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VIA ELECTRONIC MAIL ONLY

Re: *Armstrong v. Newsom*: Plaintiffs' November 2024 Review of CDCR's Accountability System at the Six Prisons
Our File No. 0581-03

Dear :

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

The cases below illustrate the same types of accountability failures that Plaintiffs' counsel have pointed out in their prior quarterly reports—incomplete and biased investigations and inappropriate discipline when evidence of staff misconduct exists. We focus in this report on the ongoing failure of CDCR, during multiple levels of review, to identify use of force policy violations and to take action to prevent staff from continuing to act with unnecessary and excessive force throughout multiple prisons. We also identify the ongoing failure of staff to confirm ADA violations resulting in the missed

opportunity to correct problems and ensure that staff members understand their obligations to accommodate class members. Lastly, Plaintiffs' counsel highlight a few egregious cases, one involving the death of a class member, that further demonstrate how the accountability system is failing.

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

Sincerely,

ROSEN BIEN
GALVAN & GRUNFELD LLP

/s/

By:

cc:

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

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

To evaluate Defendants' compliance, Plaintiffs reviewed all of the cases produced by Defendants. Plaintiffs then selected a subset of those cases for closer review.[1] Plaintiffs have written up in depth the most noteworthy of the cases.

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

1. Defendants Continue to Fail to Hold Staff Accountable for Disability-Related Staff Misconduct

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

Under Defendants' proposed modifications to their accountability system, most of the cases below would be routed for "supervisory" review rather than review by a locally designated investigator ("LDI"). Plaintiffs' counsel have expressed concerns about the change given significant evidence included in Plaintiffs' counsel's prior reports, as well as reports produced by the Office of the Inspector General, that confirm serious problems with local investigations. In a recently published November 2024 report, the OIG found

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[1] Plaintiffs selected the cases using a variety of criteria, including, but not limited to, whether: CDCR referred the case to the OIA; the case involved an allegation related to use of force or disability; the Hiring Authority sustained an allegation; and the case included video evidence. These criteria are intended to identify cases with the most serious and credible allegations of misconduct. Defendants have mischaracterized this approach as "cherry-picking" however it is necessary to focus on cases with serious and credible allegations of misconduct to evaluate whether the accountability system is working.

that local investigators performed "poor" in 51 percent of the cases that the OIG monitored. *See* November 2024 OIG Report.

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

The OIG report, the cases outlined below, and the cases included in Plaintiffs' prior reports confirm that **much more, not less, must be done to ensure complete and unbiased local reviews of allegations**.

It is essential that someone with a clear understanding of the relevant ADA policies and knowledge of ADA requirements review the disability-related cases in order to identify conduct that is in violation to ensure appropriate action in response. If more is accomplished through the supervisory reviews than has been done through LDI investigations to address allegations of staff misconduct regarding the failure to accommodate disabilities, the system will improve. Any less scrutiny, reduced oversight, or any less meaningful review of these allegations will result in further harm to *Armstrong* class members and Plaintiffs' counsel will be required to seek further relief.

(a) RJD – – Local, Not Sustained

In this case, a deaf class member, ( ) alleged that he was denied a sign language interpreter ("SLI") during an interview regarding safety concerns conducted by Lieutenant Even though Mr. provided enough details in his grievance for a thorough investigation, the local investigator prematurely stopped the investigation after determining that there was no Lt. working at the time of the allegation.

Mr. noted on both his grievance and during his claimant interview that the alleged incident occurred on February 25, 2023 and stated it was "C/O Lt. who failed to provide an SLI. *See* 1824 at 2; IR at 2. He also noted that the incident was caught on body-worn camera ("BWC") footage. *See* 1824 at 2. Using his timeframe, the investigator reviewed the February 2023 Telestaff calendar for a "Lieutenant ." After only identifying one Lt. –an – who was apparently on extended leave at the time of the allegation, the investigator determined that Mr. had incorrectly identified the subject of the investigation and that she was "unable to ascertain any information to conduct a thorough inquiry." *See* IR at 2; Telestaff Roster at 6.

Despite interviewing Mr. the investigator did not ask him whether he may have gotten the name, rank or date wrong, nor did the investigator ask him what time

and where the interaction occurred so that BWC evidence could be requested. There was a strong possibility that Mr. [redacted] was mistaken about the rank of the officer given that he also referred to [redacted] as a "C/O." He also reported it was caught on [redacted] BWC, which would rule out the possibility of [redacted] being a lieutenant since only correctional officers and sergeants wear BWCs. *See* Five Prisons Remedial Plan I.B. Instead of clearing up any confusion about the identity of the subject during the interview, or investigating whether anyone else of a different rank with the initials [redacted] may have been working that day, the investigator simply stopped the investigation short and did not request audio/video surveillance system ("AVSS") or BWC footage "due to not having a specific time frame of allegation due to claimant not providing a date and time." *See* IR at 2.

Additionally, RJD policy mandates that institution staff track and document all encounters where SLI or video remote interpreting ("VRI") services are provided. *See* OP 58, Sign Language Interpretation Services at 28. The investigator should have reviewed SLI logs from February 2023 to determine whether Mr. [redacted] had an interview on February 25, 2023, and if so, who conducted the confidential interview and whether an SLI was present. A review of the February 2023 SLI log corroborates Mr. [redacted] allegation—if he was, in fact, interviewed on that day, there is no record on that log that he was provided an SLI for any interview that occurred.

The investigator should have done more to investigate Mr. [redacted] allegation of failure to ensure effective communication in this case. The investigator failed to take even the most basic steps to try to determine who the staff member was before concluding she was unable to identify the subject and was therefore "unable to ascertain any information to conduct a thorough inquiry." *See* IR at 2. Because the investigation was so incomplete, it is impossible to determine what happened here and whether staff failed to accommodate Mr. [redacted] disability.

(b) SATF – [redacted] – Local, Not Sustained

In this case, the Locally Designated Investigator (LDI) failed to complete a thorough investigation of an allegation that staff failed to accommodate a class member's disability. [redacted] ([redacted]) alleged that, despite having a confirmed disability warranting a temporary lay-in, his vocational instructor failed to accommodate him and required Mr. [redacted] to walk a long distance to personally show the instructor the lay-in chrono. *See* 602 at 10-11. This long walk caused Mr. [redacted] to injure himself, further exacerbating his disability and requiring him to seek emergent medical attention. *Id.* However, the investigator failed to resolve a key factual dispute—whether the instructor in fact made the class member walk all the way to the vocational classroom despite the lay-in, causing injury and in violation of policy.

Mr. [redacted] was assigned to an auto mechanics program in the vocational classroom on the yard and had received a lay-in chrono because he was experiencing

difficulty walking long distances due to a hernia. *See* Allegation Inquiry Report (AIR) at 2.[2] On February 2, 2023, Mr. [REDACTED] reported to work change to inform the work change officers that he had a lay-in chrono and would not be attending his class that day. *Id.* at 2-3. The work change officers, Officers [REDACTED] and [REDACTED], verified the lay-in chrono, and Officer [REDACTED] called his vocational supervisor, Mr. [REDACTED], to inform him that Mr. [REDACTED] would not be attending class. *Id.* at 3. In his interview with the LDI, Officer [REDACTED] confirmed that he called Mr. [REDACTED] but stated that his assurance to Mr. [REDACTED] that Mr. [REDACTED] had a valid lay-in chrono "wasn't good enough for instructor [REDACTED] *Id.* Officer [REDACTED] stated that "this has been a continuing issue with instructor [REDACTED] *Id.*

Central to the claim in this case is Mr. [REDACTED] allegation that Mr. [REDACTED] required him to walk through work change and all the way to his vocational classroom to show his lay-in chrono to Mr. [REDACTED] before walking all the way back to his housing unit. *See* AIR at 2. The physical strain from the walk, which could have been completely avoided if Mr. [REDACTED] had accommodated Mr. [REDACTED] disability and accepted the lay-in chrono without requiring him to report in-person, reportedly caused Mr. [REDACTED] to go "man-down" in the Facility A clinic. *Id.* Mr. [REDACTED] disputed this version of events in his interview with the LDI. He alleged that he never required that Mr. [REDACTED] report to the classroom, and that he only asked that Mr. [REDACTED] have his lay-in "confirmed by a valid source," such as a free-staff member or custody officer. *Id.* at 3-4.

The investigator failed to reconcile conflicting accounts of what happened in order to determine whether Mr. [REDACTED] neglected to accommodate Mr. [REDACTED] disability and required him to walk the extra distance to the classroom, thereby causing him to go "man-down." For example, to reconcile statements made by custody staff—which appear to corroborate Mr. [REDACTED] account of events—with Mr. [REDACTED] unsupported denial of events, the investigator could have collected video evidence from the work change officers, which may have been determinative. According to the investigation report, the 90-day threshold had passed by the time the investigator requested the footage, but it is not clear why the investigator had not requested the footage within the 90-day time limit. *See* AIR at 4. [3] The investigator also could have, but did not, review Mr. [REDACTED] medical records or interview potential witnesses in the auto mechanics class to see if they observed what happened.

The investigation was also seriously delayed, so much so that the investigator allowed the statute of limitations to lapse. *See* AIR at 5 (noting that "[t]imeframes are important as the Statue of Limitation (SOL) may be impacted."). The LDI was assigned

[2] One week after this incident, Mr. [REDACTED] had laparoscopic inguinal hernia repair surgery. *See* Surgical Consultation (Feb. 9, 2023) at 10.

[3] The LDI was assigned to this case on March 23, 2023—49 days after the incident. *See* AIR at 1. The LDI had time to request the relevant footage but failed to do so.

on March 23, 2023, but the investigation was not completed until April 15, 2024—13 months later. *Id* at 1, 5. The incomplete and delayed investigation in this case prevented verification of an allegation of failure to accommodate and resulted in the failure to implement corrective or disciplinary action in this case. This is especially concerning given statements from the Officer [redacted] who indicated that lay-in chronos are an ongoing problem with Mr. [redacted]

(c) LAC – [redacted] – Local, Not Sustained

In this case, class member [redacted] ([redacted] alleged that the canteen supervisor wrote a retaliatory rules violation report ("RVR") after he filed complaints that the supervisor denied him disability accommodations and jeopardized his safety. The evidence demonstrates that the canteen supervisor, Ms. [redacted], did write an RVR counseling chrono against Mr. [redacted] just three days after she was interviewed for the 602 staff complaint filed against her by Mr. [redacted] However, the LDI conducted a biased investigation that ignored evidence of retaliation and the Hiring Authority did not sustain the retaliation 602.[4] Although video evidence also showed additional potential misconduct, that conduct was not mentioned in the report or referred for further investigation.

Mr. [redacted] was assigned to work in canteen, where Ms. [redacted] was the canteen supervisor. On February 23, 2024, Mr. [redacted] filed a 602 alleging that Ms. [redacted] was telling Mr. [redacted] co-workers that he was a snitch and that he was reporting that his co-workers were stealing items from canteen, placing his safety at great risk. *See* LAC-[redacted] (602). He also alleged disability discrimination in that 602. *See* 602 at 1. A few days later, on February 27, 2024, Mr. [redacted] filed a separate 1824 again reporting that Ms. [redacted] was discriminating against him in his program assignment because of his walker. *See* LAC-[redacted]; 1824 at 1. Ms. [redacted] was interviewed on March 9, 2024 as part of a local inquiry in LAC-[redacted] (linked above) into the allegations of the initial 602 complaint against her which alleged that she placed Mr. [redacted] safety at risk by telling others he had snitched. That Hiring Authority sustained a finding that she had reported to other incarcerated people that he was a snitch.

On March 12, 2024—just three days after Ms. [redacted] was interviewed about the first 602—Ms. [redacted] wrote an RVR counseling chrono stating that Mr. [redacted] was "harassing" her by complaining that he was at risk of attack by other inmates and that if he was attacked he would blame her. In the chrono, later issued as an RVR, Ms. [redacted] asked that Mr. [redacted] be fired from canteen as a result of the "harassment", and he was fired. *See* Attachments at 23, 25. Mr. [redacted] then filed an instant 602 alleging that Ms. [redacted] wrote the RVR in retaliation for his staff complaint against her. *See*

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[4] Mr. [redacted] allegation of retaliation is on the ADI and should have been routed to the AIU.

Attachments at 3. The evidence described below supports that allegation, as it shows that Ms. ███ conspired with an officer to identify Mr. ███ ongoing safety concerns as "harassment" and that he was ultimately fired as a result of his complaints against her and her 602 interview.

As the video March 12, 2024 shows, the canteen officer, Officer ███, begins talking with Ms. ███ about Mr. ███ prior to Mr. ███ arriving to work at canteen. Ms. ███ states that on Saturday, she was interviewed about Mr. ███ prior 602 that alleged she endangered him. *See* BWC Clip 1 at 9:03:50. Officer ███ responds, "You could actually say he was harassing you by saying that." *Id.* at 9:04:25. Officer ███ then suggests Ms. ███ call a lieutenant and state she is feeling harassed because Mr. ███ filed a 602 against her and because she is now under investigation, which she then does. *Id.* at 9:04:40.

Hours later, Ms. ███ tells Officer ███ that Mr. ███ was talking about being assaulted and suing her, and says in front of Mr. ███ and other canteen workers that she will put this information in a 128 chrono. *See* BWC Clip 2 at 11:12:30. Mr. ███ says this is "retaliation" and he and Ms. ███ continue to argue. *Id.* at 11:13:25. Eventually, Officer ███ tells Mr. ███ he is harassing Ms. ███ and says "stop talking." *Id.* at 11:15:25. Officer ███ later asks Mr. ███ whether he has safety concerns or about getting assaulted, which Mr. ███ denies.[5] *See* BWC Clip 3 at 11:25:15. Then, consistent with Mr. ███ allegations that he was being discriminated against at work as a result of his disability, Officer ███ also comments that Mr. ███ who is seated in his walker, is working "on his butt" (suggesting that he is doing something wrong by sitting). Officer ███ goes on to say, "It might be in your best interest to find a job that you can actually do, that doesn't slow anything down." *Id.* at 11:27:10. Officer ███ later returns to canteen to talk to Ms. ███ about the language of her 128 and, inexplicably, the footage cuts out while they are in the midst of discussing what language would go in to the wording of the RVR. *See* BWC Clip 4 at 11:32:30; BWC Clip 6 at 11:37:38.[6]

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[5] It was inappropriate for Officer ███ to ask Mr. ███ about his safety concerns out in the open in canteen. Given the public setting, it is unsurprising that Mr. ███ denied safety concerns based on Ms. ███ earlier comments about the alleged snitching on coworkers for theft. Mr. ███ 602 about safety concerns was sustained. *See* Attachments at 8 (prior 602 alleging that Ms. ███ "has put my life in danger").

[6] The video also shows an officer talking to Officer ███ about a use of force that occurred the same morning and saying how he should have "used the baton on fools." *See* BWC Clip 5 at 11:33:25. Officer ███ then appears to conspire with Officer ███, in front of other officers who may have also been witnesses to the incident, regarding how they should complete their incident reports. *Id.* at 11:33:45. This is a

The LDI report in this case is biased and incomplete. First, it is unclear why the video clip ended in the middle of the staff members discussing the wording of the RVR. This evidence is material to the allegation that the RVR was retaliatory and was central to the investigation. Yet, the investigator failed to obtain the complete video. Further, the investigator appears to require an overt admission of retaliation, without acknowledging the existence of multiple facts that support the conclusion that the RVR was retaliatory. *See* Inquiry at 4 (noting on that video, "█████ never calls the inmate a snitch or informs him that she is going to write him up for anything he says or does"). The LDI ignores the evidence that Ms. ███ and the officer discussed how to frame his reporting of a problem as harassment against her and how to get Mr. █████ fired before he even showed up for work on March 12. That suggests the RVR was premeditated and retaliatory. The LDI also imitates the conclusory language from Ms. ████ chrono. For example, the LDI states, "The Claimant is observed harassing ████ by going back and forth with ████ in front of staff and inmates, telling ████ everything will come out in the interview making for an uncomfortable work environment." *See* Inquiry at 4; compare with Attachments at 23 (128 chrono stating that Mr. █████ was "harassing" her and "creating a hostile work environment"). Finally, the LDI failed to consider the 1824 that Mr. █████ filed about Ms. ███ which provided further motive for retaliation.

Ultimately, even despite the LDI's biased and incomplete investigation, the evidence here would support a finding that Ms. ███ retaliated against Mr. █████ for filing grievances against her, including for disability discrimination. Yet the Hiring Authority did not sustain any charges. *See* Closure Memo at 1. Nor did the LDI note or the Hiring Authority refer for further investigation the other potential misconduct shown on the video, including (1) Officer ████ asking about Mr. ██████ safety concerns in a non-confidential setting; (2) officers potentially collaborating on incident reports from a use of force; and (3) Officer █████ potentially discriminatory comments about Mr. ██████ disability.

Mr. █████ currently has a parole suitability hearing in February 2025. Plaintiffs request that CDCR take immediate action to rescind the retaliatory RVR in this case and to provide notice to the Board, him, and his counsel that the RVR has been rescinded if it was already produced for consideration in his Board packet.

(d) RJD-███████ RJD-███████ RJD-███████ – Local, Sustained

In addition to the above cases where CDCR failed to properly investigate alleged ADA violations, Plaintiffs' counsel identified multiple cases during this quarter where staff confirmed that an ADA violation did in fact occur, but failed to take any action in

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potential instance of additional misconduct, collaboration on report writing, which should have been referred for investigation.

response. In RJD-[redacted] and RJD-[redacted], LDIs confirmed that RJD did not provide sign language interpretation for two different class members during Protestant services over a three-week period of time. Both cases involve the exact same nucleus of facts (same worship services, same staff actors, and same failure to provide an SLI) and both were initiated after the same review of September 2023 SLI logs. *See* RJD-[redacted] IR at 1; RJD-[redacted] IR at 2. Yet, inexplicably, they were investigated separately by two different LDIs who both confirmed that a violation occurred but gave different reasons for excusing the conduct. *See* RJD-[redacted] Closure Memo at 1; RJD-[redacted] Closure Memo at 1.

In RJD-[redacted], no accountability action was taken because, although no SLI was ultimately provided, the investigator apparently determined that staff requested an SLI. *See* RJD-[redacted] Closure Memo at 2-3. However, casefile exhibits include an email exchange between the SLI service provider and RJD, which makes clear that before this incident, RJD was on notice that the SLI contractor was having trouble securing interpreters for the service. *See* ASL emails at 13-19. Further, the contractor made clear to RJD staff, prior to the second and third services, that they could not cover the Protestant services and that the prison should "reach out to the secondary" SLI service provider. *Id* at 14. There is no evidence in this case that responsible staff (the Community Resource Manager) reached out to the secondary SLI provider or took any additional action to try to secure SLI services from other contract providers. The investigator should have determined whether staff took those actions or not. If not, the Hiring Authority should have ensured that staff received training and guidance on what is supposed to happen when one of multiple SLI service providers is unable to provide an SLI.

In contrast, in the second case where a different class member also did not receive an SLI for the same services, RJD-[redacted] the closure memo simply states that "no specific staff member was identified." This is an inappropriate basis for not taking any action to correct a violation, especially in light of the information uncovered in the parallel investigation showing the Community Resource Manager was responsible and ultimately was unable to secure an SLI for the services. That further shows how this second investigation was inadequate. *See* RJD-[redacted] Closure Memo at 3; RJD-[redacted] Closure Memo at 2.

Similarly, in RJD-[redacted] [redacted] ([redacted]) whose primary method of communication is hearing aids, alleged that he was placed in the Restricted Housing Unit (RHU) without his hearing aids or disability vest. He also alleged that, as a result of not having his DME, he attended his Institutional Classification Committee (ICC) hearing without his hearing aids. *See* RJD-[redacted] IR at 1; Non-Compliance Inquiry Memo at 7. The investigator confirmed the claims in this case that Mr. [redacted] was placed in RHU without his DME and that his primary means of communication was not provided during ICC. However, it does not appear the Hiring

Authority took any corrective or disciplinary action in response to these two violations. *See* RJD-[redacted] Closure Memo.

In addition to the three RJD cases above, Plaintiffs' counsel identified at least six other notable LDI cases, across multiple different prisons, in which the investigations confirmed that disability-related staff misconduct occurred, but CDCR failed to take any corrective or disciplinary action in response. *See* COR-[redacted], COR-[redacted], COR-[redacted], SATF-[redacted], LAC-[redacted], LAC-[redacted].

Plaintiffs are seriously concerned that, as a result of the failure to take action in response to confirmed misconduct, ADA violations will persist. In a system of progressive discipline, it is essential that CDCR take action, even if only corrective action, in response to identified violations. Failing to take any action opens the door for staff to repeatedly engage in the same misconduct without awareness and, ultimately, with impunity, despite the harm caused to class members.

2. Defendants Continue to Fail to Hold Staff Accountable for Excessive and Unnecessary Uses of Force

Plaintiffs' counsel continue to identify cases in which Defendants' accountability system has failed to confirm violations of CDCR's use of force policy. In every case below, custody staff actively escalate a situation and ignore available alternatives to force, or otherwise use force when none was needed, in violation of existing policies that are designed to get officers to employ alternatives to force. CDCR is currently facing a wrongful death lawsuit, filed November 1, 2024, claiming that an officer used force, striking an incarcerated person with a projectile in the head resulting in his death, after he assumed a prone position and posed no immediate risk. *See* "CDCR sued for wrongful death" dated November 13, 2024. The continued use of immediate force when class members do not present an imminent threat jeopardizes the safety of incarcerated people –especially those with existing disabilities—places staff at risk, undermines trust between incarcerated people and staff and, on balance, make prisons less safe.

The cases below illustrate how quickly disputes with staff can result in force. Because people with disabilities must rely on staff for help, and because those interactions can sometimes result in a dispute about whether the incarcerated person requires the help they seek, these cases illustrate just how susceptible people with disabilities are to uses of force by staff. If staff continue to resort to force rather than attempting to deescalate disputes with incarcerated people, class members and staff will remain at risk. CDCR must take action to address the ongoing failure to identify force violations and to hold officers accountable.

Plaintiffs again request to meet with Defendants to discuss what remedies CDCR might take to address these serious failures that continue to endanger class members.

(a) COR – [REDACTED] – AIU, Not Sustained

In this case, a correctional officer threw a suicidal class member, [REDACTED] ([REDACTED] to the ground because the class member expressed concerns regarding being escorted by a particular officer. Several levels of the IERC process correctly identified the force as unnecessary and referred the incident to the Hiring Authority for an administrative investigation. But, for reasons that are unclear, the Hiring Authority did not sustain the misconduct, and the officer did not receive corrective or adverse action.

During the night of June 24, 2023, Mr. [REDACTED] was suicidal and told custody officers that he needed to be urgently seen by mental health staff. *See* Investigation Report at 2, 4. Before opening his cell door, Officer [REDACTED] ordered Mr. [REDACTED] to strip out in his cell and Mr. [REDACTED] complied. Officer [REDACTED] reported to the investigator that Mr. [REDACTED] jumpsuit had been cut in half and Officer [REDACTED] did not want to return the altered clothing to Mr. [REDACTED] sparking a dispute between the two. *Id*. at 4. After a back-and-forth, Officer [REDACTED] opened Mr. [REDACTED] cell door to escort him to the Triage and Treatment Area (TTA) for an urgent mental health referral. *See id*. at 5. This prior interaction between Mr. [REDACTED] and Officer [REDACTED] which precipitated the force, was relevant to the review of the case. The investigator, however, did not retain the video footage of this initial interaction.

The footage in the investigation file begins with Officer [REDACTED] opening Mr. [REDACTED] cell door. *See* BWC 1 at 22:42:01. Officer [REDACTED] escorts Mr. [REDACTED] to the officer's podium; Mr. [REDACTED] is in waist chains and using a walker because he has a mobility disability. Upon reaching the podium, Mr. [REDACTED] says to the sergeant, "Hey, I'm letting you know right now, it's going to be a problem with him, bro," referring to Officer [REDACTED] *See* BWC 1 (linked above) at 22:42:14. The sergeant responds, "Okay," and then points to the corner of the housing unit and tells Officer [REDACTED] and Mr. [REDACTED] that they are exiting in that direction. Officer [REDACTED] says to Mr. [REDACTED] "Okay, let's go." *See* BWC 1 (linked above) at 22:42:20. Mr. [REDACTED] does not move and again tells the sergeant in a calm voice that he does not want to be escorted by Officer [REDACTED] At the time, at least six custody staff and one mental health staff member are standing in the dayroom near Mr. [REDACTED] and no other incarcerated person can be seen in the dayroom. Another officer responds to Mr. [REDACTED] "That's who's escorting you." *See* BWC 1 (linked above) at 22:42:35. The sergeant then says, "You don't get to choose who escorts you, [REDACTED] And Officer [REDACTED] says, "You don't get to dictate who escorts you. Let's go. Come on." Mr. [REDACTED] does not move his body but looks at Officer [REDACTED] and says, "You going to make me? Make me." He repeats "make me" several times, and Officer [REDACTED] tells Mr. [REDACTED] that he is giving him a direct order. *See* BWC 1 (linked above) at 22:42:45. After about twenty more seconds of Mr. [REDACTED] telling Officer [REDACTED] to "make me go," Officer [REDACTED] throws Mr. [REDACTED] to the ground. *See* BWC 1 (linked above) at 22:43:14.

The BWC footage of Officer [REDACTED] partner, Officer [REDACTED], provides a clearer view of the use of force. *See* BWC 2 beginning at 22:42:45 (UOF occurs at 22:43:12). Once he decides to use force, Officer [REDACTED] immediately grabs the back of Mr. [REDACTED] neck and tries to pull Mr. [REDACTED] body weight forward over his walker. Mr. [REDACTED] then falls over his walker and to the ground. Because he is in waist chains and being pulled over his walker, he is unable to brace himself and falls forward into the ground.

Multiple levels of review during the IERC process concluded that the use of force in this case was unnecessary. Lieutenant [REDACTED], who conducted the first-level review as the incident commander, determined that "Officer C. [REDACTED] failed to maintain a professional demeanor when inmate [REDACTED] antagonized," and that "[t]he force used in this incident is unnecessary." *See* IERC at 2. Associate Warden Perez, who conducted the final level of IERC review before the Hiring Authority, similarly determined that, "[a]fter reviewing video footage and staff reports[,] it appears the use of force was not necessary, therefore; the use of force was not within compliance prior and during." *Id*. at 4. The IERC referred the incident to an administrative review by the Hiring Authority. But without explanation, the Hiring Authority did not sustain the allegation. *See* 402/403 at 1.

As the IERC correctly identified, the use of force in this case was unnecessary and violated CDCR policy. Officers are not permitted to use immediate force solely to gain compliance with a lawful order. *See* 15 C.C.R. § 3268(a)(4) ("If it is necessary to use force solely to gain compliance with a lawful order, controlled force shall be used."); DOM § 51020.4.[7] Immediate force can only be used to respond to situations "that constitute[] an imminent threat to institution/facility security or the safety of persons," including to "subdue an attacker, overcome resistance or effect custody." *See* 15 C.C.R. § 3268(a)(4); DOM § 51020.4. Mr. [REDACTED] refusal to be escorted by Officer [REDACTED] did not constitute an imminent threat to the facility or to the safety of anyone. He was cuffed, had limited mobility, was surrounded by numerous custody staff members, and was only passively resisting. One of the many officers at the scene should have de-escalated the situation and, if necessary, resorted to a controlled use of force to continue the escort. The entire situation could have been avoided had Officer [REDACTED] walked

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[7] In the investigation report, the investigator quoted this DOM section, but the investigator omitted from the quotation the sentence about controlled force being required when seeking to gain compliance with a lawful order. *See* Investigation Report at 6. Considering Officer [REDACTED] purported to use force to gain compliance with his order, that sentence of the policy is critical to assessing whether Officer [REDACTED] violated the policy. *See id*. ("[REDACTED] stated he believes the force he used was reasonable as [REDACTED] was not receptive with orders.").

away. Instead, Officer [redacted] escalated a situation with a person who was seeking mental health care because he was suicidal.

The force in this case was also excessive. When using force, officers must use "reasonable force," or "force that an objective, trained and competent correctional employee, faced with similar facts and circumstances, would consider necessary and reasonable." *See* 15 C.C.R. § 3268(a)(1); DOM § 51020.4. Throwing a man with a mobility disability who is already restrained in waist chains to the ground, in the violent manner that Officer [redacted] threw Mr. [redacted] down, is excessive and fails to take into consideration Mr. [redacted] mobility disability in the application of force.

Lastly, this incident is not the first time that Plaintiffs' counsel has raised issues with Officer [redacted] excessive and unnecessary use of force against an *Armstrong* class member. In 2021, Plaintiffs wrote a letter to Defendants about how Officer [redacted] reported, in an RVR that he authored, that he entered a DPO/DNV/DNH class member's cell with a riot shield and used the shield to violently knock the class out of his walker. *See* Letter from [redacted]. In that letter, we described a separate incident from a week later in which Officer [redacted] kicked that same class member. *Id*. at 2. It is our understanding that Officer [redacted] was not held accountable for either of those incidents. We are troubled by the fact that several years later, Officer [redacted] continues to use excessive and unnecessary force against vulnerable class members and faces no accountability, despite significant changes to the accountability system.

(b) LAC – [redacted] – AIMS to OIA, Sustained (Adverse, LOR – Collusion)

In this case, Officer [redacted] whom Plaintiffs have reported on six times prior for violating use of force policy, used improper immediate force against an incarcerated person. Plaintiffs' review of staff misconduct files revealed that Officer [redacted] has not received discipline for using improper force against a class member, despite multiple serious policy violations. Here, Officer [redacted] finally received adverse action, yet the adverse action was for collusion in report writing and not for his improper use of force. Plaintiffs remain seriously concerned about the failure to hold this officer accountable for the harm he has caused, and the failure to implement any progressive discipline in cases like this due to the ongoing failure to appropriately sustain prior violations.

Video shows Officer [redacted] use improper immediate force on [redacted] when he reached his hand through the food port during a temperature check. On February 9, 2022, Officer [redacted] was assisting a psychiatric technician during temperature checks on the upper tier. At 8:53:51, PT [redacted] approaches Mr. [redacted] cell and asks if he wants a temperature check, to which he

affirms that he does. When Officer [redacted] opens the food port, Mr. [redacted] reaches his arm upwards through the food port and says "peaceful protest." *See* BWC at 8:54:07. Immediately, Officer [redacted] grabs Mr. [redacted] wrist and repeatedly yells "put your hand inside" as Mr. [redacted] yells "why are you touching me, man?" and "you're f***ing my hand up." Other officers arrive within a minute and order Mr. [redacted] to "cuff up" while stretching his arm back, making it nearly impossible for him to submit to handcuffs. The officers handcuff Mr. [redacted] through the food port after several minutes.

Officer [redacted] and PT [redacted] continue temperature checks on the upper tier, and Officer [redacted] explains his use of force to PT [redacted] *See* BWC (linked above) at 8:57:31. Officer [redacted] says "he reached toward you, that's why I grabbed him." PT [redacted] says "I know." *See* BWC (linked above) at 8:57:50.[8] A few minutes later, Officer [redacted] and PT [redacted] finish temperature checks and have the following conversation:

> Officer [redacted] You gotta write.
> PT [redacted] Why?
> Officer [redacted] Because he reached toward you.
> PT [redacted] So I have to write?
> Officer [redacted] That's why I grabbed.
>
> …
>
> Officer [redacted] You say that I did a temperature check, opened the food port, he tried to reach toward you I grabbed his hand.

See BWC (linked above) at 8:59:43.

Concerningly, during the first three IERC reviews, the lieutenant, captain, and associate warden failed to find that the use of force violated policy. *See* IERC at 2, 3, 4. However, during the fourth level of IERC review (which appeared to occur after the OIA investigation closed), the IERC found that Officer [redacted] actions during the use of force violated policy.[9] The IERC cited the following DOM provision: "[I]n the event the inmate does not relinquish control of the food/port, the officer shall back away from the cell and contact and advise the custody supervisor of the situation." *See* DOM 51020.11.3. The IERC further commented that "controlled force may be initiated in

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[8] At 8:58:53 another officer walks by and asks what happened, and Officer [redacted] says "he tried to reach for her I grabbed his hand…I knew he was going to do it I saw it coming…he wanted to hold the food port." *See* BWC (linked above) at 8:58:53.

[9] Although the case was closed on February 15, 2023 (*see* Closure Memo at 4) and discipline upheld after a Skelly hearing in March 2023, the final IERC review is dated April 2024. The case was not produced to Plaintiffs' counsel until August 2, 2024.

accordance with DOM Section 51020.12, while staff continues to monitor the inmate." *See* IERC at 10. The IERC's finding that Officer [REDACTED] violated policy is consistent with Officer [REDACTED] failure to back away from the cell and contact a supervisor, as he instead immediately resorted to force when there was no imminent threat. Mr. [REDACTED] stated his intention to protest peacefully, reached his arm upwards, and did not make contact with PT [REDACTED]

However, the Hiring Authority ultimately did not sustain a use of force policy violation in this case. *See* 402/403 at 1. The IERC closed the case with no further action over two years after the date of incident. *See* IERC at 12.

Not only did the Hiring Authority fail to sustain a use of force violation even in the case when the IERC recognized one, but CDCR's failure to hold Officer [REDACTED] accountable for previous violations prevented the Hiring Authority from issuing progressive discipline. Plaintiffs have reported on Officer [REDACTED] six times for prior use of force policy violations.[10] LAC Hiring Authorities closed four of these six cases in 2022, half a year to one year before the 402/403 in this case was issued on February 24, 2023 at 1. *See* 402/403. Had those four prior use of force violations been sustained and appropriate discipline issued, the Hiring Authority would have been required to issue progressive discipline in this case and, therefore, stiffer penalties. Instead, the NOAA states that a review of Officer [REDACTED] file "shows [he] ha[s] no prior adverse actions." *See* NOAA at 7.

Worse, Officer [REDACTED] violated use of force policy **four times within three weeks in 2022, including this incident**. These violations include one of the most

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[10] Descriptions of and links to the six cases follow. In [REDACTED], Officer [REDACTED] used improper immediate use of force to move class member with mobility disabilities from cell. *See* Feb. 2024 Report at 11-15. In [REDACTED], Officer [REDACTED] failed to de-escalate a situation during an escort that led to a use of force. *See* Feb. 2024 Report at 14. In LAC-[REDACTED], Officer [REDACTED] unnecessarily threw a mentally ill and unresponsive class member off of the top bunk of his cell onto the concrete floor. *See* Feb. 2023 Report at 8-9. In LAC-[REDACTED], Officer [REDACTED] and a sergeant used excessive force against a class member with serious mental illness when they slammed him headfirst into the ground during an escort. Id. at 25-29. In LAC-[REDACTED], Officer [REDACTED] engaged in two use-of-force violations. First, Officer [REDACTED] initiated an improper immediate use of force against a class member who was refusing to exit a holding cage. Second, Officer [REDACTED] then unnecessarily and punitively pepper-sprayed the class member, who was locked in his cell, after the class member allegedly spit on officers. *See* May 2023 Report at 16-18. And in LAC-[REDACTED], Officer [REDACTED] and another officer initiated an improper immediate use of force against a class member who was "holding" the tray slot of his cell door, resulting in officers pepper-spraying the class member. *Id.* at 18-20.

egregious uses of force Plaintiffs have reported on thus far—Officer [REDACTED] unnecessarily throwing a mentally ill and unresponsive class member off the top bunk of his cell onto the concrete floor—which happened just two days after this incident. *See* Feb. 2023 Report at 8-9. It is highly concerning that an officer can commit consecutive, egregious policy violations that should result in adverse action, yet appear to fly under CDCR's radar.

Case No.	**[REDACTED] Policy Violation(s)**	**Incident Date**	**Sustained Allegations for [REDACTED]**	**Discipline for [REDACTED]**	**402/403 Date**	**Closure Date**
[REDACTED]	Improper immediate use of force to move class member with mobility disabilities from cell	October 18, 2022	None	None	May 23, 2023	July 21, 2023
[REDACTED]	Failure to de-escalate leading to UOF	November 23, 2022	None	None	May 30, 2023	July 21, 2023
[REDACTED]	Unnecessary and excessive force when pulling a mentally ill and unresponsive class member from the top bunk	February 11, 2022	Dropping shield during cell extraction	Corrective-LOI	4/27/2022	May 2, 2022 (from email, not closure memo)
[REDACTED]	Excessive force when Officer [REDACTED] and a Sergeant lifts a class member off his feet during an escort and slams him into the floor	November 4, 2021	None	None	N/A (violation not identified – 402/403 generated only for another officer violating UOF policy)	March 29, 2022 (from email, not closure memo)
[REDACTED]	(1) Improper immediate UOF against class member in holding cage; (2) unnecessary force (pepper spray) against class member in cell for allegedly spitting	February 24, 2022	(1) None; (2) Pls requested documents on May 12, 2023	(1) None; (2) Pls requested documents on May 12, 2023	No 402/403	September 30, 2022
[REDACTED]	Improper immediate use of force against a class member with serious illness who was holding a food port	March 1, 2022	None	None	None	September 8, 2022

In addition to the use of force violation, Officer [REDACTED] also violated policy for collusion on report writing in this case. Officer [REDACTED] instructed PT [REDACTED] to write in her incident report that he grabbed Mr. [REDACTED] because Mr. [REDACTED] reached toward her. The Hiring Authority ultimately applied disciplinary matrix category D26 (12345) for failure to perform within the scope of training. The Hiring Authority then inappropriately issued a Letter of Reprimand (Level 1 discipline). Given the violation,

the Hiring Authority should have raised the discipline based on aggravating factors, and should have considered B4 ("Any independent act(s) that prevents or interferes with the reporting of misconduct,"(45678**9**)). *See* 402/403 at 2-3; Disciplinary Matrix.

(c) SATF – [REDACTED] – AIU, Not Sustained (UOF)

In this case, the AIU failed to identify and investigate an incident of excessive and unnecessary use-of-force that stemmed from a disagreement regarding safety concerns between [REDACTED] ([REDACTED]) and Officer [REDACTED]

Mr. [REDACTED] submitted a CDCR 602-1, dated November 4, 2022, grieving an RVR he received after raising "serious health and safety concerns" at SATF on September 20, 2022. *See* 602 at 1. According to the investigation report, the incident began after Officer [REDACTED] told Mr. [REDACTED] to return to his building despite his concerns that he would "get killed or beat up." *See* Investigation Report at 3. Body-worn camera footage appears to start shortly after Mr. [REDACTED] has been told to return to his building. Mr. [REDACTED] appears frustrated at Officer [REDACTED] for dismissing his concerns. In his frustration, Mr. [REDACTED] throws a notebook near Officer [REDACTED] *See* BWC 1 at 12:46:02. Mr. [REDACTED] begins to walk away as Officer [REDACTED] follows him and then grabs Mr. [REDACTED] shirt and shoves him towards a fence to restrain him. BWC (linked above) at 12:46:03-12:46:13. Another officer, Officer [REDACTED] attempts to deescalate the situation but is unsuccessful. *See* BWC 2 at 12:46:04. Mr. [REDACTED] submits to restraints and is escorted over to a holding cage in the program office. Officer [REDACTED] is leading the escort and is the only officer holding onto Mr. [REDACTED] *See* BWC 2 (linked above) at 12:46:47. Once the holding cage door is opened, Officer [REDACTED] forcefully throws Mr. [REDACTED] into the holding cage face first and it appears that Mr. [REDACTED] hits the side of his face against the back of the holding cage. *See* BWC 2 (linked above) at 12:47:02; *see also*, AVSS at 12:47:02. This act was clearly excessive and unnecessary. Mr. [REDACTED] had already submitted to restraints and was walking without any signs of resistance to the holding cage. After excessive and unnecessary force is used, Mr. [REDACTED] spits at Officer [REDACTED] Officer [REDACTED] is clearly enraged by this action, and proceeds to slam Mr. [REDACTED] into the back of the holding cage multiple times and pushes his hands into Mr. [REDACTED] face and neck area. *See* BWC 2 at 12:47:07; *see also*, BWC 3 at 12:47:07; AVSS (linked above) at 12:47:07. This action appears to be excessive and retaliatory. A sergeant then steps in to separate Mr. [REDACTED] and Officer [REDACTED] and Mr. [REDACTED] stays in the holding cage without incident. *See* BWC 3 (linked above) at 12:47:11. At the end of the footage, Officer [REDACTED] can be seen storming off and throwing a chair in the program office hallway. *See* BWC 4 at 12:47:19; *see also*, AVSS (linked above) at 12:47:19.

In their investigation, the AIU should have recognized the multiple policy violations evident in the video footage and initiated an additional investigation into the use-of-force, but there is no indication that occurred here. Officers failed to deescalate the situation after Mr. [REDACTED] became upset after learning that he would be required to

return to his building despite expressing serious safety concerns. There were several officers in the area who could have taken control of the situation so that Officer [redacted] who was clearly agitated, could remove himself from the situation. By failing to do so, they allowed Officer [redacted] to continue his interaction with Mr. [redacted] which ultimately resulted in an unnecessary and excessive use of force when Officer [redacted] pushed Mr. [redacted] into the back of the holding cage face first. Mr. [redacted] posed no threat to the officers and had already submitted to restraints. Officer [redacted] actions escalated the encounter, prompting Mr. [redacted] to spit and then Officer [redacted] used additional, retaliatory and excessive force against Mr. [redacted] slamming him multiple times against the holding cage after he spit. This case is significant because, like many people with disabilities who rely on staff for help, Mr. [redacted] went to the program office to ask the officers to keep him safe. Instead, his safety concerns were disregarded and then met with violence after he acted in frustration.

(d) CIW – [redacted] – AIU, Not Sustained

In this case, Officer [redacted] failed to de-escalate a situation with [redacted] [redacted], and his failure to de-escalate led to a violent use of force. Ms. [redacted] filed a 602 alleging that the force was unnecessary and excessive. At the conclusion of the investigation, Officer [redacted] was ordered to complete training about de-escalation and communication so that he could "use communication and/or verbal persuasion to gain voluntary compliance." *See* IRT Memo at 1. But, despite CDCR acknowledging that Officer [redacted] should have de-escalated the situation before resorting to force, CDCR did not sustain any use of force violation against Officer [redacted]

On February 22, 2023, custody staff conducted a mass cell search in Ms. [redacted] housing unit. After completing the searches, custody staff ordered people to return to their cells. Body-worn camera shows Ms. [redacted] walking out of her cell after the searches had been conducted and discovering that her antenna (her "boost-a-roo") and her headphones had been confiscated. *See* BWC 1 at 7:32:20. She walks into the hallway and demands that staff return her antenna and headphones. Lieutenant [redacted] says that custody staff will come back to talk to her, but Ms. [redacted] becomes increasingly frustrated and loud, insisting that she needs her headphones and her boost-a-roo. *See* BWC 2 at 7:32:32. Lieutenant [redacted] says her name several times to initiate a conversation, but Ms. [redacted] looks past Lieutenant [redacted] to demand that Sergeant [redacted] return her items. After engaging with Ms. [redacted] for around 40 seconds, Lieutenant [redacted] orders Officer [redacted] to "effect custody." *See* BWC 3 at 7:32:57. In response to the lieutenant's order, Officer [redacted] walks in front of Ms. [redacted] and grabs her left arm. *See* BWC at 7:33:01 (linked above). Sergeant [redacted] body-worn camera shows that Ms. [redacted] ignores Officer [redacted] and continues to look at Sergeant [redacted] to demand that he returns her items. *See* BWC 4 at 7:32:55. She does not place her arm behind her back, but Officer [redacted] grabs her left arm and holds it straight out. He appears to be in

control of her left arm at that point. But without warning, Officer [redacted] immediately places his right hand on the back of Ms. [redacted] neck, sweeps his leg in front of Ms. [redacted] then throws her over his leg face-first into the ground. *See* BWC 3 (linked above) at 7:33:06. When Ms. [redacted] hits the ground, she asks several times, "Why are you slamming me?" *See* BWC 3 (linked above) at 7:33:08

When reviewing the force in this case, the IERC determined that the level of force in this case was appropriate and did not violate policy. *See* IERC at 11. It did, however, recommend that Officer [redacted] receive training on "de-escalation and [c]ommunication" so that he could use "verbal persuasion to gain voluntary compliance." *Id*. During the subsequent AIU investigation, the investigator concluded in the report that, after reviewing the body-worn camera footage, he "did not observe [redacted] [sic] utilize excessive and or unnecessary force during this incident." *See* Investigation Report at 6-7. The Hiring Authority, therefore, did not sustain the allegations of excessive or unnecessary use of force, even though Officer [redacted] received training about the appropriate use of de-escalation. *See* 402/403 at 1.

Officer [redacted] use of force in this case violated CDCR policy. Policy requires that custody staff "shall attempt to use verbal commands and verbal de-escalation, followed by a reasonable amount of time for compliance before resorting to use of force." *See* DOM § 51020.5 ("Whenever possible, verbal persuasion should be attempted in an effort to mitigate the need for force."). The fact that Officer [redacted] received training on his failure to use de-escalation techniques is evidence that the IERC believes he did not follow that policy, and a use of force violation should have been sustained.

In addition to the lack of verbal de-escalation and the improper immediate use of force, the amount of force used was likely excessive. When using force, custody staff must apply reasonable force. "Reasonable force is the force that an objective, trained, and competent correctional employee faced with similar facts and circumstances, would consider necessary and reasonable to subdue an attacker, overcome resistance, effect custody, or gain compliance with a lawful order." *See* DOM 51020.4. The amount of force that Officer [redacted] used here—throwing a relatively small person over his leg face-first into the ground—was much more force than was necessary to effect custody and overcome her resistance. At the time he decided to take Ms. [redacted] to the ground, Officer [redacted] appeared to have control over her arm, he was much larger than her, and numerous custody staff were in the area to support him in effecting custody. He should have called for more officers to support his attempt to cuff her before throwing her to the ground. Instead, he brought her to the ground in a dangerous manner using much more force than he needed to use.

This case highlights the lack of clarity in the Department's position on use-of-force policy violations. When a staff member uses force in a manner that violates policy, as Officer [redacted] did here, that staff member should receive corrective or adverse

action. Here, Officer [redacted] escalated situation into a violent encounter and could have seriously injured Ms. [redacted] The IERC acknowledged that his actions required training, even though they failed to recognize the policy violation. Officer [redacted] should have received a sustained violation of policy in this case to effectuate the progressive discipline process.

(e) LAC – [redacted] – AIU, Not Sustained

In this case, an officer denied a class member an incontinence shower, which ultimately resulted in an unnecessary use of force that was excessive and dangerous. The IERC and Hiring Authority failed to identify any policy violations and the officers were not held accountable.

The case arose from a 602 filed by [redacted], who alleged that staff denied him an incontinence shower and used excessive force when he asked to speak to a sergeant about the denial of the incontinence shower. *See* 602 at 4. Fixed camera footage (with no audio) shows Mr. [redacted] exit his cell with a clear plastic bag that appears to contain clothes and, after a couple minutes, walk to the shower area using his walker. *See* AVSS 1 at 17:38:32; *see also* Investigation Report at 3-4. Mr. [redacted] begins talking with Officer [redacted] gesturing with the clear plastic bag. *See* AVSS 1 (linked above) at 17:40:16. Officer [redacted] then makes a phone call. *See* AVSS 1 (linked above) at 17:41:21. Officer [redacted] BWC begins with him on another phone call about a minute later.[11] *See* BWC 1 at 5:43:00. During his AIU interview, Officer [redacted] reported that he had called the tower officer. *See* Investigation Report at 14-15. After the call, Officer [redacted] tells Mr. [redacted] that another incarcerated person is first in line to shower and Mr. [redacted] has to wait. Mr. [redacted] protests that the shower has been empty for 45 minutes and it appears he may say he has "an incontinence emergency right now." *See* BWC 1 (linked above) 17:43:32. Another incarcerated person tells Officer [redacted] that Mr. [redacted] is "saying he has an emergency" (e.g., needs an incontinence shower). That same person gestures to Mr. [redacted] refers to an "issue," and Officer [redacted] says, "I get it." *See* BWC 1 (linked above) at 5:43:45; 17:44:11. The evidence strongly suggests that Mr. [redacted] requested an incontinence shower but Officer [redacted] did not provide him an incontinence shower, as Mr. [redacted] alleged in his 602 and reported in the interview.

A couple minutes later, Mr. [redacted] appears to ask Officer [redacted] to call the sergeant (in the 602, he reported he wanted to talk to the sergeant about multiple denials of incontinence showers), to which Officer [redacted] responds that he will not call the

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[11] The BWC begins at 5:43:00, about a minute after the fixed camera footage ends and thus does not capture audio of the initial conversation between Officer [redacted] and Mr. [redacted] It is unclear why the investigator failed to request that video, as AIU was assigned to the case well within 90 days of the incident.

sergeant "for nothing." *See* BWC 1 (linked above) at 17:45:20*;* BWC 2 at 17:46:28.[12] Officer orders Mr. to cuff up, but Mr. refuses, and Officer attempts to grab Mr. right arm starting a chain of events that escalate to Officer tackling Mr. to the ground forcefully enough that Mr. and Officer heads strike the podium, and Officer BWC comes off his uniform. Right after the initial tackle, Officer yells at Mr. to stop resisting because he is not putting his hands behind his back. *See* BWC 3 at 17:46:58; AVSS 2 17:46:58. Officer then stands up and strikes Mr. forcefully on his thigh with his baton, although at the time of the strike Mr. hands appear secured by Officer See AVSS 2 (linked above), BWC 3 (linked above) at 17:47:06.

Officer use of force was excessive and avoidable. Rather than provide Mr. an incontinence shower as he requested, or allow him to receive an explanation from the sergeant, Officer made the inflammatory comment that he would not call the sergeant "for nothing," which appears to have escalated the encounter and ultimately resulted in a dangerous use of force.[13] It is unclear whether Mr. presented a threat when Officer tackled him; contrary to Officer incident report, the video does not show Mr. make a fist or any physical threats to the officers. *See* Exhibits at 39 (Incident Report Narrative); *cf.* DOM § 51020.4 (immediate force can only be used to address situations "that constitute[] an imminent threat to institution/facility security or the safety of persons"). Regardless, the degree of force was unreasonable in these circumstances. *See* DOM § 51020.4 ("Excessive force is the use of more force than is objectively reasonable to accomplish a lawful purpose."). Mr. was not moving quickly and two officers were present. To secure him in cuffs, the officers could have worked together to secure Mr. rather than Officer wrapping Mr. and tackling him to the ground with force. This is particularly so given Mr. mobility disability. In addition, Officer baton strike—wherein he rose to his feet to strike Mr. hard on his leg—was likely more than was objectively reasonable and necessary to induce Mr. to put his hands behind his back. Officer was able to pull Mr. hand behind on his down *before* Officer made the strike.

Ultimately, this use of force against a class member with mobility disabilities—including tackling him to the ground and striking him in the leg with a baton from a

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[12] BWC 2 is a continuation of BWC 1 (Officer video)—Defendants produced the BWC in two separate files.

[13] Officer claimed in the interview that Mr. did not ask for an incontinence shower, Investigation Report at 14, but this does not seem credible, given that Mr. showed Officer a plastic bag that appeared to contain clothes and another incarcerated person said Mr. had an "emergency," which Officer appeared to acknowledge.

standing position—should have been avoided with a better verbal response from Officer [REDACTED] The specific force the officers used was also excessive in the circumstances. Yet the IERC found during all levels of review that the officers' use of force did not violate policy. *See* IERC at 3, 5, 6, 20. The Hiring Authority also did not sustain any allegations. *See* 402/403 at 1, 5.

(f) COR-[REDACTED], COR-[REDACTED][14] – AIU, Not Sustained

While being escorted to a medical evaluation for difficulty breathing, chest pains, and a panic attack, [REDACTED] momentarily paused. Rather than determine the reason for his pause, in response, the escort officer immediately threw Mr. [REDACTED] to the ground face-first, while his hands were cuffed behind his back. The force was dangerous, unnecessary, excessive, and violated policy. The escort officer's narrative of the incident appears to be inconsistent with the video footage, but multiple levels of IERC review failed to identify any problems with the force used in this case, the AIU investigator failed to highlight the inconsistencies between the officer's report and the video, and the Hiring Authority did not sustain the allegation of misconduct.

The fixed camera footage provides the clearest view of the use of force. Officer [REDACTED] is seen in the video escorting Mr. [REDACTED] through the dayroom. *See* AVSS at 11:52:49. Mr. [REDACTED] is being escorted for evaluation because he is having chest pains and experiencing a panic attack. *See* IERC at 3, Investigation Report at 4. Mr. [REDACTED] is handcuffed behind his back; no other incarcerated people are in the dayroom, and at least two other custody officers are in the dayroom. *See* AVSS (linked above) at 11:52:50. As he is being escorted, Mr. [REDACTED] suddenly comes to a stop. *See* AVSS (linked above) at 11:52:52. Immediately after Mr. [REDACTED] stops, Officer [REDACTED] sweeps his right leg in front of Mr. [REDACTED] legs, then throws Mr. [REDACTED] to the floor face-first:

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[14] This incident resulted in two different case numbers: COR [REDACTED] and COR [REDACTED]. At some point during each of the investigations, it appears that the investigators learned of the investigation, and the investigations eventually merged. The findings in each investigation report overlap.

AVSS at 11:52:55

As with many other uses of force at Corcoran, the class member is cuffed behind his back when being thrown down and cannot brace his fall into the ground. (Fortunately, Mr. [redacted] was able to tuck his shoulder and land on it so that he did not land on his face.) Once on the ground, Officer [redacted] places his forearm on the back of Mr. [redacted] neck and drives his head into the ground. *See* AVSS (linked above) at 11:52:57. At least five other officers arrive at the scene to respond to the incident.

After the use of force, the first words that can be heard are from Mr. [redacted] who says, "I'm not resisting! I'm not resisting!" *See* BWC at 11:52:56. He continues to say, "I'm not resisting," and it sounds like he is having difficulty getting enough air to speak. Officer [redacted] finally asks twice, "Why did you stop my escort?" *See* BWC (linked above) at 11:53:06. Mr. [redacted] says that he "tripped a little," that he did not mean to stop the escort, and he apologized. *See* Officer [redacted] BWC (linked above) at 11:53:10. Officer [redacted] responds, "No, you didn't. Do not stop my escort ever again, you understand me?" Mr. [redacted] asks to speak with the sergeant, and asks Officer [redacted] to move off of his head because he cannot breathe. Mr. [redacted] then lays on the floor without resisting until the video clip ends.

Officer [redacted] official report of the incident in the incident report package is inconsistent with the video. [15] Specifically, Officer [redacted] wrote that Mr. [redacted]

[15] This case is not the first time that Officer [redacted] used unnecessary force against a class member and was not honest in his report of the incident. In Plaintiffs' November 2023 Report, we wrote about COR-[redacted], in which Officer [redacted] gratuitously punched [redacted] in the abdomen while Mr. [redacted] was being

"suddenly pulled away from me, attempting to break escort. Simultaneously, Inmate [REDACTED] suddenly without warning or provocation, abruptly stopped escort and pushed his body weight backwards into me. His left shoulder made contact with my chest area." *See* Incident Report Package at 48. But the video does not show Mr. [REDACTED] pulling away from Officer [REDACTED] attempting to break the escort, or pushing his body weight backwards. To the extent that Mr. [REDACTED] made contact with Officer [REDACTED] chest, it appears incidental to his stopping as his expression does not change, no words are exchanged, and it does not appear that there was any intent to disrupt. The investigator did not ask Officer [REDACTED] about any of these inconsistencies between the video footage and Officer [REDACTED] account of the force. The investigator also did not ask Mr. [REDACTED] why he paused during the escort, which is critical to understanding the use of force in this case. *See* Investigation Report at 4. And, relying on his own narrative, Officer [REDACTED] issued Mr. [REDACTED] an RVR for "Willfully Resisting a Peace Officer in the Performance of Duties." *See* RVR Log No. 7324427 at 66.

Officer [REDACTED] did not have an appropriate justification to use force in this situation. *See* 15 C.C.R. § 3268(a)(4) (allowing "immediate force" in situations "that constitute[] an imminent threat to institution/facility security or the safety of persons," including to "subdue an attacker, overcome resistance or effect custody."); DOM § 51020.4. Mr. [REDACTED] was not attacking Officer [REDACTED] nor was it clear in that moment that he was actively resisting. Instead of figuring out what was happening in that moment—had he tripped (as he said while on the floor), were his chest pains or breathing worsening causing him to stop and catch his breath, or was he attempting to refuse escort—Officer [REDACTED] rushes to force, dangerously sweeping Mr. [REDACTED] legs out from under him while he is handcuffed behind his back. Officer [REDACTED] had many other courses of action he could have taken, including asking Mr. [REDACTED] why he stopped or calling in the multiple other officers in the area for help, but Mr. [REDACTED] brief change-of-pace did not give Officer [REDACTED] license to take Mr. [REDACTED] to the ground in the violent manner in which he did.

Neither the IERC nor the hiring authority identified any issues with this use of force. Each level of the IERC found the force to be compliant with policy. Lieutenant [REDACTED] who conducted the first-level review as the incident commander, largely recycled Officer [REDACTED] narrative, noting, "[D]uring the escort[,] inmate [REDACTED] stopped the escort and turned his body as if he was attempting to break free from Officer [REDACTED] [sic] grasp, not knowing his intentions Officer [REDACTED] utilized physical force to take inmate [REDACTED] to the ground." *See* IERC at 3. As described above, however, that narrative is inconsistent with the video footage. The second level of review, conducted by Captain [REDACTED]

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restrained on a hospital bed. Officer [REDACTED] then was dishonest about the timing of and his justification for the punch, but the Hiring Authority failed to sustain any use-of-force allegations. *See* November 2023 Report at 26-28. Plaintiffs nominated this case to discuss in our quarterly case review meetings, but the parties were not able to discuss it.

similarly found the force to be compliant with policy. *Id.* at 4-5. And the third level of review, conducted by Associate Warden Perez, noted, "No UOF issues identified." *Id.* at 7. The Hiring Authority did not sustain misconduct. *See* 402/403 at 1-2.

The fact that at least four different levels of CDCR leadership reviewed this force and found it to be compliant with policy is deeply concerning. Either the process for conducting the reviews is not working because none is taking a critical look at the force and comparing the incident reports to the footage, which demonstrates a significant failure in CDCR's accountability system, or CDCR's use-of-force policy must make clear that momentarily stopping an escort for a medical emergency does not justify staff throwing someone to the ground face first while handcuffed. Either outcome requires significant changes to the Department's use of force policies and practices.

(g) LAC – [REDACTED] – AIU, Not Sustained

In this case, Officer [REDACTED] failed to de-escalate a verbal dispute and pepper sprayed class member [REDACTED] in the face. CDCR failed to consider any discipline against Officer [REDACTED] for his actions leading to an avoidable use of force. In addition, the Hiring Authority failed to address the case until after the statute of limitations expired, making adverse action impossible.

A third-party witness reported seeing Officer [REDACTED] pepper spray a person in the face after a dispute about dayroom being shut down.[16] The investigator identified the incident as involving Mr. [REDACTED] and reviewed BWC footage of the incident. About forty seconds into the video footage, Mr. [REDACTED] walks over from a dayroom table and says to Officer [REDACTED] "As soon as you say we're not having dayroom because of [me], you're automatically—that's disrespect." *See* BWC at 19:34:46. According to incident reports, officers were not releasing dayroom because of Mr. [REDACTED] reportedly refusing to go back into his cell. *See* Incident Report Package Staff Narrative at 56. Mr. [REDACTED] is therefore understandably agitated based on his belief that Officer [REDACTED] publicly blamed him for the dayroom delay, thereby risking his safety.

Despite the fact that he may have caused the situation that gave rise to Mr. [REDACTED] becoming upset and fearing for his safety, Officer [REDACTED] fails to take any action to defuse the situation. In response to Mr. [REDACTED] expressing his safety concerns, including taunting Officer [REDACTED] to go ahead and release the dayroom and "let's see who wanna

[16] The case arose from the semiannual interviews required by the Court's Five Prisons Remedial Order. As reflected on the interview sheet produced to Plaintiffs' counsel, another class member alleged, "I/m was sprayed because he was arguing with C/O [REDACTED] on 3/W. [REDACTED] said he was going to shut down program and the i/m wanted to talk to the sgt and [REDACTED] sprayed him." *See* LAC Category 4 Questionnaires, Q4 2022 Interviews (page 61).

fight" (referring to other incarcerated people who will want to fight him for delaying dayroom release), Officer states, "OK, you wanna fight?" and reaches for the OC spray canister on his right hip. Mr. backs away, saying, "It's whatever, I don't give a fuck." *See* BWC (linked above) at 19:34:59. Officer then unholsters the OC spray, steps toward Mr. and sprays him directly in the face with OC spray from only a few feet away. *Id.* at 19:35:03.

Officer violated policy by escalating, rather than de-escalating, the verbal dispute with Mr. that ultimately led to a use of force. Under CDCR policy, officers must where possible employ verbal persuasion to mitigate the need for force. DOM § 51020.5. Here, Mr. was highly agitated because he believed that Officer endangered him by blaming him in front of other incarcerated people for dayroom being delayed. Officer knew that. Instead of attempting to calm him down and assuage any safety concerns, Officer escalated the encounter by responding, "OK, you wanna fight?" a move certain to lead to a use of force, given Mr. agitation. A serious use of force then ensued.[17]

Neither the IERC review nor the AIU investigator appeared to consider the question of Officer escalation. In fact, the IERC review includes misleading statements that Officer used force to "[s]ubdue an attacker," even though Mr. did not attack or even attempt to attack Officer *See* Incident Commander's Review/Critique at 69; IERC Use of Force Review and Further Action Recommendation at 77. The IERC found that Mr. "committed the act of Assault on a Peace Officer" and that his "actions were sudden and without warning necessitating an immediate reaction from staff." *See* IERC Critique and Qualitative Evaluation at 80. That narrative inaccurately characterizes the encounter and obscures that Officer created the situation leading to the use of force. The AIU investigator also did not interview Officer to ask him about his actions, such as why he escalated the encounter following the "fight" comment.

In addition, delays by the Hiring Authority resulted in this case not being resolved until after the statute of limitations had expired. The AIU investigator completed the investigation and referred it to the Hiring Authority for review on July 11, 2023, almost eight months before the statute of limitations was to expire (on March 2, 2024).[18] *See*

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[17] Also, assuming Officer told other incarcerated people that dayroom was not happening because of Mr. Mr. was right to be concerned that Officer had endangered him. The video begins in the middle of the incident, so it is not clear whether Officer was blaming Mr. for the dayroom delay, as Mr. and the class member who reported the incident alleged.

[18] There is a discrepancy in the investigation report that suggests the date of discovery was actually November 3, 2022 during a quarterly interview, four months prior to the date entered in AASTS, making the delay more egregious.

Investigation Report at 6; 402. However, the Hiring Authority did not conduct a 402/403 conference until May 22, 2024. *See* 402. As a result, had the Hiring Authority found a policy violation (as should have occurred), the Hiring Authority could not have imposed adverse action against Officer [REDACTED] for his dangerous misconduct that resulted in a use of force.

(h) COR – [REDACTED] – AIU, Not Sustained

In this case, Officer [REDACTED] used immediate and unnecessary force during a verbal disagreement with [REDACTED]. Mr. [REDACTED] was seated in a chair and handcuffed at the time, and Officer [REDACTED] threw Mr. [REDACTED] backwards onto the floor. One level of the IERC identified that the force was unnecessary, but the subsequent investigation identified no use-of-force issues and did not sustain the misconduct despite clear video evidence that the use of force violated policy.

On April 27, 2023, Mr. [REDACTED] was experiencing chest pains while in his cell and requested to be evaluated by medical staff. Officer [REDACTED] handcuffed Mr. [REDACTED] behind his back, opened his cell door, and began escorting Mr. [REDACTED] to the first tier of his building for the medical evaluation. *See* Incident Report at 28. The video footage in the case file begins during the escort and immediately outside of Mr. [REDACTED] cell. During the escort, Mr. [REDACTED] informs Officer [REDACTED] that he is twisting his arm. *See* BWC 1 at 11:27:02. Officer [REDACTED] says he is not twisting Mr. [REDACTED] arm and orders him to walk down the stairs. *Id.* at 11:27:03. Eventually, they walk down the stairs. *Id.* at 11:27:00-11:27:28. Once Mr. [REDACTED] has been escorted down the stairs and is seated with two other officers standing by, Mr. [REDACTED] and Officer [REDACTED] continue to go back and forth about Officer [REDACTED] escort practices while medical staff assess Mr. [REDACTED] symptoms. *Id.* at 11:27:35. During the exchange, Mr. [REDACTED] says, "You expect me to not tell you that you're twisting my arm when you're twisting my arm?" *Id.* at 11:27:57. Officer [REDACTED] responds by denying that he was twisting Mr. [REDACTED] arm. *Id.* at 11:28:02. Mr. [REDACTED] continues, "Bro, I felt what you was doing, bro. Bro, you a corrupt peace officer. Just like you slammed bro on his teeth and cracked bro's teeth the other day, bro." *Id.* at 11:28:04. Shortly after, Mr. [REDACTED] comments, "You the only CO that do that weird ass shit." *Id.* at 11:28:55. Officer [REDACTED] retorts that Mr. [REDACTED] "like[s] to talk a lot." *Id.* at 11:28:58. Mr. [REDACTED] asks "what you gonna do about me talking?" and calls Officer [REDACTED] "soft" as medical staff continue their assessment. Mr. [REDACTED] and Officer [REDACTED] continue discussing the issue for several minutes. *Id.* at 11:29:14.

Mr. [REDACTED] antagonizes Officer [REDACTED] He says again that he is squeezing his arm tightly. *Id.* at 11:32:04. Officer [REDACTED] and Mr. [REDACTED] continue to argue about Officer [REDACTED] grabbing his arm tightly and Mr. [REDACTED] can be seen turning his head to speak with Officer [REDACTED] until Officer [REDACTED] places his hand on Mr. [REDACTED] chest and throws him from his chair backwards onto the concrete floor for not following his order to look forward. *Id.* at 11:32:51; *see also*, BWC 2 at 11:32:51. The two other officers who were watching over Mr. [REDACTED] assist Officer [REDACTED] in flipping

Mr. [REDACTED] onto his stomach once he hits the ground. *See* BWC 2 at 11:32:52. At the time Officer [REDACTED] decides to use force, Mr. [REDACTED] does not appear to pose a physical threat. And once on the floor, Mr. [REDACTED] maintains his composure and does not resist. Mr. [REDACTED] can be heard saying, "You just did that for no reason. I didn't even resist. I didn't even resist." *Id.* at 11:33:14. An incarcerated person off camera yells "I'm a witness.". *Id.* at 11:33:29. A sergeant comes to speak with Mr. [REDACTED] a few minutes later while he is on the ground, and Mr. [REDACTED] says, "I'm good, [REDACTED]. I'm not trying to attack nobody or nothing." *Id.* at 11:35:00. Mr. [REDACTED] is helped up by other officers and he takes a seat without further incident.

Officer [REDACTED] use of immediate force in this case was unwarranted and in violation of policy. During his AIU interview, Officer [REDACTED] claimed that he used force because Mr. [REDACTED] presented an "imminent threat" when he "was agitated, not listening to verbal orders given, turning his head and body towards his ([REDACTED] direction, attempting to get out of the chair, and fearing for [Officer [REDACTED] and staff's safety, not knowing [REDACTED] intentions, he ([REDACTED] used physical force to place [REDACTED] onto the ground." *See* Investigation Report at 5. Officer [REDACTED] only order was for Mr. [REDACTED] to face forward. However, as the video shows, Mr. [REDACTED] does turn his head to talk to Officer [REDACTED] but there is no indication that Mr. [REDACTED] was attempting to get up or turn his body to face Officer [REDACTED] in a way that would pose an imminent threat. Not only is Officer [REDACTED] statement to the AIU investigator inconsistent with the video, it is also inconsistent with his own prior descriptions of this incident. Officer [REDACTED] authored two incident reports[19] and an RVR, and none of these documents mention Mr. [REDACTED] attempting to stand up, nor do they offer a compelling explanation of how Mr. [REDACTED] presented an imminent threat.[20] His use of immediate force failed to comply with CDCR policy. *See* 15 C.C.R. § 3268(a)(4) (allowing staff to use immediate force to "subdue an attacker, overcome resistance, effect arrest and custody, or prevent escape" and not for the sole purpose of gaining compliance with a lawful order); *see also* DOM § 51020.4.

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[19] After drafting his original incident report narrative, Officer [REDACTED] was asked to provide further clarification on "what necessitated the use of force." *See* Incident Report at 28-29. Officer [REDACTED] supplemental report states he utilized force because he felt Mr. [REDACTED] "tense his right arm and slight[ly] move it up," and Mr. [REDACTED] had said Officer [REDACTED] would "not meet him in his cell to go toe to toe." *Id.*

[20] Officer [REDACTED] issued Mr. [REDACTED] for "resisting a peace officer" during this incident. *See* CDCR 115 Rules Violation Report Log# 7301540 at 59. But, after reviewing the video, the Senior Hearing Officer (SHO) found, and the Chief Disciplinary Officer (CDO) affirmed, that Mr. [REDACTED] did not resist staff. Mr. [REDACTED] was found not guilty of that offense.

One level of the IERC review, the first-level manager's review conducted by Captain ██████, flagged this case for administrative review "for possible unnecessary force." *See* IERC at 5. Then, the IERC process appears to have paused pending this AIU investigation. After the Hiring Authority did not sustain the allegation of improper force in the AIU investigation, the IERC process continued and the second-level manager's review noted only that "[n]o UOF issued [were] identified."[21]

This case, like the many other uses of force at Corcoran, underscore the problems with Defendants' use of force policies and practices. This class member raised a relatively small concern with the officer—that the officer was twisting his arm. Instead of acknowledging the complaint and responding, the officer disputes that he is causing pain, doubles down, and continues to escalate the situation over the next several minutes. Ultimately, out of apparent frustration with the class member who has mental illness, the officer throws him to the ground while handcuffed in disregard for his safety, despite him being seated in an empty dayroom and presenting no imminent threat. The force was not compliant with CDCR policy, but the IERC process and the Hiring Authority failed to hold the staff member accountable for his dangerous actions.

3. Defendants Continue to Fail to Hold Staff Accountable for Other Very Serious Misconduct

As in each quarterly report, Plaintiffs' counsel report on accountability system failures in cases where there is evidence that serious staff misconduct occurred. Defendants often object, claiming these cases are not disability-related and are not relevant to the *Armstrong* case. The failure to hold staff accountable for any incident of serious misconduct—as in the cases below, including in one where staff failed to conduct count pursuant to policy and therefore failed to identify (and potentially prevent) a death in custody—impact *all* incarcerated people. But *Armstrong* class members are uniquely impacted because, after witnessing or directly experiencing the serious harm, they still must rely on the very same staff members engaged in the misconduct to obtain needed disability accommodations. Thus, Defendants' accountability failures directly impact the ability of *Armstrong* class members to get help from staff.

(a) RJD – ██████ – AIU, Not Sustained

In this case, incarcerated witness ████████████████████ alleged that custody staff failed to follow count and security check policies resulting in the failure to

[21] The first-level manager's review in the IERC process was completed on May 18, 2023, then the allegations were routed to the AIU for an investigation. *See* IERC at 5. The AIU investigation concluded on April 16, 2024. *See* Closure Memo. It appears that the final level of the IERC process, the second-level manager's review, was then completed on May 8, 2024, after the AIU investigation had concluded. *See* IERC at 7.

discover [REDACTED] who was found deceased in his cell by an incarcerated person. *See* CST Direct Entry at 3. Despite the gravity of the allegation, the investigator conducted an incomplete investigation and failed to identify and present to the Hiring Authority relevant evidence that staff in fact did fail to follow policies. Consequently, no one was held accountable for the clear violation.

The investigator, after reviewing BWC footage, merely reported that at 12:15:36, Officer "[REDACTED] started the Custody Count on the lower tier" and at 12:17:50, he "completed the Custody Count." *See* Investigation Report (IR) at 4. The investigator failed to note that in conducting count Officer [REDACTED] walked past cell 116, where Mr. [REDACTED] was housed, and failed to confirm that Mr. [REDACTED] was "living [and] breathing." *See* BWC at 12:16:09; AVSS at 12:16:09. Mr. [REDACTED] was discovered unresponsive in his cell a little more than an hour later. *See* IR at 3.

According to the DOM § 52020.5, "[a] positive/physical count means to count a living, breathing person and physically see that person." BWC footage confirms that Officer [REDACTED] did not fulfill these requirements. In fact, Officer [REDACTED] does not even stop nor look in Mr. [REDACTED] cell. The investigator fails to even cite to the custody count requirements and then fails to include the relevant information regarding Officer [REDACTED] actual conduct during count which shows a clear policy violation.

Policy requirements regarding count and security checks—which are fundamental to the safety and security of a prison—are central to the role of the custody officer. In this case, because it was alleged that staff failed to follow policy regarding a fundamental aspect of their job and a class member died, all staff reviewing this allegation had a heightened responsibility to determine what happened here. Instead, the investigator produced an inadequate and incomplete report, failing to reference any policy requirements and failing to accurately document Officer [REDACTED] conduct in the context of those policy requirements. This had the effect of obfuscating the misconduct in the report that was provided to the Hiring Authority. Even still, given that a death occurred in this case, the Hiring Authority also should have taken steps to look more closely at this case. If that would have occurred the Hiring Authority would have independently discovered the failure of the investigator to report the clear misconduct that occurred in this case.

4. AIU Investigations Continue to be Delayed

AIU staff are continuing to fail 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,[22] and 180 days for investigations conducted by Special Agents. The chart below shows that, for investigations the AIU received in September 2023 to June 2024,[23] the AIU closed 37.1% of the investigations late. For the most recent three months of available data (April 2023 to June 2024), the AIU closed 49.9% of investigations late. The data shows that the problems with delayed investigations are getting much worse.

	Month Rec'd	Closed-On Time	Closed-Past Due	Open	Open-Past Due	Total	% Late
2023	September	142	56	0	1	199	28.6%
	October	184	50	0	1	235	21.7%
	November	141	31	0	3	175	19.4%
	December	196	54	1	6	257	23.3%
2024	January	225	71	0	41	337	33.2%
	February	159	55	0	11	225	29.3%
	March	133	69	2	5	209	35.4%
	April	148	62	0	28	238	37.8%
	May	283	140	2	120	545	47.7%
	June	163	50	1	195	409	59.9%
		1774	638	6	411	2829	37.1%

II. 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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[22] In the last fourteen months for which Plaintiffs have data (September 2023 to October 2024), the AIU assigned 98.7% of cases to be investigated by custody supervisors. The CST only assigned 59 cases (1.3%) to be investigated by Special Agents.

[23] Plaintiffs only present the data for September 2023 to June 2024 because the vast majority of investigations from more recent months (1) are not yet complete and (2) could not possibly be late because they have not yet run up against the deadlines in the Remedial Plans.