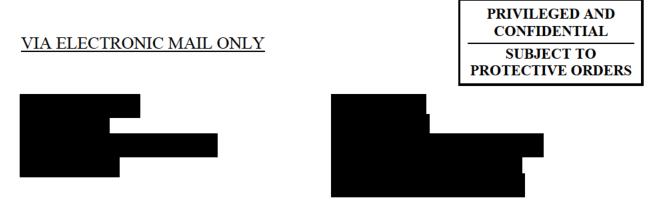


101 Mission Street, Sixth Floor San Francisco, California 94105-1738 T: (415) 433-6830 • F: (415) 433-7104 www.rbgg.com



November 15, 2024

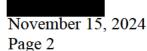


Re: Armstrong v. Newsom: Plaintiffs' November 2024 Review of CDCR's Accountability System at the Six Prisons
Our File No. 0581-03

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





## TABLE OF CONTENTS

|    |      |        |       |                         |  | Page |
|----|------|--------|-------|-------------------------|--|------|
| I. | INVE | ESTIGA | ATION | IS AND IMPOSE           | ASED AND INCOMPLETE<br>ED INAPPROPRIATE AND                | 4    |
|    | A.   |        | -     | _                       | d Inappropriate Disciplinary Decisions to Accountability   | 4    |
|    |      | 1.     |       |                         | to Fail to Hold Staff Accountable for ff Misconduct        | 4    |
|    |      |        | (a)   | RJD-                    | - Local, Not Sustained                                     | 5    |
|    |      |        | (b)   | SATF-                   | - Local, Not Sustained                                     | 6    |
|    |      |        | (c)   | LAC-                    | - Local, Not Sustained                                     | 8    |
|    |      |        | (d)   | RJD-<br>Local, Sustaine | RJD- RJD- – – – – – – – – – – – – – – – – – – –            | 10   |
|    |      | 2.     |       |                         | to Fail to Hold Staff Accountable for essary Uses of Force | 12   |
|    |      |        | (a)   | COR -                   | - AIU, Not Sustained                                       | 13   |
|    |      |        | (b)   | LAC-<br>LOR – Collusio  | – AIMS to OIA, Sustained (Adverse, on)                     | 15   |
|    |      |        | (c)   | SATF-                   | – AIU, Not Sustained                                       | 19   |
|    |      |        | (d)   | CIW –                   | – AIU, Not Sustained                                       | 20   |
|    |      |        | (e)   | LAC -                   | - AIU, Not Sustained                                       | 22   |
|    |      |        | (f)   | COR-<br>Sustained       | , COR- – AIU, Not  | 24   |
|    |      |        | (g)   | LAC-                    | - AIU, Not Sustained                                       | 27   |
|    |      |        | (h)   | COR-                    | - AIU, Not Sustained                                       | 29   |
|    |      | 3.     |       |                         | to Fail to Hold Staff Accountable for isconduct            | 31   |
|    |      |        | (a)   | RJD                     | - AIU, Not Sustained                                       | 31   |
|    |      | 4.     | AIU   | Investigations Co       | ontinue to be Delayed                                      | 32   |
| П  | CON  | CLUSI  | ON    |                         |  | 33   |

# 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.<sup>1</sup> 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

<sup>&</sup>lt;sup>1</sup> 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.

#### - Local, Not Sustained (a) RJD – 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. 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. 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

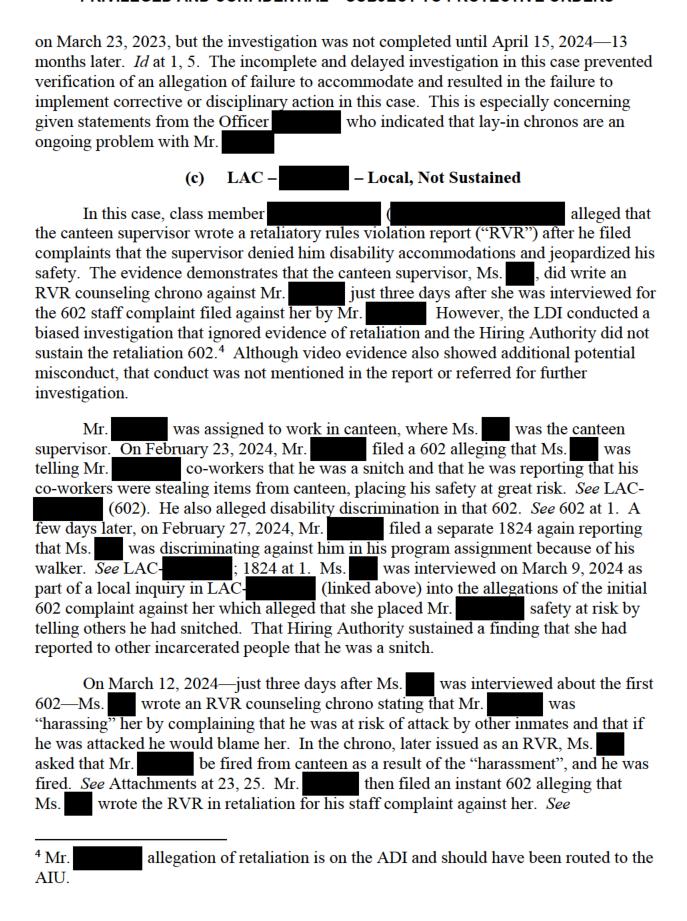
may have gotten the name, rank or date wrong, nor did the investigator ask him what time

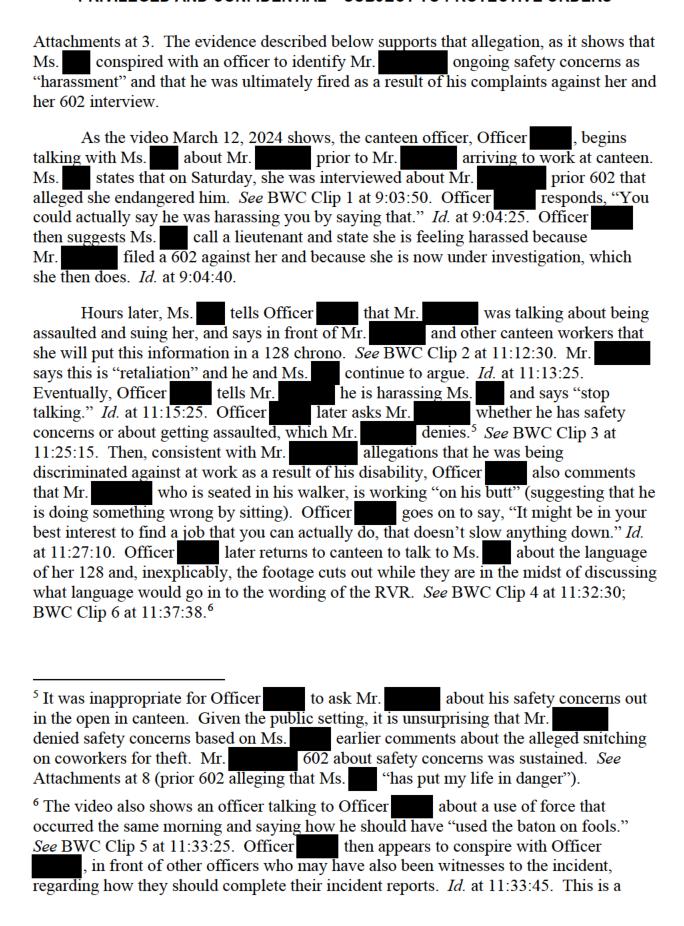
| and where the interaction occurred so that BWC evidence could be requested. There was a strong possibility that Mr. was mistaken about the rank of the officer given that he also referred to as a "C/O." He also reported it was caught on BWC, which would rule out the possibility of being a lieutenant 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 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. <i>See</i> OP 58, Sign Language Interpretation Services at 28. The investigator should have reviewed SLI logs from February 2023 to determine whether Mr. 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. 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. 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." <i>See</i> IR at 2. Because the investigation was so incomplete, it is impossible to determine what happened here and whether staff failed to accommodate Mr.  |
| (b) SATF – 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.  (a) alleged that, despite having a confirmed disability warranting a temporary lay-in, his vocational instructor failed to accommodate him and required Mr.  to walk a long distance to personally show the instructor the lay-in chrono. See 602 at 10-11. This long walk caused Mr.  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. 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. 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 and , verified the lay-in                          |
| chrono, and Officer called his vocational supervisor, Mr. , to inform him                         |
| that Mr. would not be attending class. <i>Id.</i> at 3. In his interview with the LDI,            |
| Officer confirmed that he called Mr. but stated that his assurance to                             |
| Mr. that Mr. had a valid lay-in chrono "wasn't good enough for                                    |
| instructor Id. Officer stated that "this has been a continuing issue                              |
| with instructor Id.   |
| With instructor   |
| Central to the claim in this case is Mr. allegation that Mr.                                      |
| required him to walk through work change and all the way to his vocational classroom to           |
| show his lay-in chrono to Mr. 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. had accommodated Mr. disability and accepted the                                   |
| lay-in chrono without requiring him to report in-person, reportedly caused Mr.                    |
| to go "man-down" in the Facility A clinic. <i>Id</i> . Mr. disputed this version of events        |
| in his interview with the LDI. He alleged that he never required that Mr.                         |
| report to the classroom, and that he only asked that Mr. have his lay-in                          |
| "confirmed by a valid source," such as a free-staff member or custody officer. <i>Id.</i> at 3-4. |
|   |
| The investigator failed to reconcile conflicting accounts of what happened in order               |
| to determine whether Mr. neglected to accommodate Mr. 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. account of events—with Mr. 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. <sup>3</sup> The investigator also could have, but did not, review      |
| Mr. 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              |

<sup>2</sup> One week after this incident, Mr. had laparoscopic inguinal hernia repair surgery. *See* Surgical Consultation (Feb. 9, 2023) at 10.

<sup>&</sup>lt;sup>3</sup> 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.

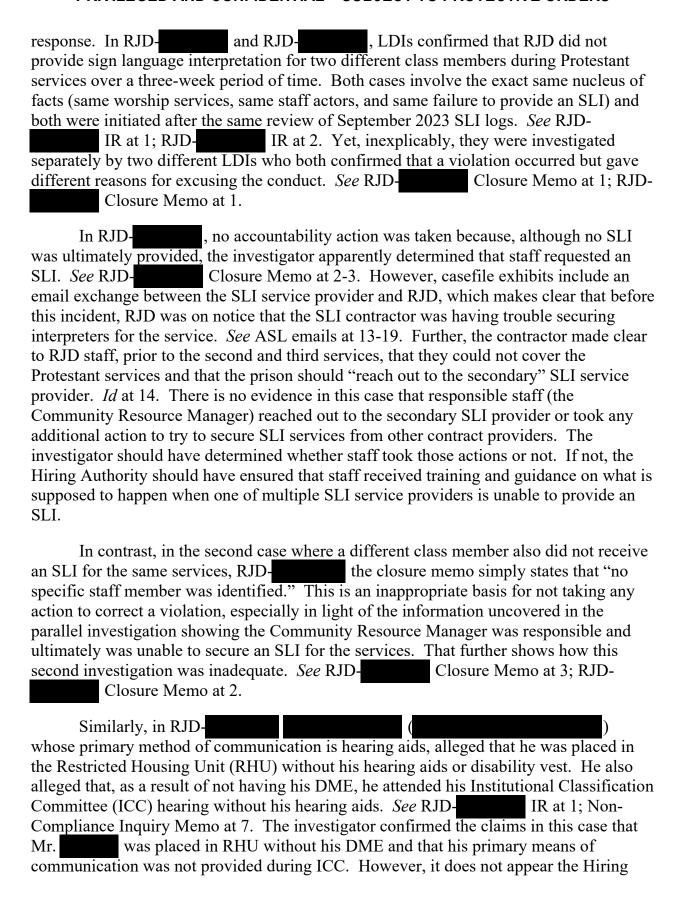


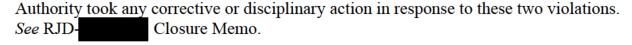


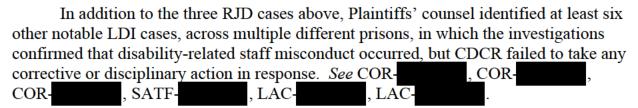
| The LDI report in this case is biased and incomplete. First, it is unclear why the   |
|--|
| video clip ended in the middle of the staff members discussing the wording of the RVR.   |
| This evidence is material to the allegation that the RVR was retaliatory and was central to  |
| the investigation. 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   |
| 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.   |
| 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

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







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.

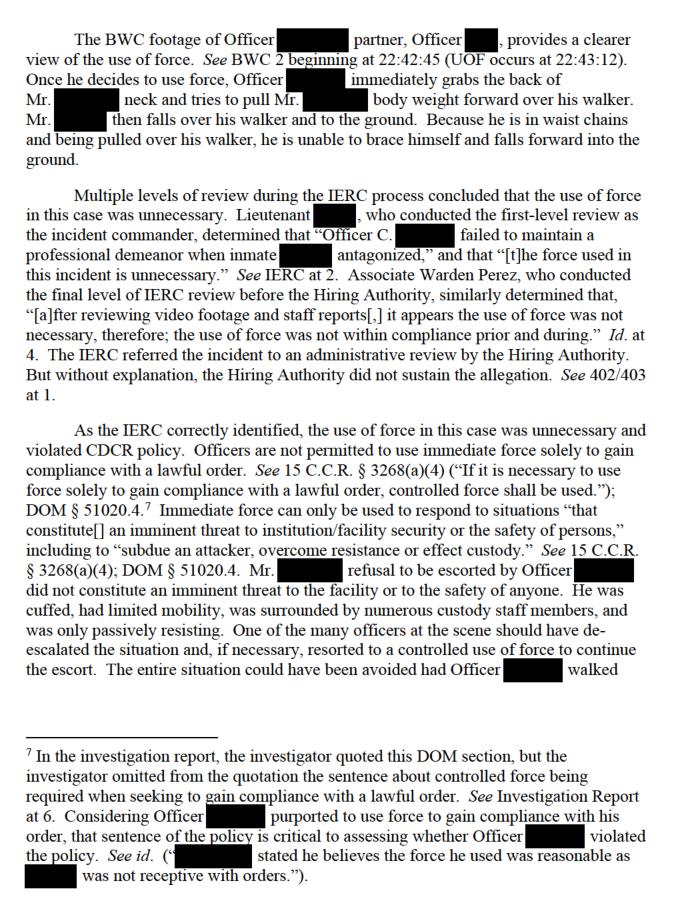
Plaintiffs again request to meet with Defendants to discuss what remedies CDCR might take to address these serious failures that continue to endanger class members.

# (a) COR - - AIU, Not Sustained

In this case, a correctional officer threw a suicidal class member, 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. 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 ordered Mr. reported to the investigator out in his cell and Mr. complied. Officer jumpsuit had been cut in half and Officer that Mr. did not want to return the altered clothing to Mr. sparking a dispute between the two. *Id.* at 4. After a back-and-forth, Officer opened Mr. 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. and Officer 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 opening cell door. See BWC 1 at 22:42:01. Officer escorts Mr. the officer's podium; Mr. is in waist chains and using a walker because he has a mobility disability. Upon reaching the podium, Mr. says to the sergeant, "Hey, I'm letting you know right now, it's going to be a problem with him, bro," referring to 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 and that they are exiting in that direction. Officer says to Mr. Mr. "Okay, let's go." See BWC 1 (linked above) at 22:42:20. Mr. does not move and again tells the sergeant in a calm voice that he does not want to be escorted by Officer At the time, at least six custody staff and one mental health staff and no other incarcerated person member are standing in the dayroom near Mr. can be seen in the dayroom. Another officer responds to Mr. "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, And Officer says, "You don't get to dictate who escorts you. Let's go. Come on." Mr. does not move his and says, "You going to make me? Make me." He body but looks at Officer repeats "make me" several times, and Officer tells Mr. that he is giving him a direct order. See BWC 1 (linked above) at 22:42:45. After about twenty more seconds of Mr. telling Officer to "make me go," Officer to the ground. See BWC 1 (linked above) at 22:43:14. Mr.



away. Instead, Officer 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 threw Mr. down, is excessive and fails to take into mobility disability in the application of force. consideration Mr. Lastly, this incident is not the first time that Plaintiffs' counsel has raised issues with Officer excessive and unnecessary use of force against an Armstrong class member. In 2021, Plaintiffs wrote a letter to Defendants about how Officer 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 . In that letter, we described a separate incident from a week later in which Officer kicked that same class member. Id. at 2. It is our understanding that Officer was not held accountable for either of those incidents. We are troubled by the fact that several years later, Officer continues to use excessive and unnecessary force against vulnerable class members and faces no accountability, despite significant changes to the accountability system. LAC -- AIMS to OIA, Sustained (Adverse, **(b)** LOR - Collusion) In this case, Officer 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 not received discipline for using improper force against a class member, despite multiple serious policy violations. Here, Officer 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 use improper immediate force on when he reached his hand through the food port during a temperature check. On February 9, 2022, Officer was assisting a psychiatric technician during temperature checks on the upper tier. At 8:53:51, PT cell and asks if he wants a temperature check, to which he approaches Mr.

| affirms that he does. When Officer                | opens the food port, Mr. reaches          |
|---|---|
| his arm upwards through the food port and says    | "peaceful protest." See BWC at 8:54:07.   |
|   | wrist and repeatedly yells "put your      |
|   | uching me, man?" and "you're f***ing      |
|   |   |
| my hand up." Other officers arrive within a min   | -   |
| while stretching his arm back, making it nearly i | mpossible for him to submit to            |
| handcuffs. The officers handcuff Mr.              | ough the food port after several minutes. |
| Officer and PT contin                             | nue temperature checks on the upper tier, |
| and Officer explains his use of force             | 11  |
|   | toward you, that's why I grabbed him."    |
|   | ove) at 8:57:50.8 A few minutes later,    |
| `   |   |
| <u> </u>  | rature checks and have the following      |
| conversation:                                     |   |
| Officer You gotta write.                          |   |
| PT Why?   |   |
| Officer Because he reached                        | toward you.                               |
| PT So I have to write?                            | ,   |
| Officer That's why I grabbe                       | d   |
| That's why I grabbe                               | u.  |
| •••   |   |
|   |   |
| Officer You say that I did a                      | temperature check, opened the             |
| food port, he tried to reach toward you I g       | rabbed 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 actions during the use of force violated policy. 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

<sup>&</sup>lt;sup>8</sup> At 8:58:53 another officer walks by and asks what happened, and Officer 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.

<sup>&</sup>lt;sup>9</sup> 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 violated policy is consistent with Officer 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. stated his intention to protest peacefully, reached his arm upwards, and did not make contact with PT   |
|---|
| However, the Hiring Authority ultimately did not sustain a use of force policy violation in this case. <i>See</i> 402/403 at 1. The IERC closed the case with no further action over two years after the date of incident. <i>See</i> 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 accountable for previous violations prevented the Hiring Authority from issuing progressive discipline. Plaintiffs have reported on Officer six times for prior use of force policy violations. 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 file "shows [he] ha[s] no prior adverse actions." See NOAA at 7.  |
| Worse, Officer violated use of force policy <u>four times within three</u> weeks in 2022, including this incident. These violations include one of the most   |
| Descriptions of and links to the six cases follow. In used improper immediate use of force to move class member with mobility disabilities from cell. See Feb. 2024 Report at 11-15. In processor of force of failed to descalate a situation during an escort that led to a use of force. See Feb. 2024 Report at 14. In LAC-processor of failed to a use of force. See Feb. 2024 Report at 14. In LAC-processor of force of the top bunk of his cell onto the concrete floor. See Feb. 2023 Report at 8-9. In LAC-processor of force of force of 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-processor of force of force against a class member who was refusing to exit a holding cage. Second, Officer of then unnecessarily and punitively peppersprayed 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-processor 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 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. | Violation(s)  | Incident<br>Date     | Sustained<br>Allegations<br>for                                      | Disciplin<br>e for   | 402/403<br>Date  | Closure<br>Date   |
|----------|---|----------------------|--|--|--|---|
|          | Improper immediate use of<br>force to move class member<br>with mobility disabilities from<br>cell  | October<br>18, 2022  | None   | None   | May 23,<br>2023  | July 21,<br>2023  |
|          | Failure to de-escalate leading to UOF   | November 23, 2022    | None   | None   | May 30,<br>2023  | July 21,<br>2023  |
|          | Unnecessary and excessive<br>force when pulling a mentally<br>ill and unresponsive class<br>member from the top bunk                                      | February<br>11, 2022 | Dropping<br>shield<br>during cell<br>extraction                      | Correctiv<br>e-LOI   | 4/27/2022  | May 2,<br>2022 (from<br>email, not<br>closure<br>memo)    |
|          | Excessive force when Officer 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,<br>2022 (from<br>email, not<br>closure<br>memo) |
|          | (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;<br>(2) Pls<br>requested<br>documents<br>on May 12,<br>2023 | (1) None;<br>(2) Pls<br>requested<br>documen<br>ts on<br>May 12,<br>2023 | No<br>402/403  | September<br>30, 2022                                     |
|          | Improper immediate use of<br>force against a class member<br>with serious illness who was<br>holding a food port  | March 1,<br>2022     | None   | None   | None   | September<br>8, 2022                                      |

In addition to the use of force violation, Officer also violated policy for collusion on report writing in this case. Officer instructed PT to write in her incident report that he grabbed Mr. because Mr. 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,

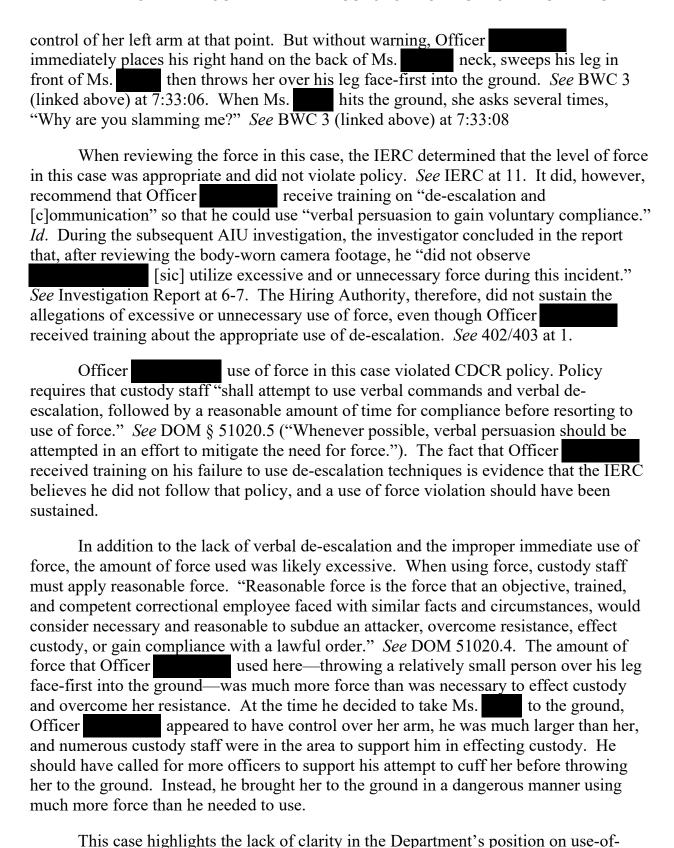
the Hiring Authority should have raised the discipline based on aggravating factors, and should have considered B4 ("Any independent act(s) that prevents or interferes with the reporting of misconduct," (456789)). See 402/403 at 2-3; Disciplinary Matrix.



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 ) and Officer between Mr. 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 told Mr. 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. has been told to return to his building. appears frustrated at Officer for dismissing his concerns. In his throws a notebook near Officer frustration, Mr. See BWC 1 at begins to walk away as Officer 12:46:02. Mr. follows him and then shirt and shoves him towards a fence to restrain him. BWC (linked grabs Mr. above) at  $\overline{12:46:03-1}2:46:13$ . Another officer, Officer attempts to deescalate the situation but is unsuccessful. See BWC 2 at 12:46:04. Mr. submits to restraints and is escorted over to a holding cage in the program office. Officer is leading the escort and is the only officer holding onto Mr. See BWC 2 (linked above) at 12:46:47. Once the holding cage door is opened, Officer forcefully throws Mr. into the holding cage face first and it appears that Mr. 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. had already submitted to restraints and was walking without any signs of Mr. resistance to the holding cage. After excessive and unnecessary force is used, spits at Officer Officer is clearly enraged by this action, and proceeds to slam Mr. into the back of the holding cage multiple times and face and neck area. See BWC 2 at 12:47:07; see pushes his hands into Mr. 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. and Officer stays in the holding cage without incident. See BWC 3 (linked and Mr. above) at 12:47:11. At the end of the footage, Officer 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.

| 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 who was clearly agitated, could remove himself from the situation. By failing to do so, they allowed Officer to continue his interaction with Mr. which ultimately resulted in an unnecessary and excessive use of force when Officer pushed Mr. into the back of the holding cage face first. Mr. posed no threat to the officers and had already submitted to restraints. Officer actions escalated the encounter, prompting Mr. to spit and then Officer used additional, retaliatory and excessive force against Mr. 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. 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 – AIU, Not Sustained  |
| In this case, Officer failed to de-escalate a situation with , and his failure to de-escalate led to a violent use of force.  Ms. filed a 602 alleging that the force was unnecessary and excessive. At the conclusion of the investigation, Officer 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 should have de-escalated the situation before resorting to force, CDCR did not sustain any use of force violation against Officer   |
| On February 22, 2023, custody staff conducted a mass cell search in Ms. housing unit. After completing the searches, custody staff ordered people to return to their cells. Body-worn camera shows Ms. 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 says that custody staff will come back to talk to her, but Ms. becomes increasingly frustrated and loud, insisting that she needs her headphones and her boost-a-roo. See BWC 2 at 7:32:32. Lieutenant says her name several times to initiate a conversation, but Ms. looks past Lieutenant to demand that Sergeant return her items. After engaging with Ms. for around 40 seconds, Lieutenant orders Officer to "effect custody." See BWC 3 at 7:32:57. In response to the lieutenant's order, Officer walks in front of Ms. and grabs her left arm. See BWC at 7:33:01 (linked above). Sergeant body-worn camera shows that Ms. ignores Officer and continues to look at Sergeant 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 grabs her left arm and holds it straight out. He appears to be in |

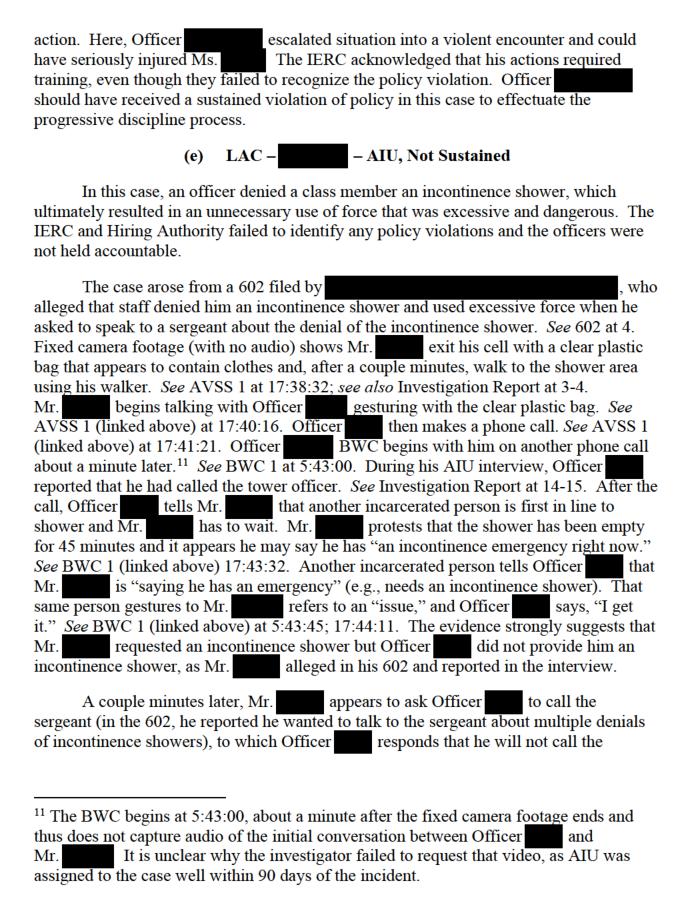


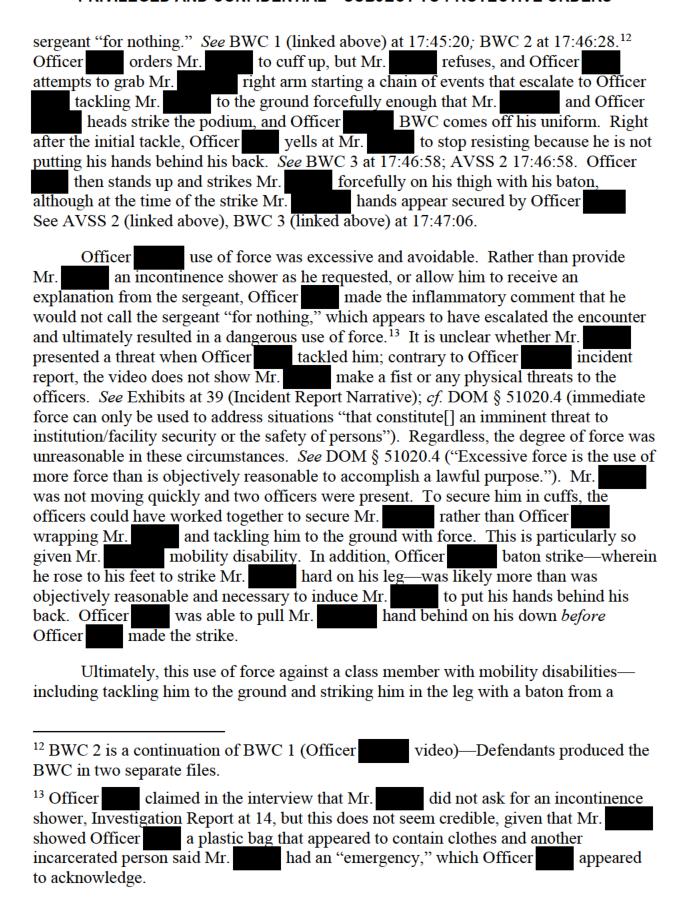
force policy violations. When a staff member uses force in a manner that violates policy,

did here, that staff member should receive corrective or adverse

[4612625.2]

as Officer





| 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- COR- 14 - AIU, Not Sustained   |
| While being escorted to a medical evaluation for difficulty breathing, chest pains, and a panic attack, momentarily paused. Rather than determine the reason for his pause, in response, the escort officer immediately threw Mr. 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 is seen in the video escorting Mr. through the dayroom. See AVSS at 11:52:49. Mr. 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. 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. suddenly comes to a stop. See AVSS (linked above) at 11:52:52. Immediately after Mr. stops, Officer sweeps his right leg in front of Mr. legs, then throws Mr. to the floor face-first:   |
|   |
|   |
|   |
| ///   |
| ///   |
| 14 This incident resulted in two different case numbers: COR and COR.  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. was able to tuck his shoulder and land on it so that he did not land on his face.) Once on the ground, Officer places his forearm on the back of 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. 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. finally asks twice, "Why did you stop my escort?" See BWC (linked above) at 11:53:06. Mr. says that he "tripped a little," that he did not mean to stop BWC (linked above) at 11:53:10. the escort, and he apologized. See Officer responds, "No, you didn't. Do not stop my escort ever again, you Officer asks to speak with the sergeant, and asks Officer understand me?" Mr. move off of his head because he cannot breathe. Mr. then lays on the floor without resisting until the video clip ends. Officer official report of the incident in the incident report package is inconsistent with the video. <sup>15</sup> Specifically, Officer wrote that Mr. <sup>15</sup> This case is not the first time that Officer 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-, in which Officer gratuitously punched in the abdomen while Mr.

| "suddenly pulled away from me, attempting to break escort. Simultaneously, Inmate 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. pulling away from Officer attempting to break the escort, or pushing his body weight backwards. To the extent that Mr. made contact with Officer 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 about any of these inconsistencies between the video footage and Officer account of the force. The investigator also did not ask Mr. 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 issued Mr. and RVR for "Willfully Resisting a Peace Officer in the Performance of Duties." See RVR Log No. 7324427 at 66. |
|--|
| Officer 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. was not attacking Officer 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 rushes to force, dangerously sweeping Mr. legs out from under him while he is handcuffed behind his back. Officer had many other course of action he could have taken, including asking Mr. why he stopped or calling in the multiple other officers in the area for help, but Mr. brief change-of-pace did not give Officer license to take Mr. 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 who conducted the first-level review as the incident commander, largely recycled officer narrative, noting, "[D]uring the escort[,] inmate stopped the escort and turned his body as if he was attempting to break free from Officer [sic] grasp, not knowing his intentions Officer utilized physical force to take inmate to the ground." <i>See</i> IERC at 3. As described above, however, that narrative is inconsistent with the video footage. The second level of review, conducted by Captain  |
| restrained on a hospital bed. Officer 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. <i>See</i> 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.

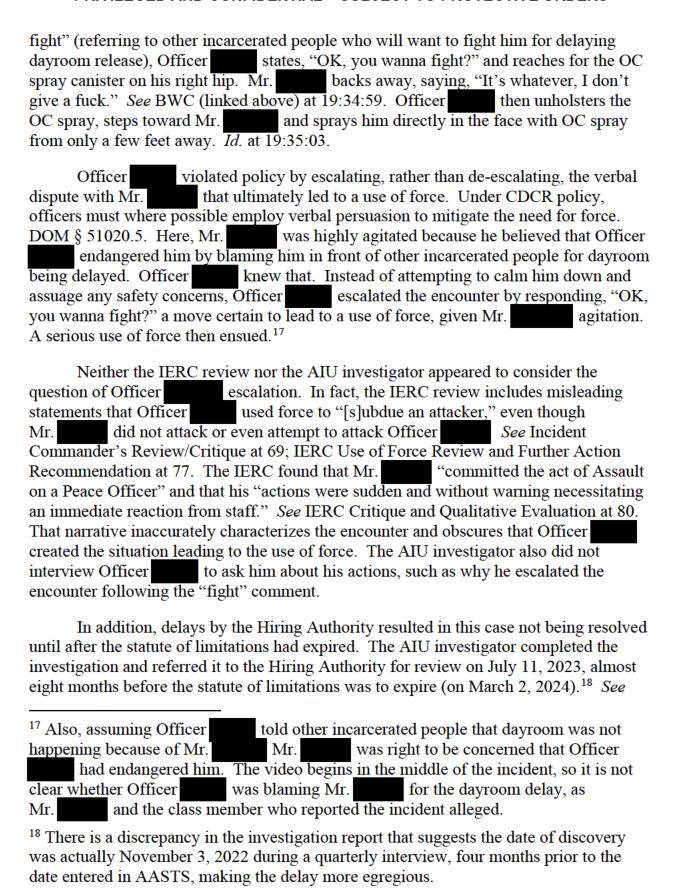
# \_ AIU, Not Sustained

In this case, Officer failed to de-escalate a verbal dispute and pepper sprayed class member in the face. CDCR failed to consider any discipline against Officer 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.

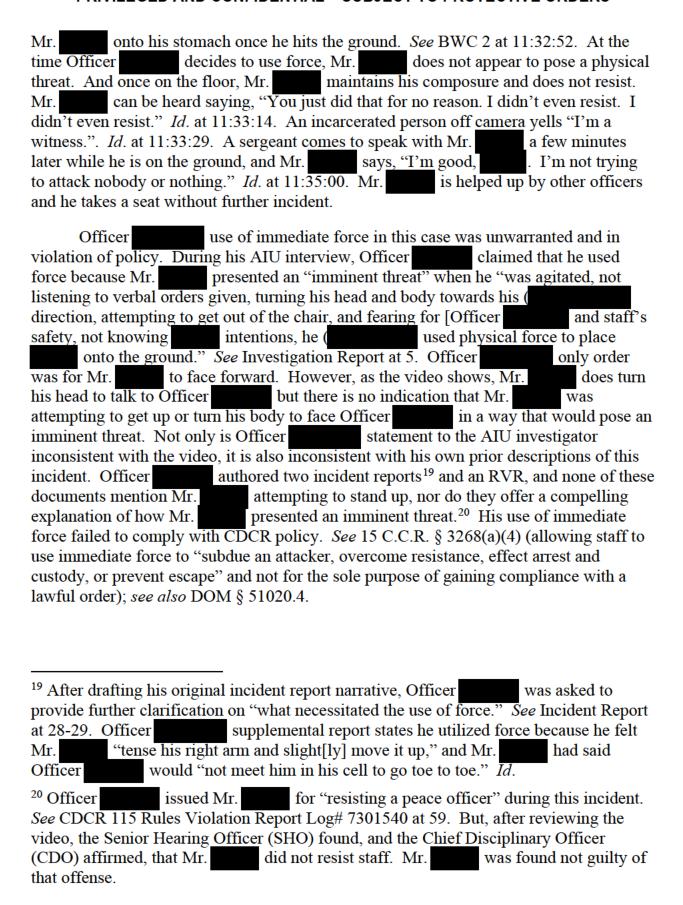
A third-party witness reported seeing Officer pepper spray a person in the face after a dispute about dayroom being shut down. 16 The investigator identified the incident as involving Mr. and reviewed BWC footage of the incident. About forty seconds into the video footage, Mr. walks over from a dayroom table and "As soon as you say we're not having dayroom because of [me], says to Officer you're automatically—that's disrespect." See BWC at 19:34:46. According to incident reports, officers were not releasing dayroom because of Mr. reportedly refusing to go back into his cell. See Incident Report Package Staff Narrative at 56. Mr. therefore understandably agitated based on his belief that Officer 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. becoming upset and fearing for his safety, Officer fails to take any action to defuse the situation. In response to Mr. expressing his safety concerns, including taunting Officer to go ahead and release the dayroom and "let's see who wanna"

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 on 3/W. said he was going to shut down program and the i/m wanted to talk to the sgt and sprayed him." *See* LAC Category 4 Questionnaires, Q4 2022 Interviews (page 61).



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 for his dangerous misconduct that resulted in a use of force. COR -(h) - AIU, Not Sustained In this case, Officer used immediate and unnecessary force during a verbal disagreement with . Mr. was seated in a chair and handcuffed at the time, and Officer threw Mr. 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. was experiencing chest pains while in his cell and On April 27, 2023, Mr. requested to be evaluated by medical staff. Officer handcuffed Mr. behind his back, opened his cell door, and began escorting Mr. to the first tier of his building for the medical evaluation. See Incident Report at  $\overline{28}$ . The video footage in the case file begins during the escort and immediately outside of Mr. that he is twisting his arm. See During the escort, Mr. informs Officer BWC 1 at 11:27:02. Officer says he is not twisting Mr. arm and orders him to walk down the stairs.  $\overline{Id}$ . at  $\overline{11}$ :27:03. Eventually, they walk down the stairs. Id. has been escorted down the stairs and is seated at 11:27:00-11:27:28. Once Mr. with two other officers standing by, Mr. and Officer continue to go back and forth about Officer escort practices while medical staff assess Mr. symptoms. *Id.* at 11:27:35. During the exchange, Mr. 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. responds by denying that he was twisting Mr. Officer arm. Id. at 11:28:0<del>2</del>. Mr. 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. comments, "You the only CO that do that weird ass shit." Id. at 11:28:55. Officer retorts that Mr. to talk a lot." *Id.* at 11:28:58. Mr. asks "what you gonna do about me talking?" "soft" as medical staff continue their assessment. Mr. and calls Officer continue discussing the issue for several minutes. *Id.* at 11:29:14. and Officer antagonizes Officer He says again that he is squeezing his arm tightly. *Id.* at 11:32:04. Officer continue to argue about and Mr.



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."<sup>21</sup>

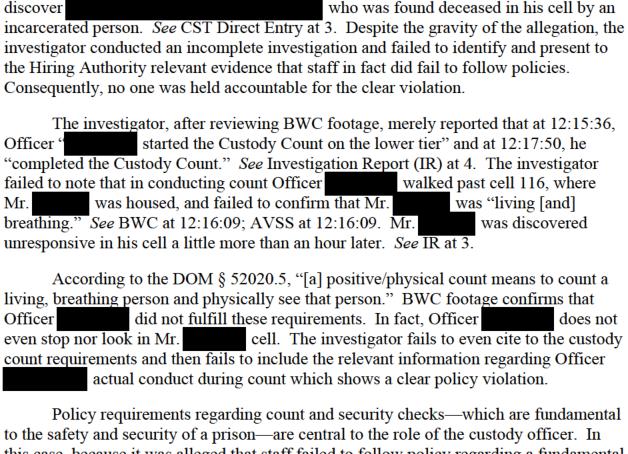
This case, like the many other uses of force at Corcoran, underscore the problems with Defendants' use of force policies and practices. This class member raised a relatively small concern with the officer—that the officer was twisting his arm. Instead of acknowledging the complaint and responding, the 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.

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

<sup>&</sup>lt;sup>21</sup> 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.



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—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, <sup>22</sup> 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, <sup>23</sup> 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<br>Rec'd | Closed-<br>On Time | Closed-<br>Past Due | Open | Open-<br>Past Due | Total | %<br>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.

[4612625.2]

<sup>&</sup>lt;sup>22</sup> 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.

<sup>&</sup>lt;sup>23</sup> 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.