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PRIVILEGED AND CONFIDENTIAL

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[redacted]

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

Dear [redacted]:

We write regarding our review of Defendants' system for holding staff accountable for misconduct. The enclosed report is based on our review of investigation and discipline files produced from CSP-Los Angeles County ("LAC"), California Institution for Women ("CIW"), R.J. Donovan Correctional Facility ("RJD"), California Substance Abuse Treatment Facility ("SATF"), CSP-Corcoran ("COR"), and Kern Valley State Prison ("KVSP") (collectively "Six Prisons").

Plaintiffs continue to find that investigations and discipline fail to comply with the *Armstrong* Court Orders, as affirmed in relevant part by the Ninth Circuit, and with the RJD and Five Prisons Remedial Plans. *See* Dkts. 3059, 3060, 3217, 3218, 3393; *Armstrong v. Newsom*, 58 F.4th 1283, 1288 (9th Cir. 2023).

Plaintiffs' counsel remains especially concerned about the ongoing failure to identify violations of the Americans with Disabilities Act ("ADA") and *Armstrong* Remedial Plan ("ARP") which are central to the case and the Court's efforts to bring CDCR into compliance. The focus of this abbreviated report is to highlight a few of the egregious examples of Defendants' failures to identify and issue discipline when staff

violate the ADA rights of class members. In one case a full-time wheelchair user is dragged half-naked from his wheelchair and left on the floor of his cell without assistance or the ability to get up in retaliation for an altercation with staff. In another case staff denied a class member access to classification because there was no wheelchair accessible holding cage for him to use. And in another case staff acknowledge that they failed to provide a class member use of a wheelchair that he was assigned, which ultimately led to an unnecessary use-of-force. CDCR did not confirm any ADA violations in these cases. The ongoing failure of CDCR to identify violations of the ADA and the ARP and to rectify problems is alarming. We look forward to receiving your response and remain hopeful that the parties will be able to implement remedies to the system to address these longstanding systemic failures, and to improve accountability for staff misconduct.

Sincerely,

ROSEN BIEN
GALVAN & GRUNFELD LLP

/s/ [redacted]

By: [redacted]

cc: [redacted]

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I. ONGOING FAILURES TO IDENTIFY ADA VIOLATIONS

Plaintiffs' counsel continue to identify, every quarter, multiple cases in which staff's failure accommodate someone's disability is not confirmed by CDCR's accountability system and thus the opportunity to prevent further harm – either through corrective action or discipline – is missed. In two cases below, the failure to accommodate disabilities ultimately resulted in the unnecessary use-of-force. Neither case was identified as a failure to accommodate and neither was identified as a problematic use-of-force. Plaintiffs' counsel acknowledge that CDCR has hired a use-of-force expert to make recommendations regarding training, policies and practices regarding force. These cases are illustrative of the need for action.

Two additional cases below that illustrate basic failures to accommodate class members arose at SATF, a prison under Court-ordered investigation.

These cases illustrate precisely the type of ongoing violation the *Armstrong* Court has sought to stop for years, by requiring "Defendants to develop effective internal oversight and accountability procedures to ensure that Defendants learned what was taking place in their facilities, in order to find violations, rectify them and prevent them from recurring in the future, without involvement by Plaintiffs' counsel or the Court." August 22, 2012 Order, Dkt. 2180, at 10 (describing intent of January 18, 2007 Injunction). Unfortunately, nearly two decades after the Court's 2007 Injunction, accountability is still not occurring.

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

This case represents one of the worst failures of the accountability system that Plaintiffs' counsel have observed since Defendants first began producing investigation case files from the Six Prisons. [redacted] ([redacted])—an elderly, full-time wheelchair user in waist chains—requests assistance accessing his cell in [redacted]. Mr. [redacted] wheelchair is too wide to fit through the doorway, a known issue in some housing units at LAC. Instead of accommodating him, as he claimed a sergeant and lieutenant had done previously, the officers forcibly removed Mr. [redacted] from his wheelchair and dragged him, partially naked, onto the floor of the cell. After removing his restraints, officers then leave Mr. [redacted] lying half naked on the floor in retaliation for "kicking" an officer during the struggle. The officers then close Mr. [redacted] wheelchair so they can fit it through the cell door, push it into the cell, and close the door, while Mr. [redacted] is yelling that he cannot get into his wheelchair without help.

LAC did not sustain any allegations and did not impose any discipline related to this egregious failure to accommodate Mr. [redacted] disability, the resultant unnecessary force, and the disability-related retaliation. The fact that no CDCR staff member, through multiple levels of review, identified this case as a problem decades into this lawsuit and

nearly five years after the Court's staff misconduct orders, shows there are still miles to go before CDCR comes into compliance with the ADA.

Video shows four officers surrounding Mr. [redacted] who is sitting in his wheelchair in front of cell 119, in a section of the dayroom that otherwise appears to be empty. *See* AVSS at 1:07:27. Officer [redacted][1] wheels Mr. [redacted] forward to the cell entrance, and says, "So we're going to help you up to your feet and then I'm going to help you into your cell." *See* BWC 1 at 1:07:52. Mr. [redacted] protests, explaining that he needs his wheelchair in his cell. He further explains that the way he gets into and out of the cell is by having officers fold up the wheelchair for him and holding onto the sink. Officer [redacted] tells Mr. [redacted] he can hold onto the food port, and Mr. [redacted] says "I don't do it like that … I'll fall, I'm a fall risk." Mr. [redacted] explains that a lieutenant is aware of the accommodations Mr. [redacted] needs to get into the cell. Officer [redacted] states that he and another officer, Officer [redacted] will pick Mr. [redacted] up and carry him into the cell. When Mr. [redacted] does not comply with Officer [redacted] orders for him to get out of his wheelchair so that they can carry him, an officer sounds his alarm. Mr. [redacted] pleads for the officers to wait so that they can contact a supervisor, but the officers ignore him.

Officer [redacted] Officer [redacted] and another officer then forcibly remove Mr. [redacted] from his wheelchair against his will. *See* BWC 2; BWC 3 at 1:09:33. Once Mr. [redacted] is out of the wheelchair, Officer [redacted] grabs Mr. [redacted] under both arms and drags him on the ground into the cell. Mr. [redacted] is wearing only a smock or hospital gown, and is naked from the waist down.

Officer [redacted] then enters the cell. Mr. [redacted] moves his right leg toward Officer [redacted] shin and makes contact with it with very little force. Officer [redacted] states "we're going to leave him on the floor, he kicked my legs." *See* BWC 2 (linked above); BWC 3 (linked above) at 1:10:04. Officer [redacted] rolls Mr. [redacted] onto his side and the officers place a shield over him. Officer [redacted] then removes the waist restraints. The officers back out of the cell with Mr. [redacted] lying on the floor. An officer tries to push his wheelchair into the cell, but it cannot fit through the door. The officer then folds up the wheelchair and pushes it into the cell. As the cell door closes, Mr. [redacted] yells "I can't get into my wheelchair!" *See* BWC 2 (linked above) at 1:11:44.

The officers later issued Mr. [redacted] a serious RVR for Battery on a Peace Officer. The Hearing Officer found Mr. [redacted] guilty and sanctioned Mr. [redacted] with 150 days of lost credits, 10 days of yard restriction, and 90 days of package and day room restrictions. *See* RVR at 73.

[1] Plaintiffs have reported on Officer [redacted] violation of use-of-force policy in a prior report. *See* February 2024 Report at 22-23.

Mr. [redacted] made a complaint of unnecessary or excessive use of force. *See* 602 at 4-5. After an AIU investigation, the Hiring Authority did not sustain any allegations against any officer. *See* Closure Memo at 1.

The failure to sustain any violations in this case was egregious. First, the Hiring Authority failed to sustain any allegations for the officers' serious violations of Mr. [redacted] rights under the *Armstrong* Remedial Plan and the ADA. Mr. [redacted] repeatedly tried to explain that he could enter the cell with his wheelchair if provided certain accommodations. The officers ignored his requests for accommodation and his requests to speak with a lieutenant or sergeant who knew of the needed accommodations. Instead, the officers offered Mr. [redacted] the unreasonable, dehumanizing, and embarrassing "accommodation" of carrying him into his cell. Officer [redacted], in his investigation interview, all but admitted the unreasonableness of his actions; when asked how he assisted Mr. [redacted] into the cell, he stated, "I slowly dragged him for lack of better words." *See* AIU Report at 6. The Hiring Authority, however, did not even consider any disability-related allegations and looked only at whether the officers violated use-of-force policies.

Second, the Hiring Authority failed to sustain allegations against Officer [redacted] and Officer [redacted] for retaliating against Mr. [redacted] for allegedly kicking Officer [redacted]. Mr. [redacted] explained to the officers that he could not get up off of the ground on his own. Nevertheless, Officer [redacted] explicitly instructed his fellow officers to leave Mr. [redacted] on the ground because, as Officer [redacted] stated, "he kicked me." The officers had a number of legitimate means to address Mr. [redacted] actions, such as restraining Mr. [redacted] and issuing an RVR. But it violated the ADA for officers, after becoming upset with Mr. [redacted], to retaliate by knowingly leaving him helpless on the ground of his cell with no means of getting up as a result of his disability. Such conduct constitutes disability-related retaliation and violates the ADA and court orders in this case. The Hiring Authority, however, did not consider imposing any discipline regarding this violation either.

Third, the Hiring Authority failed to sustain any allegations for the officers' unnecessary use of force against Mr. [redacted]. At the time that Officer [redacted] and Officer [redacted] lifted Mr. [redacted] out of his wheelchair without his consent, Mr. [redacted] did not pose an imminent threat. In fact, in his investigation interview, Officer [redacted] stated that Mr. "[redacted] was not resistant at the time." *See* AIU Report at 6. Accordingly, the officers were not authorized to use immediate force, but nevertheless did so. Moreover, the officers failed to deescalate the situation. Mr. [redacted] explained that he required specific accommodations to enter the cell. The officers, however, insisted that they would carry him, without exploring with Mr. [redacted] how he could enter the cell or conferring with a sergeant or lieutenant who had accommodated Mr. [redacted] previously. Had staff made any effort to work with Mr. [redacted], rather than insisting on dehumanizing and embarrassing him by dragging him naked into the cell, the officers

likely could have avoided any force. Instead, as a result of their failure to provide a reasonable accommodation to Mr. [redacted], the officers initiated an improper immediate use of force that then resulted in an assault on staff and substantial discipline for Mr. [redacted]. The Hiring Authority did consider allegations of unnecessary and excessive use of force, but did not sustain any of them.[2]

The complete failure of the Hiring Authority to hold staff accountable for these serious disability-related policy violations that were captured clearly on video is extraordinarily concerning. The accountability system will never serve its intended purpose if CDCR cannot discipline staff for such fundamental and obvious violations of class members' disability rights.

The investigation into the misconduct was also incomplete and biased. First, the investigator provided a narrative of the video that is misleading and omits critical information. The investigator did not mention (1) that Mr. [redacted] requested that officers provide him with an accommodation other than being carried into the cell, but that staff refused; (2) that Officer [redacted] ordered that officers leave Mr. [redacted] on the cell floor because he had kicked Officer [redacted]; or (3) that Mr. [redacted] stated he could not reach his wheelchair when officers left him on the floor. *See* AIU Report at 5. The investigator also highlights multiple verbal statements by Mr. [redacted] that paint him in a poor light but are irrelevant to the allegation. *Id.*

Second, the investigator allowed Officer [redacted] to review his BWC footage in advance of the interview. *See* AIU Report at 6. This is a poor investigative practice that allows staff to conform testimony to the video in an exculpatory manner rather than providing their recollection of the incident.

Third, the investigator did not mention in the investigation report that Officer [redacted] omitted from his incident report the fact that he dragged Mr. [redacted] into the cell. Officer [redacted] wrote in his report "Officer [redacted] maintain[ed] control of [redacted] right arm and assisted me in lifting [redacted] out of his wheelchair. I pivoted my body so that I was inside of the cell and *placed* [redacted] in a seated up right position. At this time [redacted] ceased all his resistive actions. I *placed* [redacted] to the front his bunk and was going to assist him onto the bunk." *See* Incident Report at 31 (emphasis added). This omission is peculiar because the investigator questioned Officer [redacted] at length about this discrepancy—that the video shows him dragging Mr. [redacted] but that he wrote in his incident report that he "placed" him.

[2] The IERC completed its first level of review before Mr. [redacted] filed his grievance. The lieutenant who completed the review concluded that the officers did not violate policy. *See* IERC at 2.

Fourth, the investigator did not interview any of the other staff involved in the incident, even though they all failed to ensure disability accommodations for Mr. [redacted].

Fifth, the investigator highlighted negative but irrelevant information about Mr. [redacted]. As an example, the investigator wrote in the narrative for Officer [redacted] interview: "[redacted] is hostile, and difficult. [redacted] explained every interaction with [redacted] is negative because of his choice of language. [redacted] makes a lot of racial comments like, 'I don't want Mexicans touching me.'" *See* AIU Report at 6. Those comments shed no light on whether the officers violated policy by failing to accommodate Mr. [redacted] or used unnecessary or excessive force against him, but do serve to bias any reader against Mr. [redacted].

In sum, this case represents a tremendous failure of the accountability system.

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

In this case, staff's denial of an ADA accommodation resulted in an unnecessary use of force on [redacted] ([redacted]). On July 16, 2024, Mr. [redacted] who was DPM and already had a cane and walker, was also issued a temporary wheelchair. *See* DPP Accommodation Report at 58. On July 20, 2024, while Mr. [redacted] was housed in [redacted] at KVSP, he was summoned to the medical clinic to address his reports of chest pains. When Officer [redacted] and Officer [redacted] removed him from his cell, Mr. [redacted] requests his wheelchair. Officer [redacted] denies his request. Officer [redacted] stated in his investigation interview he "did not allow [redacted] to utilize his wheelchair because he did not know if the wheelchair [in the hall across from cell] was [redacted]." *See* Investigation Report at 8. Mr. [redacted], who is in waist chains with a triangle, then appears to fall as he exits his cell. *See* BWC 1 at 11:04:37. The officers immediately utilize force, forcing him face down on the ground to restrain him. Mr. [redacted] call out "I fell, man, I fell! Didn't you see I fell?! My leg gave out, my left leg.... I told you my left leg messed up, that's why they gave me the wheelchair!" *See* BWC 2 at 11:04:33. A third Officer calls "resistive inmate." *See* BWC 1 (linked above) at 11:04:43. Mr. [redacted] describes to another responding officer the reason he had been issued a wheelchair, that it didn't fit in his cell, and that prior to escort he had told the officers that he needed it because his left leg was messed up. *See* BWC 2 (linked above) at 11:05:26.

Mr. [redacted] filed a complaint alleging that officers denied him access to his wheelchair, and that they violated use-of-force policy when they jumped on his back after he fell. *See* 602 at 1-2. Despite camera footage confirming, and the officer's acknowledging that he requested but was not permitted to use his wheelchair, Mr. [redacted] allegation that he was denied access to this accommodation was not sustained. *See* Closure Memo at 8. This decision by the Hiring Authority was inappropriate and reflects a lack of understanding disability-related issues. The Hiring

Authority failed to recognize that the use of force occurred because staff initially failed to accommodate Mr. [redacted] by providing him with his wheelchair.

In addition, the investigation report omitted critical information. Though the report confirms that Mr. [redacted] was assigned a wheelchair and that a wheelchair was in close proximity to Mr. [redacted] cell, the report omits from its summary of the video the most relevant part of the interaction, where Mr. [redacted] requests to use his wheelchair and staff respond "no." *See* Investigation Report at 4.

Lastly, the officers improperly issued Mr. [redacted] an RVR for willfully resisting a peace officer in the performance of his duties. Plaintiffs acknowledge that, under the circumstances, it may have been reasonable for the officers to use force against Mr. [redacted] when he fell given that his fall could have reasonably been perceived as resistance in that moment. But the fact that force may have been justified (i.e., that the officers reasonably perceived a threat in the moment) does not, by itself, justify the issuance of an RVR. In the RVR, staff stated that Mr. [redacted] "tensed up his body, and without warning or provocation … lunged forward and dropped his body weight…" and that force was necessary "to overcome Inmate [redacted] resistive behavior." *See* RVR at 17-19. But the evidence—the video showing his request for his wheelchair and his immediate explanation that, once on the ground with officers on top of him, he had fallen and that doctors recently prescribed a wheelchair because of issues with his left leg—strongly supports the conclusion that he fell accidentally. Under such circumstances, the evidence does not support the charge that Mr. [redacted] willfully resisted in this case. Moreover, there is no recognition that if staff would have accommodated Mr. [redacted] with his wheelchair from the outset of the escort, he would not have fallen and the officers would not have needed to use force. The investigator noted in the Investigation Report, that CDCR had not heard the RVR through the date of the investigation report, nine months later. *See* Investigation Report at 3. **Plaintiffs' counsel requests to know the outcome of this RVR. If the RVR was sustained, Plaintiffs' counsel requests immediate reconsideration in light of footage that suggests he accidentally fell, and that just prior to the incident he was denied access to his wheelchair.**

(c) SATF-[redacted] – Local, Not Sustained

This case is an example of an institutional failure to provide access to an Institutional Classification C meeting to a person in a wheelchair and a failure of the local investigator to conduct a comprehensive investigation.

On December 19, 2024, [redacted] ([redacted]) who was housed in [redacted], was scheduled for his ICC. BWC shows Officer [redacted] inform Mr. [redacted] that he would have to be placed in a non-ADA accessible holding cell prior to his hearing. He tells Mr. [redacted] that any refusal to be placed in the holding cell will be considered a refusal of his ICC. Mr. [redacted] is adamant that he is not refusing and wants to attend his hearing, but that he cannot transfer out of his wheelchair to a non-ADA

accessible holding cage. He asks why he can't simply remain in his own cell while waiting. *See* BWC 1. Officer [redacted] tells Mr. [redacted] he will see what he can do. When he returns, he reports back that the Captain and CCII are aware of Mr. [redacted] issue, but that there are no wheelchair accessible holding cages available and there is nothing he can do. *See* BWC 2. Mr. [redacted] repeats that he is unable to transfer into a non-wheelchair accessible cell. Officer [redacted] responds that Mr. [redacted] will be deemed to have refused the ICC.

The investigation performed by the LDI was substantially incomplete. The only investigative actions performed by the LDI were to interview Mr. [redacted] and to obtain and review the video of Officer [redacted] BWC. But the LDI did not inspect the holding cell at issue to determine whether it was accessible to DPW class members. And the LDI did not interview Officer [redacted] the Captain who was presiding over the ICCs, or other staff members with whom Officer [redacted] may have discussed Mr. [redacted] issue (e.g., the CCII that Officer [redacted] stated was "aware" of the issue). Those interviews were crucial to determine what, if any, efforts staff made to accommodate Mr. [redacted] and to ask why they deemed his decision not to endanger himself as a refusal.

The LDI also appeared to misunderstand the nature of the ADA violation that occurred. Specifically the investigator wrote in the report, "Inquiry Note: SOMS DPP Disability/Accommodation Summary shows [redacted] is a DPW inmate with no Transfer restrictions." *See* IR at 3. But in CDCR, there is no such type of holding cell. The holding cells that are accessible to DPW class members are large enough such that the person can enter the holding cell in his or her wheelchair. As such, the LDI's report demonstrates a lack of understanding of basic disability accommodations within CDCR.

As for the result of the investigation, Officer [redacted] should have received at least corrective action. Though he attempted to find a solution, he not only failed to determine a way to accommodate Mr. [redacted], he also improperly construed Mr. [redacted] decision not to endanger himself by being placed in an inaccessible holding cell as a refusal of the ICC. The ICC is a crucial due process event in CDCR. Officer [redacted] violated the ARP and Mr. [redacted] rights by forcing him to choose between participating in his ICC and his disability-related safety. Put simply, there was an obvious and important ADA violation shown on video, yet nobody was held accountable. In all likelihood, the Captain who Officer [redacted] spoke with should also have been held accountable; as a supervisor, he was also responsible for ensuring that CDCR accommodated Mr. [redacted] so that he could participate in his ICC. These serious accountability failures regarding an obvious ADA violation at one of the prisons that houses the largest number of wheelchair users are very concerning.

(d) SATF-[redacted] – Local, Not Sustained

This is another case of non-compliance with the ARP and failure of the local investigator to ensure accountability for the non-compliance.

On December 11, 2024, [redacted] ([redacted]) (incorrectly identified in the Report as [redacted], was scheduled for a podiatrist appointment in the CTC. According to his grievance, earlier on the day of the appointment, he asked officers about it but was told he would need to wait until he was called to go. *See* Exhibits at 1. BWC shows the officer in the control booth, Officer [redacted] announcing over the PA system for people to head to CTC, but does not show any attempt to notify Mr. [redacted] of this announcement, either by flashing the lights or by personal notification. As a result, Mr. [redacted] missed the CTC transport. *See* BWC 1 at 8:38:05. Because he missed the transport, staff concluded that he refused his appointment. *See* BWC 2 at 8:44:18.

In his March 11, 2025 interview with the investigator, Officer [redacted] admitted that on the date of the incident, he was new to that particular housing unit and was "still familiarizing himself with the program and inmates." *See* IR at 3. Although Officer [redacted] stated that he was currently aware of Mr. [redacted] disability and ensures effective communication by flashing lights and/or sending an ADA worker to provide personal notification, he did not recall Mr. [redacted] refusing any appointment on that date and did not claim he provided Mr. [redacted] personal notification on that date. The transport officer had left CDCR employment on December 31, 2024, and so could not be interviewed. *See* IR at 3-4.

This allegation was not sustained despite the obvious policy violation. *See* Closure Memo at 1. The investigator failed to identify the specific policies in the ARP requiring staff to provide notifications to ensure effective communication of alarms and announcements to people with hearing disabilities. *See* ARP § IV.I.2.b. ("Each institution/facility (DPP designated institutions, non designated institutions and reception centers) shall ensure that effective communication is made with inmates who have hearing impairments impacting placement regarding public address announcements and reporting instructions, including those regarding visiting, yard release and recall, count, lock-up, unlock, etc.")

Additionally, the Hiring Authority failed to identify the violation. As a result, there was no accountability to prevent harm and ensure compliance going forward.

II. ONGOING FAILURE TO ENSURE APPROPRIATE DISCIPLINE

Plaintiffs' counsel continue to identify cases each quarter where, despite sustaining violations, Defendants fail to ensure appropriate discipline. The following case is illustrative of this ongoing problem.

(a) LAC-[redacted] – Sustained, Level 3 Discipline Reduced to Corrective Action

In the following case, Officer [redacted] used improper immediate force, but the Hiring Authority inexplicably reduced the penalty from Level 3 discipline to corrective action based on an immaterial typo. Earlier this year, Plaintiffs reported on CDCR's failure to hold Officer [redacted] accountable for use-of-force violations. *See* Plaintiffs' May 2025 Review of CDCR's Accountability System at the Six Prisons at 16-17 (May 9, 2025). In that report, Officer [redacted] escalated an interaction with a class member and resorted to force too quickly, in violation of policy. Despite a finding of a violation and the initial imposition of adverse action, CDCR later reduced the discipline to corrective action. The instant case represents a failure of the progressive discipline system where the same officer had another sustained violation for a serious force incident and again received only corrective action.

Video shows [redacted] ([redacted]) sitting on a bucket on the top tier near the stairs while multiple incarcerated people are moving around the dayroom. *See* AVSS. Both Mr. [redacted] and Officer [redacted] confirmed that, before the video begins, Officer [redacted] instructed Mr. [redacted] to wait for his shower on the dayroom floor instead of on the tier. *See* IR at 5, 6. Officer [redacted] BWC begins as he then walks up the stairs to talk to Mr. [redacted] *See* BWC. At no point during the interaction is Mr. [redacted] a threat. Officer [redacted] orders Mr. [redacted] to "cuff up" while approaching Mr. [redacted], who is simply waiting for his shower on the top tier. Officer [redacted] again tells him to "cuff up" and backs Mr. [redacted] towards the wall. Mr. [redacted] slightly shakes his head as he backs up, at which point Officer [redacted] reaches towards Mr. [redacted] who pulls his hands up and away from Officer [redacted] saying he is not doing anything, as he continues to walk backwards. An alarm sounds, and Officer [redacted] grabs Mr. [redacted] arm. Officer [redacted] and two other officers struggle for about a minute to put Mr. [redacted] in handcuffs as Mr. [redacted] grabs the top tier railing. Additional staff arrive and walk Mr. [redacted] off camera in handcuffs.

The Hiring Authority (the now-former LAC warden) found that Officer [redacted] used unnecessary force and issued Level 3 discipline on June 10, 2024. *See* 402/403 at 2-4. Video shows that Officer [redacted] used force solely to comply with an order. Mr. [redacted] posed no threat and Officer [redacted] clearly initiated the incident that led to the use of force. This kind of behavior from officers jeopardizes their legitimacy and the security of the prison.

However, eight months later on February 14, 2025, the Hiring Authority held a second 402/403 conference and reduced the discipline to corrective action. *See* 402/403 (reconvene) at 1-3. The revised 402/403 contains a note that reads "upon further review of the case factors after the initial 402/403, based on flaws in the case, it was determined corrective action would be taken based on the discrepancy with the date of the allegations and the AIU Report," followed by the statement "correct date of allegation should have

been 5/28/23." *See* 402/403 (reconvene) at 3. The 402/403 gives no other reason for reducing the discipline.

Although the AIU report lists June 3, 2023 as the incident date at the beginning of the report (which is incorrect), the investigator otherwise refers to the incident as occurring May 28, 2023. For example, the investigator references the incident reports from May 28, 2023. *See* IR at 2. Also, the video in the case file, which aligns with the investigator's description, is from May 28, 2023.

The typo regarding the date was also immaterial with regards to the statute of limitations. The statute of limitations for the case was June 14, 2024, one year after the date that CDCR Mr. [redacted] 602-1 alleging use-of-force violations. The Hiring Authority issued the Level 3 discipline on June 10, 2024, within the statute of limitations deadline. *See* 402/403 at 2. The error in the investigation report therefore had no effect on whether the discipline was issued within the statute of limitations.[3]

Despite three confirmed use of force violations, and a history of reports of problematic interactions with Officer [redacted], Plaintiffs' counsel are unaware of any serious discipline issued to this officer. Accordingly, CDCR's progressive discipline system has failed completely in addressing the ongoing harm that Officer [redacted] is causing to class members.[4]

III. CONCLUSION

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

[3] Several other cases in this production also showed a reduction in discipline after CDCR stipulated at SPB, including LAC-[redacted], LAC-[redacted], and LAC-[redacted].

[4]Additionally, in this production, in LAC-[redacted], the Hiring Authority also found a third instance where Officer [redacted] violated use-of-force policy, sustaining unnecessary and/or excessive force and issuing Level 3 discipline. However, the Hiring Authority then stipulated to a Letter of Reprimand after Officer [redacted] appealed to the SPB.