the incident occurred October 2, 2023 and requested video footage. *Id.* at 4. However, that footage turned out to be from after the incident. *Id.* The investigator then attempted to obtain more footage but could not "due to the 90-day retention expiring." *Id.*

- **RJD-[redacted]**: The class member alleged that on July 15, 2023, an officer refused him medical attention. The local investigator requested BWC footage on September 21, 2023, and learned a day later that the camera was not on during the requested time. *See* Investigation Report at 3. AIU determined that the officer may have failed to comply with BWC activation requirements, but did not elevate the allegation for investigative review until March 11, 2024, almost five months after the 90-day retention period had expired. *Id.* at 1, 3. The AIU investigator found that the officer exchanged his BWC for a loaner device but could not request footage from the loaner device because the 90-day period had elapsed. *Id.* at 5.

- **SATF-[redacted]**: The class member alleged that an officer endangered him when he called him a "ChoMo" in front of other incarcerated people. The investigator requested video footage for the wrong date. *See* Investigation Report at 6. By the time the investigator realized the error, CDCR had destroyed the video from the correct date based on the 90-day retention period. *See* Clarification Memo.

- **LAC-[redacted]**: A class member alleged that on June 21, 2024, several officers failed to provide a different incarcerated person with medical attention after a medical emergency. The investigator obtained video from about seven minutes on June 21, 2024, which the investigator determined "occurred after the incident." *See* Investigation Report at 4. The investigator then submitted a new request for earlier footage, but "the ninety day retention period ended upon conclusion of the second request." *Id.*

4. Unexplained Unavailability of Video

- **SATF-[redacted]**: The class member alleged staff used excessive force on November 1, 2021. The class member submitted a 602 on November 29, 2021, which was forwarded to the AIU on August 22, 2022. *See* Investigative Report at 1. The investigator requested AVSS and BWC footage of the incident writing, "AVSS/BWC Fight. Although this is an old request this footage was used for

disciplinary process."[17] *See* CDCR 1118 BWC Video Evidence Request at 8. However, the footage was not produced: "No footage. Footage expired." *Id.* It is not clear from this response why footage was not available given that the case involved a use of force and was used in an RVR hearing.

5. Review of Inappropriately Short Video Clips

- **KVSP-[redacted]**: The class member alleged that he was assaulted by three incarcerated people during morning yard on September 4, 2024, and that the yard officers failed to protect him because they had left the yard unsupervised before the attack. The local investigator stated that the AVSS footage "does not depict any staff exiting the yard area prior to the claimant being attacked," but he reviewed the AVSS footage for less than a two-minute time period prior to the assault, during which no officers are in view on the yard on any of the three camera angles (which is consistent with the class member's allegation). *See* Inquiry Report at 4. The investigator should have reviewed additional video footage before the assault to determine how long the officers left the yard unsupervised.

E. Failures to Sustain Allegations Supported by Evidence and to Impose Appropriate Discipline

In the following cases, Hiring Authorities either inappropriately failed to sustain allegations of misconduct or sustained an allegation but did not take appropriate action.

1. RJD-[redacted] – AIMS, Sustained – Corrective Action

In this case, the Hiring Authority sustained allegations that Officer [redacted] violated policy when she engaged in conduct intended to harm [redacted] by inducing him to refuse his limited segregation yard time and then cursed at him. *See* 402/403 at 77-79. BWC footage captures Officer [redacted] telling another officer that her "plan is to get [Mr. [redacted] today" by getting him to refuse his access to the yard. *See* BWC at 9:09:54. She then tells another officer that Mr. [redacted] is a "little bitch." *See* BWC (linked above) at 9:12:18. After Mr. [redacted] declines his access to the yard, he gets into a verbal dispute with Officer [redacted] Officer [redacted] says "fuck you" to Mr. [redacted] and threatens Mr. [redacted] by saying that "when [he] gets back on the yard… [she'll] be right there." *See* BWC (linked above) at 9:14:40.

[17] RVR documentation included with this investigation file confirms that AVSS footage was available and considered during the RVR hearing on November 11, 2021. *See* RVR at 6.

The Hiring Authority appropriately sustained charges for D1 (Discourtesy, **1**23456), D3 (Intentional Endangerment, 45**6**789), D14 (Disruptive, Offensive or Vulgar Conduct, 2**3**456), and D15 (Intimidation, Threat, or Assault without the intent to inflict serious injury toward an inmate, 34**5**678). *See* 403 at 79. Nevertheless, Officer [redacted] did not face any adverse action because the statute of limitations had expired. The incident occurred on April 6, 2022. Even though the AIU completed the investigation on February 23, 2023, it did not refer it to the Hiring Authority until May 31, 2023, by which time the statute of limitations had already expired. *See* 403 at 78-79; Investigation Report at 3; Administrative Review Memo at 2-3. This case therefore presents yet another example of a failure of the accountability system because of CDCR's inability to timely resolve allegations of misconduct. *See* Plaintiffs' Reports dated November 15, 2024, August 16, 2024, May 20, 2024.

2. KVSP-[redacted] – AIU, Sustained – Corrective Action

In this case, nine officers failed to follow a security check protocol and violated BWC policy when [redacted], a class member with serious mental illness, reported suicidality while housed in a short-term restricted housing unit. The Hiring Authority sustained allegations against all nine officers but imposed inappropriately low penalties (corrective action – letter of instruction) for misconduct that endangered Mr. [redacted] and could have resulted in serious harm to him.

The investigation confirmed that six of the nine officers violated security check protocols on October 29, 2023, by failing to visually observe or verbally contact Mr. [redacted] after he obstructed his cell window with a sign stating he was suicidal. *See* 402 at 27, 54, 62, 77, 87, 96. The Hiring Authority cited a host of aggravating factors and no mitigating factors for each of the six officers, and sustained D26 (failure to perform within the scope of training), which carries a base level penalty of 1. *See* 403 at 28, 55, 63, 78, 88, 97. Failure to conduct security checks should have triggered, at a minimum, application of D2 (negligent endangerment, 1**2**3) and arguably, D3 (intentional endangerment, 45**6**789), given that the purpose of CDCR's security/welfare check policy is to ensure the safety and well-being of incarcerated persons, and the Hiring Authority found that the officers' failure to conduct safety checks was "intentional and willful." *Id.*

Yet for all six officers, the Hiring Authority only imposed corrective action, in the form of letters of instruction. *Id.* Even based only on the sustained violations for failure to perform within the scope of training, it was improper for the Hiring Authority to impose less than the base level penalty where, as here, there were no mitigating factors. *See* DOM § 33030.17 ("The Hiring Authority shall impose the base penalty unless aggravating or mitigating factors are found.").

The investigation also confirmed that six of the nine officers violated BWC policy—specifically, by deactivating their cameras at unauthorized times (*e.g.*, during

meals), allowing the lens to be obstructed in ways that rendered footage unusable, or removing the camera entirely from their person. *See* 402 at 3, 12, 27, 40, 62, 96. The Hiring Authority sustained violations of the following disciplinary matrix categories for all six officers: 1) failure to perform within the scope of training (D26, **1**2345); 2) failure to carry required equipment (I2, **1**2345); and 3) misuse or non-use of issued equipment (I3, **1**2345). *See* 403 at 4, 13, 28, 41, 63, 97. Yet the Hiring Authority again only issued corrective action despite finding no mitigating factors and multiple aggravating factors for each of the six officers, in violation of the DOM. *Id.* None of these officers were held accountable for their violations of the court-ordered BWC policy.

It is concerning that the investigation uncovered violations of CDCR's welfare check and BWC policies by multiple officers on one shift in the same housing unit, revealing widespread noncompliance with policies designed to keep the incarcerated population safe and to ensure that officers can be held accountable for misconduct.

Yet rather than take these findings as a warning sign that many officers may not understand or take seriously their obligations to comply with these critical policies, the Hiring Authority imposed only a slap on the wrist for this serious confirmed misconduct by the nine officers. Imposing only corrective action in this case signals to staff that following the court-ordered BWC policy and protecting the safety of incarcerated people are not priorities, as sustained violations will not carry meaningful consequences.[18]

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

In this case, class member [redacted] alleged Officer [redacted][19] used excessive force in the Triage Treatment Area ("TTA") when he struck Mr. [redacted] four times in the face. Mr. [redacted] also

[18] A similar instance of an inappropriate imposition of corrective action occurred in **KVSP-**[redacted], where an investigator confirmed that a Control Officer failed to secure the section doors of a housing unit, resulting in several incarcerated individuals gaining unauthorized access to the section and stabbing a class member with a homemade weapon. Although the Hiring Authority sustained the violation, he did not apply any disciplinary matrix categories, and only issued corrective action, a CDCR 1123 counseling record. *See* 402/403 at 3-5; Employee Counseling Record. This sends a troubling message that protecting incarcerated people from harm is not a priority. The Hiring Authority should have sustained violations for both D26 (failure to perform, **1**2345) and D2 (negligent endangerment, 1**2**3) and, at a minimum, imposed the base level penalty, especially given the serious harm that actually occurred to the class member because of the misconduct.

[19] Officer [redacted] is a different from Officer [redacted], about whom Plaintiffs have repeatedly written.

alleged that officers failed to activate their BWCs during the incident. The investigation confirmed that, in violation of policy, the three officers present failed to activate their BWCs when Mr. [redacted] became disruptive. In fact, one officer deactivated *immediately* before the force. The Hiring Authority, however, failed to sustain any allegations about the BWC violations. The investigation also confirmed that Officer [redacted] struck Mr. [redacted] in the head; yet, because the officers failed to turn their BWCs on, no footage of the incident exists to assess whether the head strikes were excessive.

The incident occurred June 20, 2023. Mr. [redacted] is in a suicide-resistant smock, waist chains, and leg restraints, and is standing in a medical examination room. He and three officers are having a tense verbal exchange. Officers [redacted] and [redacted] have their BWCs deactivated, but Officer [redacted]'s BWC is on. *See* BWC at 10:40:00. The officers want him to sit down on the examination table, but Mr. [redacted] is not complying. Officer [redacted] and Officer [redacted] eventually order Mr. [redacted] to sit and then corner him in a part of the examination room. *Id.* at 22:41:55. One of the officers reaches for Mr. [redacted] Mr. [redacted] pulls away and responds, "Don't touch me." One of the officers says "Don't do all that extra stuff." At this point, Mr. [redacted] asks, "Why are your cameras off?" *Id.* at 22:42:03. Officer [redacted] then deactivates his BWC. *Id.* at 22:42:10.[20]

A use of force occurred after Officer [redacted] deactivation. Officers [redacted] and [redacted] activated their BWCs at some point after the use of force. *See* BWC (linked above) and AIU Report at 6. Officer [redacted] never activated his camera, claiming that his BWC was knocked off during the incident and that he was unable to activate it; Officer [redacted] BWC footage appears to show, however, that the officers present were wearing BWCs after the incident. *See* BWC (linked above) at 22:46:55. Though no video of the force exists, Officer [redacted] admitted that he struck Mr. [redacted] once in the face. *See* Exhibits at 30.

All four of the officers violated the BWC policy. The policy[21] states that officers should deactivate BWCs "[d]uring a medical assessment, appointment, or consultation wherein the expectation for confidentiality is assumed." *See* Exhibits at 56.[22] It also

[20] The video freezes at 22:42:10 upon the deactivation, then starts playing again at 22:46:46.

[21] The investigator and the IERC wrongly cited to the BWC deactivation condition that applies when officers are at an outside medical visit. *See* AIU Report at 4; IERC at 2, 3 (citing provision related to "arrival to an outside hospital, private doctor's office, or medical clinic").

[22] At the time of the use of force, there were not medical staff members in the room with Mr. [redacted] and the officers. However, about a minute before the use of force, a

provides, however, that officers must activate their BWCs if an incarcerated person "becomes assaultive or disruptive." *See* Exhibits at 57

Here, Mr. [redacted] was "disruptive" and possibly "assaultive," such that all three officers in the room should have activated their BWCs. The officers gave him a direct order to sit down and approached him to gain compliance with that order. As one of the officers reaches to grab Mr. [redacted] he pulls away in an aggressive manner clearly noticed by the officers. Under any interpretation of the policy, they should have all turned their cameras on. Instead, Officer [redacted] whose camera may have been mistakenly on when Mr. [redacted] was receiving medical care,[23] turns his camera off.

The Hiring Authority did not sustain any force violations against the officers, which is unsurprising given the lack of footage of the force. However, the Hiring Authority also did not find that any officers violated BWC policy, even though the evidence shows they did. *See* 402/403 at 1, 6, 9. The Hiring Authority's failure to hold these officers accountable may lead to future failures to reactivate and additional cases where incidents are not captured on video.

II. IN RECENT MONTHS, THE AIU IS FAILING TO TIMELY COMPLETE INVESTIGATIONS IN OVER 80% OF CASES

Increasingly, AIU staff are failing to complete investigations by the deadlines set in the Remedial Plans: 120 days for investigations conducted by custody supervisors (Sergeants and Lieutenants), who conduct nearly all AIU investigations,[24] And 180 days for investigations conducted by Special Agents. The chart below shows that, for investigations the AIU received in February to November 2024, the AIU closed 63.7% of the investigations late. For the three most recent months of available data (September to November 2024), the AIU closed more than 80% if investigations late. The data shows that the problems with delayed investigations have gotten much worse and are at or near a breaking point. It is not acceptable for the AIU to fail to meet deadlines on nearly 90% of investigations, as it did for investigations received in November 2024. CDCR should be taking all available measures, including hiring additional investigators, to ensure that

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medical staff member offered Mr. [redacted] Tylenol and then left to go get it for him. Given the imminent return of the medical staff member to the room to provide medication, the officers likely did not violate the BWC policy by having their BWCs off before Mr. [redacted] became disruptive.

[23] During the IERC process, LAC issued training to Officer [redacted] for failing to deactivate his BWC in the TTA when he initially arrived, but not for his impermissible deactivation and failure to have his camera on when Mr. [redacted] became disruptive. *See* IERC at 2.

[24] In the last fourteen months for which Plaintiffs have data (February 2024 to March 2025), the AIU assigned 99.0% of cases to be investigated by custody supervisors.

the AIU processes investigations timely and that the statute of limitations for imposing adverse action does not expire on allegations.

	MONTH RECEIVED	CLOSED-ONTIME	CLOSED-PASTDUE	OPEN	OPEN-PASTDUE	Total	% Late
2024	February	158	63	0	7	228	30.7%
	March	133	69	2	3	207	34.8%
	April	149	87	0	9	245	39.2%
	May	283	236	2	28	549	48.1%
	June	162	207	0	43	412	60.7%
	July	134	139	0	104	377	64.5%
	August	108	118	1	219	446	75.6%
	September	71	56	0	294	421	83.1%
	October	54	16	1	306	377	85.4%
	November	29	4	0	246	279	89.6%
	TOTAL	1281	995	6	1259	3541	63.7%

III. OIG FINDINGS ARE CONSISTENT WITH PLAINTIFFS' FINDINGS

The OIG has recently issued a number of reports consistent with Plaintiffs' findings. The OIG reports also expound on other serious issues within the accountability system that CDCR must address.

In the 2024 Annual Staff Misconduct Monitoring Report, the OIG found serious issues with CDCR investigations. The OIG reported that investigators conducted "poor" investigations in 99 of the 162 investigations (61%) it monitored in 2024. *See* OIG 2024 Staff Misconduct Report at 9.[25] Many of those poor investigations were a result of investigation delays, including in conducting the initial case conference, the first interview, or the final interview. *Id.* But the OIG also found issues related to the quality of the investigations, including "a lack of preparedness, ineffective questioning during interviews, failure to collect relevant evidence, and unnecessary duplication of investigative work."[26] *Id.* In addition, according to the OIG, department attorneys share

[25] The citations refer to the page number of the PDF.

[26] The OIG's report makes clear that CDCR is failing to prevent duplicative investigations. The OIG found that around 12% (19 of 162) of the cases it monitored were duplicative investigations. *See* OIG Annual 2024 Staff Misconduct Report at 13. Defendants also waste resources by splitting allegations into multiple investigations. The OIA reported 950 of the investigations it completed in 2024 were related to its process of splitting cases. *Id.* at 15.

much of the blame for these poor-quality investigations—department attorneys provided poor advice to investigators about investigations in 41 of the 83 cases (49%) that the OIG monitored. *Id*. at 17.

In the same report, the OIG found that Hiring Authorities made poor substantive decisions in nearly one-quarter of the cases it monitored (39 of 162 cases, or 24%) and generally performed poorly in 64% of the cases it monitored. *Id*. at 21. The OIG highlighted a number of concerns that will not be automatically addressed by the creation of the Centralized Allegation Resolution Unit. Similar to investigators, Hiring Authorities consistently received poor advice from department attorneys in 39 of the 83 cases (47%) that department attorneys were involved in. *Id*. at 17.

In the 2023 Annual Use of Force Monitoring Report (the most recent annual review of force conducted by the OIG), the OIG, consistent with Plaintiffs' counsel's reporting, found that CDCR must improve its de-escalation tactics and provide training to staff on avoiding use of force incidents. *See* OIG 2023 Use of Force Monitoring Report at 26. Officers, according to the OIG, did not adequately attempt to de-escalate situations in 39% of incidents in which there was an opportunity to use de-escalation techniques (54 of 137 incidents). *Id.* In addition, the OIG reported that officers continue to "use[] immediate force instead of controlled force when no imminent threat was present." *Id.* at 12. And the OIG found that officers still use potentially deadly chokeholds when deadly force was not authorized and even though California regulations prohibit the use of choke holds.[27] *Id.* at 29. CDCR declined to comment on the OIG's annual use of force report. *Id.* at 45. The OIG most recently published case blocks regarding use of force cases closed by the Field Investigations Monitoring Unit from September to December 2024, which also contained incidents in which staff failed to de-escalate, and used immediate force with no imminent threat present. *See* OIG September-December 2024 UOF Case Blocks.

The OIG's 2024 annual report on local inquiries also supports Plaintiffs' findings. CDCR's performance in conducting staff misconduct investigations into complaints not on the allegation decision index, referred to as "local inquiries" was poor in 65% of cases (270 of 415 cases). *See* OIG 2024 Local Inquiry Report at 3. When the OIG reviewed cases retrospectively, meaning when they reviewed cases that the OIG was not contemporaneously involved in, they found that an even higher percentage of cases, 77%, of the local inquiries were poor (222 of 289).[28] *Id*. at 19. Concerningly, the OIG found

[27] Also, the OIG found that in 15% of use of force incidents there was a material discrepancy between information in a written report and the incident as presented on video (69 of 457 incidents). *See* OIG 2023 Use of Force Monitoring Report at 37.

[28] When the OIG conducted a retrospective review into local inquiries completed by the California Correctional Health Care Services (CCHCS), to assess inquiries into

that the inquiries were "compromised" because investigators, OIA managers, and Hiring Authorities failed to identify the relevant policies and procedures. *Id*. at 14-15 (investigators failed to obtain departmental rules or standards applicable to the allegations in 57% of monitored cases (235 of the 415)).[29] Also, CDCR failed to resolve local inquiries timely—in 48% of monitored local inquiries, CDCR did not resolve local inquiries within 90 days of the CST receiving the complaints. *Id*. at 11. The OIG's most recent case blocks, covering cases closed by the OIG in December 2024, found similar failures. *See* OIG December 2024 Local Inquiries Case Blocks.

Additionally, the OIG found that CDCR failed to retain video and failed to hold staff who violate body-worn camera policy accountable. For example, in the OIG 2024 Staff Misconduct Report, the OIG reported that delays in the investigative process resulted in a failure to obtain video before the 90-day retention period expired. *See* OIG 2024 Staff Misconduct Report at 11. For local inquiries, the OIG found that investigators did not collect and review all relevant evidence, including video evidence, in 61% of cases monitored (253 of 415 cases). *See* OIG 2024 Local Inquiry Report at 32. The OIG also expressed concern that CDCR "continues to allow each prison's investigative services unit to determine what video footage is relevant to the investigator's inquiry," despite the OIG's recommendations in 2022 that CDCR provide investigators with the ability to independently identify and obtain video. *Id*. at 35. And the OIG found that officers often failed to activate their body-worn cameras, yet were not held accountable. *See* OIG 2023 Use of Force Monitoring Report at 36.

IV. CONCLUSION

Plaintiffs will continue to work with Defendants and the Court Expert to attempt to bring Defendants into compliance with the Court's Orders and the Remedial Plans.

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allegations of misconduct against health care staff, **the OIG found 100% of the cases were poor (40 of 40 cases).** *See* OIG 2024 Local Inquiry Report at 22. Plaintiffs continue to be concerned at the lack of investigations into staff misconduct by health care staff produced in the *Armstrong* quarterly productions, which limits our monitoring ability into these types of allegations.

[29] Plaintiffs note that in light of CDCR's new process for conducting local inquiries, the OIG recommended that CDCR "develop and implement a policy requiring supervisors who conduct fact-finding during routine reviews to obtain and attach the laws, regulations, policy, procedure, or standards applicable to each allegation of staff misconduct to the record of every routine review." *See* OIG 2024 Local Inquiry Report at 16.