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PRIVILEGED AND CONFIDENTIAL

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[redacted]
Court Expert
[redacted]

[redacted]
CDCR Office of Legal Affairs
[redacted]

Re: *Armstrong v. Newsom*: Plaintiffs' Review of Investigation and Discipline Documents from R.J. Donovan Correctional Facility, California Substance Abuse Treatment Facility and State Prison, CSP-Corcoran, and Kern Valley State Prison
Our File No. 0581-03

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

We write regarding our review of investigation and discipline documents from R.J. Donovan Correctional Facility (RJD), California Substance Abuse Treatment Facility and State Prison (SATF), CSP-Corcoran (COR), and Kern Valley State Prison (KVSP).[1] As detailed below and in the accompanying **Table A** (which is a separate Excel file), Plaintiffs found that Defendants have failed to comply with the *Armstrong* Court Orders and the RJD and Five Prisons Remedial Plans. *See* Dkts. 3059, 3060, 3217, 3218, 3393. Collectively, the cases reviewed by Plaintiffs indicate that Defendants continue to fail to hold officers accountable for violating the rights of class members. The serious problems identified by Plaintiffs include:

[1] For RJD and SATF, the production included documents for cases closed between March 2-May 31, 2022 (produced on August 3, 2022 and in a supplemental production on October 14, 2022). For KVSP and COR, the production included documents for cases closed between April 1-July 1, 2022.

- Hiring Authorities are continuing to fail (1) to sustain allegations of misconduct where a preponderance of the evidence established that the misconduct occurred (*see, e.g.*, **SATF –** [redacted]; **RJD –** [redacted]; **RJD –** [redacted]),[2] and (2) to impose appropriate discipline after finding that misconduct occurred (**SATF –** [redacted]; **SATF –** [redacted]; **SATF –** [redacted]; **SATF –** [redacted]; **KVSP –** [redacted]). Troublingly, cases in this and past productions show a pattern of Hiring Authorities failing to enforce CDCR's use-of-force policies with respect to incarcerated people with disabilities. These policies require staff to attempt to deescalate situations, forbid staff from using force to simply gain compliance with orders, and permit immediate (rather than controlled) use of force *only* when a person is an imminent threat to the safety and security of the institution, themselves, or other people. *See* **RJD –** [redacted] (Hiring Authority found no violation of policy even though video shows no need for immediate force); **SATF –** [redacted] (Hiring Authority found staff violated policy by using immediate force rather than initiating a controlled use of force, but did not issue any adverse action); Plaintiffs' Review of SATF Q1 2022 Production, June 3, 2022, [redacted], at 4-8 (discussing unnecessary, immediate use of force against a severely mentally ill class member who did not pose any imminent threat); Plaintiffs' Review of Q4 2021 Production of Investigation from RJD, June 6, 2022, Case DAI – [redacted], at 14-18 (discussing unnecessary, immediate use of force against a class member who was peacefully refusing to return to his housing unit). These cases show that CDCR officers, in violation of policy, continue to resort to using force far too quickly and continue to inflame situations, rather than attempt to deescalate them. These failures to deescalate matter. CDCR's policies allow use of force only after other strategies have failed because, *inter alia*, use of force presents a significant risk of injury to staff and incarcerated people, especially elderly class members with disabilities. Resorting quickly to the use of force, especially when unnecessary, also perpetuates a fear of staff among class members and inhibits access to disability accommodations. This culture of force and violence will only stop when Hiring Authorities begin to discipline staff for violating policy.

- Investigators are continuing to fail to collect important and relevant evidence, especially video footage. *See, e.g.*, Section III, *infra*; **SATF –** [redacted]; **SATF –** [redacted]; **COR –** [redacted]. In Section III, *infra*, we have summarized three recurrent problems related to the retention and review of video evidence:

[2] The case numbers listed here are hyperlinks to the detailed discussions of the cases below.

(1) investigators delaying in requesting footage such that the footage has been destroyed before it can be reviewed; (2) investigators requesting unreasonably short time periods of video (e.g., 1-5 minutes of video) and then concluding that no misconduct occurred based on a review of the improperly truncated video; and (3) investigators requesting the wrong time period of video and then concluding that no misconduct occurred based on the irrelevant video. These cases show that investigators, despite having access to audio-visual surveillance system ("AVSS") and body-worn camera ("BWC") footage, are still failing at their most basic task—figuring out what happened in a given incident.

- Investigators are continuing to conduct biased investigations and to produce biased investigation reports that omit or misrepresent relevant facts and evidence or show explicit bias against incarcerated people and in favor of staff. *See, e.g.*, **SATF –** [redacted]; **RJD –** [redacted]; **COR –** [redacted].

- Officers are continuing to fail to comply with Defendants' BWC policies. *See* Section **IV**, *infra*.

Many of the problems identified in this report involve incomplete and biased investigations conducted by Office of Internal Affairs ("OIA") investigators (both Allegation Inquiry Management Section investigators and OIA Special Agents) and inappropriate decisions by Hiring Authorities—actors whose roles remain the same or very similar in Defendants' old and new investigation systems.[3] It is discouraging that, more than two years after the court's initial order, and even with the implementation of AVSS and BWC at the Six Prisons, the analysis, decision-making, and outcome of investigations has not significantly changed.

The new staff misconduct complaint process is only as good as the actors making decisions in that process. Accordingly, in Section VI of this report, we make a number of requests for information and documents about Defendants' efforts, under the Remedial

[3] Defendants' newly adopted regulations for the investigation process make clear, when compared to prior regulations, that they simply renamed AIMS as the Allegation Investigation Unit ("AIU"). As such, the role and responsibilities of people completing current investigations remain the same or similar under the old and new systems. *See* August 15, 2022, Corrected Renotice to 22-06 at 3, "Subsection 3486(d)(1) is amended to change AIMS (Allegation Inquiry Management Section) to AIU (Allegation Investigation Unit) as this internal CDCR office has changed its name."

Plans, to train staff and address investigators and Hiring Authorities who are not meeting expectations.

I. DEFENDANTS SUSTAINED ALLEGATIONS AGAINST STAFF IN ONLY 17 OF 309 CASES AND IMPOSED ADVERSE ACTION IN ONLY 4 CASES

In its Orders, the Court found that "the root cause of the violations of the ARP and class members' ADA rights is the systemic and long-term failure by CDCR to effectively investigate and discipline violations of the ARP and class members' ADA rights by RJD staff." Dkt. 3059 § V; *see also* Dkt. 3217 § III.B ("[T]he root cause of the ongoing violations of the ARP and ADA is … the ineffectiveness of the current system for investigating and disciplining violations of the ARP and ADA and the resulting staff culture that condones abuse and retaliation against disabled inmates."). The documents reviewed show that Defendants are still failing to hold officers accountable for discriminating against and otherwise harming class members.

The productions we reviewed included 309 unique and closed case files. In 292 of the cases (94%), no allegations were sustained against any staff members. In 17 of the cases (6%), allegations were sustained against at least one staff member (3% in last report.). In those cases with a sustained allegation, adverse action was imposed against at least one staff member in only 4 cases[4] (5 in last report). In the remaining 13 cases with

[4] The four sustained cases for which adverse action was imposed are as follows: RJD-[redacted]; RJD-[redacted]; COR [redacted]; SATF [redacted]. Note that in SATF [redacted], adverse action was recommended but never imposed since the subject had already retired from CDCR.

a sustained allegation, corrective action was imposed[5] or no action was taken[6] (4 in last report). The chart below breaks down the cases by institution.

	Cases	Sustained	Corrective Action	Adverse Action	% Sustained	% Adverse
RJD	48	2	0	2	4%	4%
COR	91	2	1	1	2%	1%
KVSP	27	4	4	0	15%	0%
SATF	143	9	6	1	6%	1%
Total	309	17	11	4	6%	1%

The low rate of discipline across these four prisons suggests that Defendants continue to fail to hold staff accountable for discriminating against or otherwise harming class members. And as discussed in more detail below and in Table A, even the limited case files reviewed by Plaintiffs revealed at least some cases where camera footage captured misconduct on video and Defendants' investigation process still failed to confirm that misconduct occurred. In other cases, serious deficiencies in the investigations, and the failure of CDCR to adequately police their own investigation and disciplinary decision-making, have interfered with the ability to discover misconduct and hold staff accountable.

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[5] The 11 sustained cases for which only corrective action was imposed are as follows: COR [redacted]; **KVSP –** [redacted]; KVSP [redacted]; KVSP [redacted]; KVSP [redacted]; **SATF –** [redacted]; SATF [redacted]; SATF [redacted]; SATF [redacted]; SATF [redacted]; SATF [redacted]; SATF [redacted]. Note that in KVSP [redacted], the claimant's allegation was not sustained, but in the course of the investigation, the investigator found that the subject had failed to take appropriate action regarding potential enemy/safety concerns for the claimant and the subject received corrective action.

[6] In two cases, the allegations were sustained, but neither adverse nor corrective action was imposed. In SATF [redacted], the allegations were sustained, but no penalty was recommended because the subject was no longer employed by CDCR. In **SATF –** [redacted], the Hiring Authority ordered adverse action against one employee, but it was rescinded at the employee's *Skelly* hearing. In that same case, the Hiring Authority sustained the allegations against another employee, but no penalty was recommended because that subject was no longer employed by CDCR.

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

As one remedy for Defendants' violations of class members' rights, the Court ordered Defendants to reform their investigation and discipline system to ensure that "that CDCR completes unbiased, comprehensive investigations into all allegations of staff misconduct violative of the rights of any class member under the ARP or the ADA … [and] imposes appropriate and consistent discipline against employees who engage in violations of the ARP or ADA with respect to class members …." Dkt. 3060 § 5.c.; *see also* Dkt. 3218 § 5.c. (requiring CDCR to conduct "unbiased, comprehensive investigations into all allegations of staff misconduct" against class members). The Remedial Plans state that Defendants' investigators must conduct "comprehensive and unbiased investigations and ensure all relevant evidence is gathered and reviewed" and that Hiring Authorities must impose appropriate and consistent discipline. RJD Remedial Plan § II.B.; Five Prisons Remedial Plan § II.B.

Plaintiffs' counsel closely reviewed 52 cases from the productions to determine if the investigations were complete and unbiased and if the discipline, if any, was appropriate and consistent: 12 cases from RJD; 15 cases from SATF; 15 cases from COR; and 10 cases from KVSP. The cases were selected using a variety of criteria, including whether: the case was referred to OIA, AIMS conducted an inquiry, the case involved an allegation related to a use of force or disability discrimination, and the case included video evidence.

Plaintiffs' complete findings are contained in Table A. Note that the findings for each prison appear in separate tabs of the Excel file.

Below, Plaintiffs have provided detailed narrative summaries of cases that illustrate serious, ongoing problems related to investigations and discipline.

1. RJD

a. RJD – [redacted]

This case involves alleged retaliation against [redacted], who was [redacted] at the time of the allegation, and is a staff misconduct declarant. Mr. [redacted] filed a complaint alleging that after he requested that staff help him with the power in his cell, Officers [redacted] and [redacted] retaliated against him by conducting a retaliatory cell search and then, a few hours later, issued him a false Rules Violation Report ("RVR") for

delaying a peace officer. The allegations regarding the cell search and the RVR were split by OIA/AIMS even though Mr. [redacted] alleged the cell search and RVR were part of a continuing course of retaliation involving the same officers over a period of few hours. Plaintiffs previously reported on the investigation into the false RVR case. *See* Letter re Review of Q4 2021 Production of Investigation from RJD, June 6, 2022, Case DAI – [redacted] at 5-7.[7] The instant case involves only the investigation into the allegation of a retaliatory cell search.

The investigation into this allegation uncovered clear video evidence that the officers' search of Mr. [redacted] cell was in retaliation for him asking for help. The BWC footage shows Officer [redacted] saying to Officer [redacted] "[redacted] went down to complain." Officer [redacted] responds, "[l]et's do a cell search and let's make it count." AIMS report at 12.[8] The officers then proceeded to search Mr. [redacted] cell.

Nonetheless, the Hiring Authority concluded that no retaliation occurred.[9] The Hiring Authority appears to have attributed a non-retaliatory motive to the officers' search of Mr. [redacted] cell. Specifically, the Hiring Authority found that when Officer [redacted] stated, "let's do a cell search and let's make it count," he meant that he

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

[8] The case file produced by Defendants does not include this video. The quotations come from the investigation report, in which the investigator indicates that he reviewed the video and these statements were made at approximately 20:15. Both of the videos produced, however, start at 21:00, and therefore neither video includes the critical statements of the officers. Plaintiffs' counsel initially requested the video of the correct timeframe in March 2022, but Defendants never produced it. *See* Plaintiffs' Letter re Retaliation Against Class Member Declarant [redacted] at RJD, Mar. 24, 2022 at 2.

[9] A handwritten note on the first page of the AIMS inquiry report indicates that the Hiring Authority did not take action to refer the retaliatory cell search allegation to OIA, though a different staff misconduct allegation was referred to OIA stemming from this investigation. The Central Intake Panel rejected the referral and OIA did not conduct an investigation or approve direct adverse action.

intended for it to count as one of the three cell searches required per housing unit per day.[10]

This conclusion is contradicted by the evidence gathered in this case. First, none of the staff members interviewed in the inquiry stated that they searched Mr. [redacted] cell as one of three searches for the day. According to Sergeant [redacted] she ordered Officers [redacted] and [redacted] to conduct a security check to determine whether he had power in his cell. *See* AIMS report at 10-11. Officer [redacted] confirmed Sergeant [redacted] instructed him to confirm whether or not there was power in the cell, which he did. *See* AIMS report at 12. In contrast, Officer [redacted] states that they were instructed to search the cell for a power cord. *See* AIMS report at 8. The officers both state a reason why they searched the cell and neither mentions that it was done as one of the three searches conducted that day. That basis for the search has no support anywhere among the evidence uncovered in the investigation report.

Second, Officer [redacted] statement—"Let's do a cell search and let's make it count"—was directly preceded by the statement from Officer [redacted] that Mr. [redacted] complained. The natural conclusion is that they searched Mr. [redacted] cell because he complained, not for any other purpose. This inference is crucial because, even if the officers' true reasoning was to select Mr. [redacted] cell for one of the three searches that day, it would be improper for them to do so because he had sought help or complained.

Third, if the officers' intent had been to search Mr. [redacted] cell as one of the three searches for the day, they likely would have used different language, such as "Let's search his cell as one of the three" or "Let's search his cell as part of our daily searches." The phrase "let's make it count" suggests an impermissible motive.

Instead of holding the officers accountable for their serious misconduct, the Hiring Authority manufactured an exonerating explanation for their statements and behavior out of thin air. The failures of the Hiring Authority are particularly discouraging. If the evidence in this case—officers stating their retaliatory intent on camera—was not

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[10] The AIMS inquiry report contains a hand-drawn line from the statement "let's make it count" down to the bottom of the page. AIMS report at 12. At the end of the line, someone wrote "Meaning, count for 1 of 3 daily searches." *Id.* The handwriting appears to match handwriting from the Hiring Authority on the first page of the inquiry report. AIMS report at 1. The handwritten note likely refers to the CDCR policy that housing unit officers must conduct three cell searches per day per housing unit. *See* DOM § 52050.16.

sufficient to sustain a retaliation allegation, it is difficult to imagine a scenario in which any evidence would be sufficient.

Plaintiffs' counsel have now reviewed both investigations into Mr. [redacted] allegations of retaliation by Officers [redacted] and [redacted] The evidence in each case is sufficient, standing alone, to support findings of misconduct, though the Hiring Authority did not make such findings in either case. Taken together, they show an even clearer picture of retaliation. CDCR's ongoing practice of dividing related complaints into separate allegations results in incomplete and biased investigations and obstructs accurate fact finding, which in turn increase the likelihood that Hiring Authorities will wrongly exonerate staff. This practice must be stopped.

In addition, we note the serious consequences for Mr. [redacted] as a result of CDCR's deficient accountability system. As a result of ongoing retaliation and the related loss of his DME, Mr. [redacted] undertook a 53-day hunger strike. During that time he was hospitalized and he underwent medical protocols for hunger strike monitoring. This harmful, expensive, and resource-intensive outcome likely could have been avoided had CDCR held its staff accountable for retaliating against Mr. [redacted] Mr. [redacted] hunger strike reflects the same "hopelessness" in the incarcerated population identified by CDCR's Ombudsman during the December 2019 Strike Team interviews at RJD.

b. RJD – [redacted]

In this case, an officer unnecessarily slammed [redacted], to the ground in order to handcuff him after Mr. [redacted] failed to return to his cell from the dayroom. The investigation into this incident was biased and incomplete. And despite obvious violations of the use-of-force policy, the Hiring Authority did not sustain any allegations.

The video of this incident shows Mr. [redacted] standing in the dayroom when Officer [redacted] approaches him, repeatedly asking "Where do you stay at? Where are you housed at?" When Mr. [redacted] refuses to answer the question, Officer [redacted] escalates the situation, saying "You're gonna make me do this for real?" and "What the fuck's the deal?" Despite never having explicitly ordered Mr. [redacted] to return to his cell, Officer [redacted] begins accusing him of refusing an order. At this point, Officer [redacted] orders Mr. [redacted] to turn around and submit to handcuffs. When he does not, Officer [redacted] and two other observing officers initiate an immediate use of force against Mr. [redacted] and force him to the ground.

Mr. [redacted] a 65-year old class member with a mobility disability and a history of chronic lower back pain with left-sided sciatica, was injured during the incident. He reports in his 602 that he defecated on himself during the incident and that the incident caused severe pain in his neck and numbness in his extremities. Health care records confirm he required transport to an outside hospital following this incident. *See* Outside Records-Hospital dated December 28, 2021.[11]

This use of force violated multiple aspects of CDCR's use-of-force policy. First, just as in the [redacted] case at **SATF –** [redacted], *infra*, Officer [redacted] utilized immediate force when there was no imminent threat to his safety or the safety of others. *See* DOM §§ 51020.4, 51020.10 (permitting the use of immediate force only when there is an imminent threat to institutional security or the safety of persons). Throughout the interaction, Mr. [redacted] presents in a non-threatening manner. If any force was ultimately necessary to return him to his cell, given the lack of any imminent threat, a controlled use of force should have been initiated.

Second, before resorting to force, Officer [redacted] failed to utilize any alternatives, such as giving Mr. [redacted] a direct order to return to his cell, giving him a period to cool off, using a better tone in an effort to persuade Mr. [redacted] to comply, or threatening to issue him an RVR. *See* DOM § 51020.5 ("Whenever possible, verbal persuasion should be attempted in an effort to mitigate the need for force").

Third, Officer [redacted] failed to take Mr. [redacted] disability into account when using force, even though Mr. [redacted] was wearing his disability vest. The *Armstrong* Court found that "RJD staff failed to provide reasonable accommodations for class members' disabilities when RJD staff failed to use less force or no force when performing their penological duties, such as by throwing class members out of wheelchairs, punching them, kicking them, or using pepper spray where the undisputed evidence shows that the class members posed no threat to RJD staff that would warrant the use of such force." Dkt. 3059 at 59; *see also* DOM § 51020.5. The same appears true in this case.

The investigator conducted the investigation in an inappropriate and biased manner. Rather than interviewing Mr. [redacted] in a confidential setting, the investigator

[11] The 7219 completed by RJD states "no injuries found" for Mr. [redacted] and the IERC documents state that Mr. [redacted] had no injuries, and thus appear to be inconsistent with Mr. [redacted] medical record. The IERC documents do note that two officers suffered injuries as a result of the incident.

called Mr. [redacted] to the podium in the middle of his housing unit for the interview. Mr. [redacted] became justifiably upset and protested the way the interview was being conducted. The investigator terminated the interview because Mr. [redacted] was "belligerent" and yelled "right here, this is how you conduct yourself for an interview"? *See* Confidential Report at 1. The investigator did not acknowledge and the Hiring Authority did not identify that the investigator's manner of conducting the interview was the underlying cause of the need to terminate the interview.

In reviewing the BWC footage, the investigator shows further bias towards Mr. [redacted] when he determined that immediate force was necessary to "subdue an attacker, overcome resistance, and effect custody." *See* Confidential Report at 3. As discussed above, the video shows that immediate force was not necessary and that Officer [redacted] failed to comply with multiple use-of-force policies.

Ultimately, the investigator concluded that Mr. [redacted] allegation was without merit and recommended no further action. *See* Confidential Report at 4. The Hiring Authority adopted the recommendation and closed the allegation as unfounded.[12] *See* Closure Memo. As a result, no one was held accountable for this use of force that likely could have been avoided, but instead caused injuries to Mr. [redacted] and two officers.

c. RJD – [redacted], [redacted], [redacted], [redacted]

In the most recent production for RJD, Defendants produced videos of two separate incidents involving Officer [redacted] in which he unnecessarily escalated tensions by confronting *Armstrong* class members in crowded, open dayrooms about minor rule infractions, which ultimately led to him unnecessarily using pepper spray on them. The first incident (RJD – [redacted]) occurred on February 12, 2022. In that case, Officer [redacted] pepper sprayed Ms. [redacted]—a transgender class member at RJD who was a staff misconduct declarant—after Officer [redacted] confronted her and another transgender woman about whether they had to put on shirts over their sports bras. *See* BWC at 7:43:30. The second incident ([redacted]) occurred one week later on February 19, 2022. In that case, Officer [redacted] pepper sprayed Mr. [redacted], and then chased him through the housing unit and pepper sprayed him again, because Mr. [redacted] argued with Officer [redacted]

[12] Of note, the IERC found, apparently without reviewing the video footage of the incident, that staff's actions prior to, during, and after the incident were appropriate. *See* IERC Critique and Qualitative Evaluation at 1.

about whether he had to put on his state-issued blue t-shirt over his white undershirt before leaving the housing unit. *See* BWC.[13]

The videos of these incidents are alarming. In both cases, Officer [redacted] started and then escalated arguments about minor rules violations that did not have any bearing on the immediate safety of the institution. Given the public and confrontational nature of his interactions with these class members, it is not surprising that both cases escalated into arguments. If the goal was to gain compliance with prison rules (in both cases prison wardrobe requirements), Officer [redacted] could have taken the class members aside to speak with them or conveyed the compliance expectations less publicly to give people an opportunity to comply without having to grandstand. If that did not work, he could have sought assistance from a supervisor or issued rules violations for their failure to comply. *See* DOM § 51020.5 (stating that staff should mitigate the need for force whenever possible by using alternatives to force, such as verbal persuasion and verbal orders). Instead, after escalating tension in both cases, Officer [redacted] initiated an immediate use of force when there was no imminent threat to his safety or the safety of others. *See* DOM § 51020.4, § 51020.10 (permitting the use of immediate force only when there is an imminent threat to institutional security or the safety of persons).

There is some uncertainty regarding the status of the investigations into and any potential discipline against Officer [redacted] for these incidents.[14] On October 7, 2022,

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[13] Note that the BWC footage was produced in RJD – [redacted], a complaint by a witness to this incident. RJD – [redacted], which is the investigation into the 602 filed by Mr. [redacted] is not yet closed and therefore has not yet been produced to Plaintiffs' counsel.

[14] For the February 12 incident, the AIMS inquiry report indicates that the investigator was investigating whether Officer [redacted] (1) discriminated against Ms. [redacted] and (2) used unnecessary force. The file includes a closure memorandum indicating that Ms. [redacted] discrimination claim was not sustained and closed, but the file produced to Plaintiffs is silent on the status of the use-of-force investigation. Accordingly, it is unclear whether the use-of-force allegation was also closed or whether there was an OIA referral for or investigation into the use of force. For the February 19 incident, Defendants have not yet produced the case file for the investigation into Mr. [redacted] 602. Defendants have produced two files regarding related investigations into allegations made by people other than Mr. [redacted] ([redacted] and [redacted]), one of which included video of the incident. *See* BWC. RJD – [redacted] included a memorandum to "Plaintiffs' Counsel," indicating that the use of

Plaintiffs wrote an email to Defendants requesting an update on the status of the various investigations into these incidents and inquiring whether Officer [redacted] was still employed by CDCR and/or had been placed on administrative time off or reassigned. Plaintiffs sent a follow-up email on October 19, 2022. Defendants have responded by stating only that if an investigation is still pending it will not be produced. Due to the lack of clarity of this response, the status of these use-of-force investigations remains unclear. Moreover, the RJD production that Plaintiffs' counsel received on October 28, 2022, did not include any documents for [redacted] ([redacted] or [redacted] ([redacted] Because Plaintiffs do not yet know the status of the investigations or whether any discipline has been imposed against Officer [redacted] Plaintiffs will refrain from reporting fully on these cases in this report but will include them in a future report. Plaintiffs repeat our questions from the October 7 email:

1. **Is Officer [redacted] still employed by CDCR?**

2. **Did CDCR place Officer [redacted] on ATO or reassign him when it became aware of these incidents? If yes, please specify what actions were taken.**

3. **What is the status of the investigation into the use of force against Ms. [redacted]**

4. **What is the status of the investigation into the use of force against Mr. [redacted]**

5. **Given the similarities between the incidents, has CDCR combined the investigations? Is the same investigator investigating both incidents and the multiple allegations that have emanated from them?**

6. **Has Officer [redacted] been previously accused of or found to have engaged in similar misconduct? Has Officer [redacted] previously had any sustained allegations of misconduct?**

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force against Mr. [redacted] was being separately investigated in [redacted]. The memorandum also indicates that Mr. [redacted] allegations have been referred to OIA and that the investigation file will be produced to Plaintiffs' counsel once it is closed. That case file has not yet been produced to Plaintiffs.

2. SATF

a. SATF – [redacted]

This case involves the failure to address safety concerns raised by [redacted], a then-71-year-old class member with mobility and vision disabilities. Initially, staff ignored Mr. [redacted] requests for help, which resulted in him being assaulted by his cellmate, [redacted] and hospitalized. Upon Mr. [redacted] return to SATF, a series of subsequent failures to address his safety concerns would have, absent intervention by Plaintiffs' counsel, caused him to be returned to the yard with the person who attacked him. Plaintiffs' counsel have written about this case at greater length in a letter from [redacted] to Defendants. *See* Plaintiff's Objections to OIA Investigation [redacted] (Failure to Protect Class Member at SATF) and the letter's Exhibits, Nov. 4, 2022. Below is a summary of the serious problems with the investigation and discipline in this case. Most notably, although Defendants do not dispute that staff failed to document and act on Mr. [redacted] reported safety and enemy concerns, Defendants did not hold anyone accountable.

On May 11, 2021, Mr. [redacted] requested that custody staff move him away from Mr. [redacted] but staff did not act on that request. On May 12, Mr. [redacted] attacked Mr. [redacted] resulting in Mr. [redacted] being sent to an outside hospital due to the blunt force trauma he sustained to his head and arm. Later that same day, Sergeant [redacted] drafted a confidential memorandum, which was then signed by Facility D Captain [redacted] describing Mr. [redacted] safety concerns. Per policy, the memorandum should have been placed in Mr. [redacted] and Mr. [redacted] custody files. That did not happen for 16 days.

Meanwhile, on May 13, Mr. [redacted] returned to SATF from the hospital and was placed on quarantine status on Facility E. Over the next two weeks, both Mr. [redacted] and Plaintiffs' counsel repeatedly raised his safety concerns about being moved back to Facility D, where Mr. [redacted] had, within earshot of officers, threatened to kill Mr. [redacted] if he returned. Mr. [redacted] reported his safety concerns to multiple housing officers, who told him that he would nonetheless be sent back to Facility D once he cleared quarantine. He submitted an emergency 602 on May 16, explaining that if he was returned to Facility D it "*would endanger my life. I am 71 years old and I am effectively blind, and therefore I cannot defend myself.*" *See* Emergency 602 at 4 (emphasis added). The grievance was forwarded to Facility E Captain [redacted] and Facility D Captain [redacted] but no action was taken. On May 25, after a confidential legal call, Plaintiffs' counsel told the escort officer, Officer [redacted] of Mr. [redacted] safety concerns. Officer [redacted] reported, during the subsequent investigation, that after his conversation with Prison Law Office

("PLO"), he called a supervisor to inform her of Mr. [redacted] safety concerns. However, by the time the supervisor was interviewed pursuant to the investigation, she did not recall these events. In any event, the telephonic notice from Plaintiffs' counsel did not result in staff preventing Mr. [redacted] from being moved back to Facility D. The PLO then sent an advocacy letter regarding Mr. [redacted] safety on May 26, and a follow-up email on May 28, 2021. *See* Plaintiffs' Email at 11.

It was only after the May 28 email was forwarded to ADA Coordinator Critchlow that SATF took any action to ensure Mr. [redacted] was not returned to Facility D. ADA Coordinator Critchlow admitted the next morning that, in response to the PLO's email, the institution found that Mr. [redacted] was literally in the process of being returned to Facility D. She wrote: "[t]he confidential document that was done [regarding Mr. [redacted] safety and enemy concerns] was never uploaded and the enemy was never added to soms," and that "I am unsure who dropped the ball on D yard but [AW] Marsh is aware and we will figure out what happened on Tuesday and hold accountable if needed." The ADA Coordinator ended the email as follows: "*It was a very close call. I am glad I checked my email yesterday evening or it could have been bad.*" *See* May 29, 2021 email at 10 (emphasis added).

Despite the admission that staff at SATF had dropped the ball in a way that could have been very dangerous, no one at SATF was held accountable, sending a strong message to staff that the safety of people with disabilities is not important. The case involved at least three undisputed violations of policy: (1) the confidential memorandum was not entered into Mr. [redacted] and Mr. [redacted] files (most likely by either Sergeant [redacted] or Captain [redacted] (2) Captain [redacted] failed to appropriately respond to Mr. [redacted] emergency 602; and (3) no action was taken to protect Mr. [redacted] after the PLO informed Officer [redacted] that Mr. [redacted] had safety concerns. The Hiring Authority only sustained one allegation—against Captain [redacted] for inappropriately handling the emergency 602. Even for that allegation, the Hiring Authority took no action and imposed no discipline because Captain [redacted] retired before the OIA investigation concluded.[15] No staff received any adverse or even corrective action for the other serious

[15] The Hiring Authority found that Captain [redacted] had committed staff misconduct in two Disciplinary Matrix categories—one with a base penalty level of 2, and one with a base penalty level of 1. *See* 403 for Captain [redacted] Disciplinary Matrix (D2, D26). Yet the Hiring Authority nevertheless determined that the misconduct only warranted a Letter of Reprimand (Level 1), even though the Hiring Authority found no mitigating factors to

violations. Accordingly, even though the misconduct would have, absent Plaintiffs' counsel's interventions, resulted in Mr. [redacted] being returned to the yard where he had just been assaulted and even though ADA Coordinator Critchlow admitted it was a "very close call" that "could have been bad," no one was held responsible for these failures. The lack of accountability in this case is especially problematic given SATF's documented history of failing to take safety concerns seriously and the tragic consequences of those failures, including multiple brutal deaths of class members at the hands of their cell- and dorm-mates.

The failure to hold staff accountable stemmed, at least in part, from the incomplete investigation conducted by OIA. As but one example, it was undisputed that Sergeant [redacted] placed the memorandum in Captain [redacted] box, that Captain [redacted] then signed it, but that the memorandum was not delivered to the records department to be placed in Mr. [redacted] file. The investigator did nothing to investigate why the memorandum was not delivered, making it impossible to determine who was responsible for the failure. For such a serious allegation with admitted policy violations, the investigator should have done more to determine who was at fault.

b. SATF – [redacted]

This case occurred around the same time as the [redacted] case and involved two of the same captains—Captain [redacted] and Captain [redacted] engaging in the same type of misconduct—failing to address a class member's safety concerns. In this case, the class member's safety concerns were also reported by Plaintiffs' counsel. Despite the Hiring Authority's detailed findings, no one was disciplined. Captain [redacted] retired before the Hiring Authority imposed any punishment. And the Hiring Authority initially imposed an inadequate Letter of Reprimand to Captain [redacted] then inappropriately withdrew even that punishment after a *Skelly* hearing.

The Hiring Authority found that on May 28, 2021, Plaintiffs' counsel emailed OLA to report that *Armstrong* and *Coleman* class member [redacted], who at the time was [redacted], and housed on Facility E, had safety concerns on Facility D, where he had previously been housed. *See* [redacted] NOAA at 5. On June 1, the ADA Coordinator emailed Captain [redacted] (in charge of Facility D) and Captain [redacted] (in charge of Facility E) to ensure that Mr. [redacted] was interviewed about his safety concerns. *Id.* at 6. Captain [redacted] also assured the ADA Coordinator

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justify the reduction and identified nine aggravating factors that warranted increasing the penalty.

during a June 1 telephone call Captain [redacted] "would have [Mr. [redacted] interviewed as the allegations were pretty serious." *See* June 4, 2021 email at 3. On June 2, at 9:19 a.m., Captain [redacted] emailed Captain [redacted] to ask if Mr. [redacted] safety concerns were addressed when he was previously housed on Facility D. One minute later, Captain [redacted] replied, "Yes, the confidential was done, his enemy is inmate [redacted] Neither statement was true. No confidential memo had ever been completed or initiated, and Mr. [redacted] was not Mr. [redacted] enemy. As outlined above, Mr. [redacted] was Mr. [redacted] enemy. Captain [redacted] did not attempt to verify the false statements in Captain's [redacted] email, and Mr. [redacted] was subsequently re-housed on Facility D. For two days, he remained on Facility D, where his enemy was housed, until the ADA Coordinator discovered, contrary to what Captain [redacted] had reported, that no confidential memorandum existed.

Neither Captain [redacted] nor Captain [redacted] faced any consequences for their failure to appropriately document Mr. [redacted] safety concerns. Captain [redacted] retired before the investigation was complete.[16] The Hiring Authority initially issued a Letter of Reprimand[17] to Captain [redacted] a penalty not consistent with the Matrix.[18] The Hiring

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[16] In addition, the Hiring Authority waited eight months after receiving authorization from OIA to impose direct adverse action against Captain [redacted] before issuing the 402/403. OIA approved direct adverse action on September 1, 2021, *see* OIA email at 1, but the Hiring Authority did not act until May 16, 2022. Had the Hiring Authority not delayed so long, she would have been able to impose discipline against Captain [redacted] whose last day of work was January 28, 2022, and who retired on March 21, 2022. *See* [redacted] Retirement.

[17] The case file contains a Form 403 stating that Captain [redacted] was suspended for five days without pay. However, the actual Notice of Adverse Action and the *Skelly* hearing document both indicate that the only discipline imposed on Captain [redacted] was a Letter of Reprimand, later rescinded.

[18] The Hiring Authority found that Captain [redacted] had committed staff misconduct in four matrix categories, two with a base penalty of Level 3. *See* [redacted] 403. Yet, the Hiring Authority initially issued only a Letter of Reprimand (Level 1). *See* [redacted] NOAA. That decision was not justified. There were only two mitigating factors—that the misconduct was unintentional and Captain [redacted] had previously received commendations. But the fact that the conduct was "unintentional" fails to appropriately capture that even if unintentional, Captain [redacted] conduct was grossly negligent.

Authority then withdrew the adverse action at Captain [redacted] *Skelly* hearing. Thus, just as in the [redacted] case discussed above, Captain [redacted] and Captain [redacted] faced no consequences for their endangerment of a person with disabilities.

CDCR's failure to impose any discipline in this case is especially egregious given the facts in the [redacted] case. The evidence in the two cases shows that supervisory staff generally, and possibly Captain [redacted] specifically, played a central role in failing to take steps required by policy to ensure that two class members were protected from people who had previously assaulted them. And yet the Hiring Authority did not hold anyone accountable. CDCR investigated these two cases in isolation, as neither investigation acknowledges the other, despite the pattern of similar alleged conduct, time period, and subject officers.

The SATF production included another case, SATF – [redacted], which was an investigation into an allegation that a 72-year-old, hard-of-hearing class member was killed by his pod-mate after staff failed to respond appropriately to his safety concerns.[19] *See* Investigative Report. The evidence in that case is more mixed, in part because the investigation was not conducted until two years after the homicide and because the investigator did not interview the alleged assailant. Nonetheless, the incident underscores the potential life-or-death consequences of SATF staff's failures to appropriately respond to safety concerns. These risks are especially high for class members who, as a result of their disabilities, are less able to protect themselves from threats when staff fail to take action to protect them. No discipline was imposed in any of these three cases involving *Armstrong* class members who were killed, seriously harmed, or carelessly placed at risk of further violence. The total lack of accountability signals to all staff that class members' safety concerns do not matter.

c. SATF – [redacted]

This case arose from an incident where Officers [redacted][20] and [redacted] unnecessarily initiated a premeditated immediate use of force against [redacted],

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And even assuming the two mitigating factors were appropriate, they should not have outweighed the five aggravating factors identified by the Hiring Authority.

[19] The protection from harm allegation in this case again was reported by Plaintiffs' counsel.

[20] Plaintiffs have reported on the conduct of Officer [redacted] in a previous letter. *See* Plaintiffs' Review of SATF Q1 2022 Production, June 3, 2022, Case [redacted], at 32.

[redacted], a *Coleman* class member. In the incident, which is partially captured on Officer [redacted] BWC, Mr. [redacted] isolated himself in the housing unit's rotunda/sallyport and refused orders to return to his cell after the officers denied him permission to use the dayroom telephone. Though the local investigator conducted an incomplete and biased investigation in which he concluded that no misconduct occurred,[21] the Hiring Authority rightly determined that the officers had violated policy by initiating an immediate use of force when Mr. [redacted] posed no imminent threat and could have been secured in the rotunda. The Hiring Authority referred the case to OIA, which authorized direct adverse action.[22] The Hiring Authority then concluded that Officers [redacted] and [redacted] had (1) used unnecessary force and (2) failed to follow policy and training.[23] The Hiring Authority, however, failed to impose adverse action, issuing the officers only Letters of Instruction.

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[21] The investigation was incomplete and biased in numerous ways. Other than Officer [redacted] the investigator did not interview any of the multiple officers involved in the use of force. The investigator did not interview Mr. [redacted] The investigator did interview (1) an officer not present during the incident, from whom the investigator included an irrelevant statement in the investigation report that the officer had "never heard of Officer [redacted] beating up any inmate," and (2) an incarcerated person housed in a *different building* on the date of the incident, from whom the investigator included an irrelevant statement in the investigation report that he had never seen Officer [redacted] beat up anyone in his building. The investigator did not review BWC footage for anyone other than Officer [redacted] even though Officer [redacted] BWC footage is obstructed for part of the use of force.

[22] The documents produced were missing the OIA referral packet.

[23] The disciplinary documents in this case are confusing and inconsistent. The 402s for each officer indicate that the Hiring Authority sustained allegations of unreasonable use of force against each officer. *See* 402s for Officer [redacted] and Officer [redacted] The 403s for each officer only indicate that the applicable Disciplinary Matrix section was for failure to observe and perform within the scope of training, post orders, duty statements, department policy or operational procedures (D26), not for using unreasonable force. *See* 403s for Officer [redacted] and Officer [redacted] Meanwhile, the Letters of Instruction are not entirely clear, but the most natural reading is that they include findings that the officers used unreasonable force *and* failed to follow the controlled use-of-force policy. *See* Letters of Instruction for Officer [redacted] and Officer [redacted]

The Hiring Authority correctly determined that the immediate use of force was unreasonable and violated policy. Officer [redacted] BWC footage shows Mr. [redacted] run from the dayroom into the rotunda at 13:27:35 and stand by the housing unit's front door. Beginning at 13:27:40, before even ordering Mr. [redacted] to return to his cell, Officers [redacted] and [redacted] can been heard discussing their plan to call a Code One. Officer [redacted] tells Officer [redacted] "we'll hit an alarm, we'll just do a 'disruptive inmate,' we'll hit an alarm and he can sit there on the door, he can hold by the door, and we'll have staff hit him on that side and we'll hit him on this side." At 13:29:00, the officers approach the rotunda, and Officer [redacted] states: "[redacted] your opportunity to go back to the house," but at this point the officers are already blocking his way out of the rotunda. At 13:29:12, Officer [redacted] calls over the radio, "Code One Echo Building Four disruptive inmate in the rotunda at the front door holding us hostage," as he and Officer [redacted] advance on Mr. [redacted] in the rotunda. Mr. [redacted] stands at the front door throughout, not responding to orders but showing no signs of aggression or any indication that he poses a threat to anyone. Even as the officers confront him, Mr. [redacted] makes no movement towards them, and simply stands with his arms crossed at the front door, which is opened at 1:29:44. At 1:29:47, Officer [redacted] grabs Mr. [redacted] arm as he is ordering him to turn around to be handcuffed, initiating an immediate use of force, at which point the responding officers enter from outside the building. There is then a scuffle during which three officers suffered minor injuries.

The Hiring Authority should have imposed at least a Level 2 adverse action against both officers, but instead issued only Letters of Instruction. The Disciplinary Matrix sets a base level penalty of 2 for an unnecessary use of force, and a base level penalty of 1 for failure to observe and perform within the scope of training. *See* Disciplinary Matrix (L1, D26). In the 403s, the Hiring Authority did not point to any mitigating factors to justify decreasing the penalties and therefore should have, at a minimum, imposed a Level 2 penalty. *See* 403s for Officer [redacted] and Officer [redacted] *see also* 15 C.C.R. § 3392.4(c)(9)(11) (Mitigating and Aggravating Factors).

In fact, there were aggravating factors present here that might have warranted increasing the penalty level. First, the use of immediate force was premeditated and intentional. As the Hiring Authority noted, Officers [redacted] and [redacted] "are heard via Body-Worn Camera (BWC) footage discussing how [they] are going to handle the incident" after [redacted] was "non-receptive to [their] direct orders," and initiated an immediate use of force even though "there was no imminent threat, and [redacted] was in a controlled situation/area" by himself in the rotunda, such that the officers "should have first contacted a supervisor to determine the use of force necessary in this situation." *See* Letters of Instruction for Officer [redacted] and Officer [redacted] The misconduct also had

serious consequences, another aggravating factor, by creating a situation that resulted in Mr. [redacted][24] and three officers sustaining injuries, which could have been avoided had the officers initiated the controlled use of force protocols or otherwise attempted to deescalate the situation. *See* Incident Report Package at 17; Letters of Instruction for Officer [redacted] and Officer [redacted] In any event, it was inappropriate for the Hiring Authority to issue only Letters of Instruction to these officers for misconduct that resulted in injuries to Mr. [redacted] and three officers.

3. COR

a. COR – [redacted]

In this case, [redacted] class member, alleged that on April 17, 2022, when he went man down in his cell for hypoglycemia (low blood sugar), staff denied him access to medical care because they thought he did not look sick. *See* Investigation Report at 5.[25] Hypoglycemia is a dangerous condition that, if left untreated for too long, can lead to seizures, coma, and even death. *See* American Diabetes Association.

The investigation report produced for this incident confirms that staff did not call medical in response to Mr. [redacted] request. This conduct violated CDCR's policy that "[p]atients may request medical attention for urgent/emergent health care needs from any CDCR employee" and that "[t]he employee *shall, in all instances*, notify health care staff." *See* HCDOM § 3.7.1.d at 1. (emphasis added). The incomplete and biased investigation failed to even mention this policy. And the Hiring Authority failed to hold any staff accountable for this violation.

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[24] Mr. [redacted] reported to Plaintiffs' counsel that he suffered significant injuries from the incident, but that staff refused to document his injuries. The 7219 form completed later that day lists no injuries, though the intensity of the incident as shown on the video suggests Mr. [redacted] could have been injured.

[25] Mr. [redacted] medical records indicate that he does experience hypoglycemia. During a February 10, 2022 visit, he reported that he had a sensation that he was "going to have a seizure," and his blood sugar was recorded as falling below the normal range at 59. The assessment/plan from the follow-up visit on February 11, 2022 states he is "encouraged to report to medical if having any symptoms of hypoglycemia." *See* Outpatient Progress Note (dated February 11, 2022).

Correctional Lieutenant [redacted] conducted the local investigation.[26] The evidence was undisputed that Mr. [redacted] asked for medical assistance from multiple officers but that none of them contacted medical staff. When Officer [redacted] was asked in his interview why he did not remove Mr. [redacted] from the cell for medical attention, he stated that Mr. [redacted] "seemed to be fine," and that Mr. [redacted] seeks medical attention "without reason" and this appeared to him to be one of those situations. Investigation Report at 21-22. The second officer interviewed, Officer [redacted] was asked whether he knew Mr. [redacted] was having a medical emergency and he acknowledged that he did, stating that Mr. [redacted] "told me he was man down." When asked if he observed whether he needed medical attention he admitted that he did not even make visual contact with him stating, "he had his window covered up, I couldn't see him, but he was talking to me."[27] Investigation Report at 22. Lastly, the control booth officer, Officer [redacted] was questioned about whether Mr. [redacted] was denied access to medical care to which he replied that he was not, because "[he] was not in need of medical attention […]." Investigation Report at 22. The investigator, after reviewing BWC video,[28] also concluded that "Inmate [redacted] appears to not need immediate medical attention […]" *See* Investigation Report at 23.

The investigator and the officers all commit the same mistake of supplanting their judgment for the judgment of trained medical professionals—the exact risk the CDCR

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[26] For reasons unclear, even though this complaint was filed in April 2022, it was not screened by the Centralized Screening Team. Instead, the appeal was screened by local grievance staff, who determined that the allegation was not on the Allegation Decision Index ("ADI") and routed it for a local investigation. The misconduct alleged in Mr. [redacted] complaint amounts to endangerment, which is on the ADI. The allegation therefore should have been routed to AIMS for investigation. *See* Investigation Report at 8.

[27] The BWC footage for Officer [redacted] depicting this interaction was not produced to Plaintiffs' counsel but was reviewed by the investigator and cited in his report.

[28] The BWC footage confirms the investigation report. Mr. [redacted] states that he has a "medical emergency" and that the officers in the unit are denying him access to medical care. Officer [redacted] says, "What's your medical [emergency]? You look good though." Mr. [redacted] says, "You don't know." Officer [redacted] says, "Exactly, I'm not a doctor." Mr. [redacted] then says, "My sugar is low." Officer [redacted] then moves away from the cell front, completes his rounding, and returns to Mr. [redacted] cell, but never does follow policy for seeking medical attention for Mr. [redacted]

policy is intended to eliminate. Even if Mr. [redacted] had previously requested unwarranted medical attention, the policy prohibits custody staff from denying Mr. [redacted] access to medical care. Their conduct was especially problematic here where the condition about which Mr. [redacted] complained—hypoglycemia—is not something that can be readily identified by looking at someone, and can lead to serious health consequences. When Mr. [redacted] went man down in his cell, staff were required to contact medical staff. That the investigator did not even mention the policy suggests bias against Mr. [redacted]

There is additional evidence of bias in the investigation report, including the fact that the investigator interviewed all three staff members about the incident but chose not to interview Mr. [redacted] Further, while the investigator omitted problems with the officers' conduct in his report, such as Officer [redacted] failure to provide Mr. [redacted] with a 602 upon request, he included mention that Mr. [redacted] appeared "aggressive" and "agitated."

Staff should have been held accountable for endangering Mr. [redacted] but were not, in part because the investigation report was incomplete and biased.

4. KVSP

a. KVSP – [redacted]

In this case, [redacted], a *Coleman* class member, reported to staff that he had safety concerns about another incarcerated person in the housing unit. The BWC footage shows that Officer [redacted] was dismissive of Mr. [redacted] explored the safety concerns directly with the purported enemy in ways that may have endangered Mr. [redacted] and failed to act appropriately in response to the safety concerns. CDCR policy provides that incarcerated people "are responsible for providing sufficient information to positively identify the claimed enemy." DOM 61020.3.4. Once that happens, "[s]taff shall make concerted efforts to evaluate, verify, and document this information. Verification may include an interview with the alleged enemy *when it can be done without jeopardizing an investigation or endangering the inmate*." *Id.* (emphasis added). The Hiring Authority only imposed corrective action for the violation: a half-hour training on respect. This case represents another example of failures to hold staff accountable for inappropriate responses to class members' safety concerns.

Officer [redacted] BWC shows that on February 17, 2022, at 11:11:51, Mr. [redacted] stepped into the housing unit custody office to report that the person below him had threatened his life. Throughout the entire conversation, Officer [redacted] is rude, unprofessional, and dismissive. Officer [redacted] starts by asking, "You pulling

shit out of the air or is this for real?" Officer [redacted] then asked if the alleged enemy would admit threatening Mr. [redacted] or if Mr. [redacted] neighbors would corroborate the threat. Mr. [redacted] said he did not know if his neighbors heard it. Officer [redacted] then attempts to end the conversation, saying he would "write it down" and then repeatedly saying "bye" to Mr. [redacted] in a dismissive manner. Officer [redacted] also said that he would "tell the sergeant." When Mr. [redacted] asked for Officer [redacted] name, Officer [redacted] stood up, and said "get out of my cell." Officer [redacted] followed Mr. [redacted] back into the housing unit and walks directly to the alleged enemy's cell to ask, "Are you threatening to beat up the guy upstairs?" The alleged enemy responded, "Who said that?" Although Officer [redacted] did not identify Mr. [redacted] it would have been obvious to anyone watching and listening that Mr. [redacted] was the accuser, given that Officer [redacted] followed Mr. [redacted] out of his office and immediately went to the enemy's cell.

About forty minutes later, at 12:33, Officer [redacted] again interviewed Mr. [redacted] about his safety concerns, although the interview itself was not captured on BWC because Officer [redacted] deactivated his BWC for the interview with a potential confidential informant. *See* BWC 2. Even after this interview, Officer [redacted] failed to "evaluate, verify, and document" the information Mr. [redacted] provided. As Officer [redacted] admitted to the local investigator, he "began to document the interview on a 128B; however, stated he became extremely busy and forgot to finish the document." *See* Attachment C at 2. Officer [redacted] told the investigator that he reported Mr. [redacted] safety concerns to a sergeant on an unspecified date. *Id.* That sergeant told the investigator that he assumed Mr. [redacted] safety concerns were not substantiated because Officer [redacted] was still "working on a document," and Mr. [redacted] had not been moved. *Id.* at 3. During his interview with the investigator, Officer [redacted] stated that "he [was] not fully aware of what would need to happen" to address an incarcerated person's safety concerns. *Id.* at 2.[29]

The investigator correctly concluded that Officer [redacted] (1) did not take appropriate steps when informed of Mr. [redacted] safety concerns and (2) used inappropriate language with Mr. [redacted] The Hiring Authority agreed. Yet the only action taken against Officer [redacted] was a single, half-hour paid training on "Rights and Respect of Others." *See* [redacted] – OJT. This training on the topic of respect was appropriate; Officer [redacted] actions toward Mr. [redacted] fell far below the

[29] The investigator should have obtained Officer [redacted] training records to determine if he had been trained on how to address safety concerns.

standard of respect expected of officers. But even if only corrective action were appropriate, the training should have covered how to address safety concerns, an area of policy Officer [redacted] admitted he did not understand.

Moreover, the evidence supports a conclusion that Officer [redacted] negligently endangered Mr. [redacted] by violating CDCR policy (D2), which carries a base penalty of 2. Yet there is no indication that this policy failure was even identified or considered. Mr. [redacted] 602 precipitated an interview by Sergeant [redacted] on February 22, 2022, which substantiated Mr. [redacted] safety concerns. *See* Attachment C at 3-4. Although Mr. [redacted] was not attacked by his alleged enemy in the five days between February 17 and February 22, Officer [redacted] failure to follow policy placed Mr. [redacted] in danger. Given the serious nature of Officer [redacted] misconduct, the Hiring Authority should have referred the case to OIA for authorization to impose adverse action. That the Hiring Authority instead gave Officer [redacted] corrective action that did not even address his knowledge deficit regarding policies for safety concerns presents further evidence that CDCR does not take seriously the safety of class members. Until staff are held accountable for this type of misconduct, they will continue to violate policy and to endanger class members.

III. DEFENDANTS FAILED TO REVIEW VIDEO EVIDENCE IN INVESTIGATIONS AND TO PRODUCE VIDEO EVIDENCE TO PLAINTIFFS' COUNSEL

Pursuant to the Remedial Plans and Defendants' BWC policy, video footage must be retained for all triggering events, including, but not limited to, any allegation of staff misconduct, any PREA allegation, any allegation of misconduct by an incarcerated person (e.g., serious RVR), any suspected felonious criminal activity, and any use-of-force incident. *See, e.g.*, RJD Remedial Plan, § I; RJD Remedial Plan, Attachment B ("Operational Plan No. 28"), § VII.B; RJD Remedial Plan, Attachment A ("Operational Plan No. 131"), § VI.B. Furthermore, "AVSS and BWC will be reviewed and considered with other available evidence for any triggering event." RJD Remedial Plan, § I; Five Prisons Remedial Plan, § I; CIW Local Operating Procedure 210 at 2-3. If an inquiry/ investigation in which video was reviewed and retained involved an *Armstrong* class member at RJD or a disabled inmate at the Five Prisons, Defendants must produce the video in the quarterly production. RJD Remedial Plan § IV; Five Prisons Remedial Plan § V. Defendants' policies require video evidence to be reviewed and considered in all investigations into allegations of staff misconduct when video should have been available for review.

These requirements are in place because of the importance of video evidence for investigations and ultimately for accountability. Prior to the Court's Orders, the lack of video evidence at the Six Prisons meant that most investigations boiled down to an unresolvable conflict between incarcerated people's allegations and staff's denials. Video can provide objective evidence of what transpired between staff and incarcerated people, thereby providing the evidence necessary to hold officers and other staff accountable when they violate policy and to exonerate them when they do not. It is therefore critical that Defendants retain video in accordance with policy, that investigators and Hiring Authorities make reasonable efforts to obtain and review relevant footage, and that Defendants produce to Plaintiffs and the Court Expert video that was considered by investigators and Hiring Authorities.

There are limited circumstances in which video should not be reviewed during an investigation: (1) the video was appropriately deleted (meaning the complaint was made more than 90 days after the incident and the incident was not a triggering event that should have automatically led to retention); (2) the investigator cannot locate video evidence, after exhausting reasonable efforts to identify the date, time, and location of the alleged incident; or (3) the investigator concludes that the incident occurred under circumstances where video does not exist (e.g., during a circumstance in which staff are required to deactivate their cameras or prior to implementation of video at an institution). Where the investigator does not obtain and review any video evidence, the investigator should explain in the investigation report why they could not obtain and review video.

As part of Plaintiffs' substantive review of investigations and discipline (§ II, *supra*), Plaintiffs considered whether Defendants failed to retain, review, or produce relevant video evidence. The violations listed below are also captured in Table A, and reproduced here because of the importance of this issue to Defendants' compliance with the Court's Orders and the Remedial Plans.

Plaintiffs found several problems with Defendants' retention, review, and production of or failure to produce video evidence, all of which should be remedied going forward. Three problems that arose repeatedly deserve special attention.

First, investigators are delaying their investigations, or at least their requests for available video footage, until after the 90-day retention period has expired, meaning video evidence sometimes cannot be reviewed. For example, in RJD-[redacted], the claimant alleged that when he was assaulted by another incarcerated person on September 5, 2021, two officers failed to respond. BWC footage was essential to show whether the subject officers saw the assault while it was happening. A lieutenant

interviewed the subject on October 11, 2021 for unclear reasons, as the lieutenant was not the AIMS investigator. That lieutenant reviewed AVSS footage confirming the assault occurred, but failed to retain it. The case was referred to AIMS a week later, on October 18. On November 15, the AIMS investigator reviewed other AVSS footage that does not appear to show the incident. Not until March 21, 2022—five months after the referral—did the AIMS investigator interview the lieutenant, who identified the officers who may have witnessed the incident. When the AIMS investigator requested those officers' BWC footage, it had been destroyed under the 90-day retention policy. Absent the investigator's delays and the initial failure to retain footage, relevant AVSS and BWC footage would have been retained and available to review. Similar issues arose in other cases. *See also* KVSP-[redacted]; COR-[redacted]; COR-[redacted]; SATF-[redacted]; SATF-[redacted]; RJD-[redacted].

Second, investigators are requesting inappropriately short windows of video footage. For example, in SATF-[redacted], the investigator failed to request sufficient BWC footage to assess the allegation that the subject officer spoke negatively about the claimant to two other incarcerated people to incite violence against the claimant. The claimant wrote that the event occurred at 4:30 p.m., but the investigator only requested video *for exactly one minute* from 4:30 p.m. to 4:31 p.m. The investigator should have requested a wider range of video at the outset. Moreover, that BWC footage showed an in-progress interaction between the subject officer and one of the incarcerated people the claimant identified. Viewing that excerpt should have led the investigator to fix their original mistake by requesting BWC footage from a larger time window. Instead, the investigator concluded that the misconduct did not occur, because the officer did not make any comments about the claimant in the one minute of requested video. Similar problems occurred in other investigations. *See also* RJD-[redacted]; RJD-[redacted]; KVSP-[redacted].

Third, investigators are requesting video footage from the wrong window of time, and then relying on the absence of evidence to exonerate accused staff. In SATF-[redacted], the claimant also alleged misconduct occurred at 2:35 p.m. (threatening a retaliatory RVR) and 3:15-3:37 p.m. (a retaliatory search of the claimant's pod). The investigator requested only six minutes of footage from an entirely different time window—3:41-3:46 p.m.—and concluded based on that footage that the subject officers did not commit misconduct. Similarly, in RJD-[redacted], the claimant alleged that misconduct occurred around 10:00 a.m. The investigator requested footage beginning at 10:00 a.m. The investigator should have requested footage *surrounding* 10:00 a.m. to genuinely evaluate whether the alleged incident occurred. *See also* KVSP-[redacted].

As a related issue, Defendants' form for requesting video footage—Form 1118—does not require the person requesting the video to indicate the date he or she made the request. The absence of this information on the form occasionally makes it difficult to determine whether the investigator made a timely request for video. Plaintiffs have raised this issue previously. *See* Plaintiffs' Review of Q4 2021 Production of Investigation from RJD, June 6, 2022, at 10.

KVSP

[redacted]	The investigator failed to review relevant BWC footage, even though the grievance specified the date and time of the incident. The investigator timely requested the subject officer's BWC footage, but received an email from KVSP ISU stating "there was no BWC footage for [the officer]" that date. The investigator failed to investigate why the officer had no BWC footage from that day, including whether he failed to comply with BWC policies. The investigator also failed to review BWC footage from the other officer working with the subject officer during the incident. The AVSS footage the investigator reviewed lacks audio, and shows that the other officer was potentially within audio range of the conversation between the subject officer and the claimant. The other officer's BWC could have provided audio relevant to the investigation.
[redacted]	The investigator failed to timely request relevant BWC footage to ensure that it was retained. The claimant identified January 15 and January 17, 2022 as dates he was denied incontinence showers. Although the investigator requested footage for both dates, BWC footage for January 15 was unavailable "due to being outside of the available time range." Also, the investigator requested an inappropriately short window of BWC footage from January 17, 2022. The claimant indicated that the incident occurred at "approximately 0900 hours." The investigator requested BWC footage for the subject officer from only 8:55-9:05. Because that video included no interaction between the subject and the claimant, the investigator relied on it, in part, to conclude the officer did not deny the claimant an incontinence shower. Given the claimant's statement that the incident happened at approximately 9:00 a.m., which indicates some uncertainty about the precise time, the investigator should have requested and reviewed BWC footage from, at minimum, 8:30-9:30.

COR

[redacted]	Although the incident occurred October 24, 2021, and the case was referred to AIMS on November 30, 2021, the investigator did not start the investigation and attempt to conduct the first interview until February 10, 2022—after the 90-day retention period had expired. As a result, the file states that AVSS and BWC footage capturing the interaction between the office and the claimant was not retained.
[redacted]	Defendants did not produce the accused officer's BWC footage to Plaintiffs' counsel, even though the investigator referenced viewing that footage.
[redacted]	The investigator failed to request AVSS and BWC footage in part because the accused officer worked a 16-hour shift on the day in question. However, the investigator could have watched the AVSS footage at high speed to identify any time where the accused officer walked past the claimant's cell, and then requested BWC footage from that relevant period.
[redacted]	The investigator did not begin the investigation until over six months after the allegations were received. As a result, relevant AVSS and BWC footage from the subject officers was not retained and the investigator did not review it.
[redacted]	The investigator did not review BWC footage from the incident at issue—in which the subject officer threatened to use OC spray on the claimant, as the officer had stated during the interview.

SATF

[redacted]	SATF inappropriately denied the investigator's request for AVSS footage for Second Watch on the two days in question because the time frame was too large. Although the claimant did not remember the specific times, the claimant remembered the dates and shift, and the investigator failed to timely interview the claimant—contributing to his failure to remember the times in question.
[redacted]	The investigator requested both AVSS footage and BWC footage from the subject officer, but SATF wrote back that "the BWC server showed there no footage recorded" by Officer [redacted] BWC. The file contains a handwritten note on the last page of the Memorandum to the Hiring Authority reviewing the AIMS inquiry, stating "review case further into

	the lack of BWC footage," but there is no indication that this potential violation of the BWC policy was actually investigated. Plaintiffs have previously reported on Officer [redacted] non-compliance with BWC policies. *See* Plaintiffs' Review of Q4 2021 Production of Investigation from RJD, June 6, 2022, at 18.
[redacted]	SATF received the grievance on November 29, 2021 and did not refer it for investigation until January 3, 2022. By the time the investigator requested BWC footage, it was no longer available, as 90 days had already elapsed since the October 15, 2021 incident. BWC footage would have helped resolve contradictory testimony and address gaps in memory.
[redacted]	See discussion above.
[redacted]	See discussion above.

RJD

[redacted]	The investigator failed to request sufficient BWC footage to determine whether, as alleged, the subject officer refused to provide the claimant with food. The claimant said that he interacted with the officer at "approx. 3:00 during third watch." The investigator, however, only requested video from 2:59 to 3:03 p.m. When that video did not show any interaction between the two, the investigator concluded that the misconduct did not occur. The investigator should have requested a wider range of footage that captured the interaction between the claimant and the officer, especially given the claimant's uncertainty about the precise time of the event.
[redacted]	See discussion above. In addition, the investigator failed to obtain other relevant BWC footage. The involved teacher mentioned during her interview that she recalled an interaction with the claimant on February 1, 2022. The investigator pulled AVSS footage showing an interaction between an incarcerated person and a non-uniformed person, likely the claimant and subject teacher. *See* RJD_3.9_0140L__02-01-2022__1000-1040__APP_229154 from 10:17:30-10:17:55. During the entire interaction, an officer was standing only a few feet away and, during the middle of the interaction, another officer approached. According to the investigation report, the investigator did nothing to identify these officers to obtain and review their BWC footage, or to interview them.

[redacted]	This investigation concerned whether the subject officer failed to contact a sergeant about the claimant's safety concerns, after promising that he would do so. For unclear reasons, the investigator only requested four minutes of BWC footage (12:14-12:17 p.m.). The investigator should have requested additional BWC footage from the officer's shift to determine if he contacted a sergeant, especially given the officer's statement in the interview that he could not recall whether he contacted a sergeant.
[redacted]	See discussion above.

IV. OFFICERS ARE NOT COMPLYING WITH BWC POLICIES

Plaintiffs have repeatedly notified Defendants of officers' widespread noncompliance with the BWC activation/deactivation policies negotiated by the parties. *See*, *e.g.*, Letter from [redacted] to [redacted] & [redacted] (June 18, 2021); *see also* Letter from [redacted] to [redacted] & [redacted] (Feb. 9, 2022) (regarding SATF noncompliance); Letter from [redacted] to [redacted] & [redacted] (Mar. 3, 2022) (regarding SATF noncompliance); Letter from [redacted] to [redacted] & [redacted] (Apr. 19, 2022); Letter from [redacted] to [redacted] & [redacted] (June 3, 2022); Letter from [redacted] to [redacted] & [redacted] (June 6, 2022); Plaintiffs' Review of Investigation and Discipline Documents from LAC, RJD, CIW, COR, KVSP, at 30-33 (Sept. 2, 2022). The Court Expert's September 30, 2022 report also discussed officers' noncompliance with the BWC policies. *See* Dkt. 3433 at 5.

The policies mandate that officers' BWCs are to remain on for the entirety of an officer's shift, except for specified deactivation events. *See* Connie Gipson, Update to Body-Worn Camera Deactivation Events (Aug. 19, 2021); *see, e.g.*, Operational Plan No. 28 § VI.B.10; Five Prisons Remedial Plan, Attachment B (Local Operations Procedure 944) § VI.B.10. Before deactivating their cameras, officers must announce the reason for the deactivation so that it is recorded by the BWC. Operational Plan No. 28 § VI.B.10; Local Operations Procedure § VI.B.10. And officers must reactivate their cameras as soon as the deactivation event has concluded, and announce their reactivation. *Id.*, § VI.B.11; Local Operations Procedure § VI.B.11.

Our review of the BWC footage in the productions shows that staff continue to violate these policies.

Moreover, the case files indicate that investigators and the Hiring Authorities are failing to take appropriate action when BWC videos reflect intentional noncompliance.

The Remedial Plans require that "[i]f, during the course of the investigation, the [Office of Internal Affairs ("OIA")] investigator discovers additional misconduct, they shall investigate the additional misconduct if it is directly related in time and scope to the incident being investigated. If the additional misconduct is not directly related to the incident, the OIA investigator shall refer" the case for additional investigation. RJD Remedial Plan § II.B.; Five Prison Remedial Plan § II.B.[30]

Plaintiffs reviewed each deactivation/reactivation for all unique BWC videos produced by Defendants to determine whether (1) the officer, as required by policy, announced the reason for the deactivation, (2) the deactivation appeared to be for an appropriate deactivation event, and (3) the deactivation may have been an intentional effort by the officer to interfere with the camera capturing misconduct ("code of silence").

As reflected in the table below, officers frequently fail to announce reasons for deactivations and reactivations.

Prison	Failure to Announce Violations
COR	[redacted]: S CENT KIT 6 201066, 8:21:59 (reactivation)
	[redacted]: 3A 3 PROGRAM SGT ASU EOP 210354, 9:24:04 (reactivation)
SATF	[redacted]: Z PROGRAM SGT ASU 290402, 8:16:07 (reactivation)
	[redacted]: Z CNTRL 391902, 15:20:40 (reactivation)
	[redacted]: E PROGRAM SGT 350323; 9:24:44-9:27:57 (deactivation and reactivation)
RJD	[redacted]: HCA C CLINIC 1 C042034, 14:02:49-14:44:20 (deactivation and reactivation)

Plaintiffs also found that an officer at COR deactivated his camera in impermissible circumstances. *See* BWC from COR-[redacted]. At 11:34:13, the officer claimed the circumstance for deactivation is an "RVR interview." However, an RVR interview is not a permissible reason to deactivate a camera. The investigator did not mention the officer's BWC noncompliance in the investigation report. However, the

[30] Although investigators are not required to review every deactivation in every BWC video in a case file to determine whether the officer complied with the BWC policies, investigators are required to either investigate or refer for investigation any instance of BWC noncompliance they discover in the ordinary course of their investigation.

officer's BWC noncompliance related directly to the allegation at issue in the case—that officers were disrespectful and biased during the claimant's RVR hearing. The investigator should have investigated the officer's BWC compliance as part of the same investigation. *See* Five Prisons Remedial Plan § II.B. Instead, the investigator relied on the BWC footage produced, which consisted of only the first few seconds of the RVR hearing, to exonerate the subject officers.

In another case, SATF-[redacted], the officer deactivated his video in what appear to be improper circumstances with no audible announcement, and reactivated his video with no announcement. *See* BWC. Prior to the deactivation, the officer was on the yard speaking with an incarcerated person about grievances he filed, retaliation he was experiencing, and his inappropriate transfer to SATF. The officer replied "let me talk to my boss," and, upon entering the program office, deactivated his camera at 21:24:45. When the officer reactivated his BWC a little over three minutes later, at 9:27:57 he was back on the yard with the incarcerated person. No circumstance justifying deactivation appears present. Similarly, in SATF-[redacted], the officer reactivated his BWC while sitting at his desk on his computer. *See* BWC at 8:16:07. The officer did not announce the reason for reactivating and it does not appear to be a permissible deactivation circumstance. The officer also appears to be wearing his BWC under a coat, in a way that obscures the field of vision. SATF's local operating procedures for BWC state "…staff shall ensure they wear the body-worn camera…in a location that will facilitate an optimum recording field of view." *See* Five Prisons Remedial Plan, Attachment B § VI.B.7. In each case, the investigators should have addressed these apparent BWC violations in the investigation report, but failed to do so.

Additionally, at KVSP an officer appeared to be wearing his BWC in a non-compliant fashion.[31]

[31] The officer in KVSP – [redacted] announced his deactivation at 12:33:15 under proper circumstances, but strangely, the video suggests that his BWC was not mounted on his chest, which violates KVSP's local operating procedures. Those procedures state "dependent on the type of BWC mount the staff wears to support the BWC, staff shall ensure they wear the BWC outside of the uniform and on the upper chest area, facing forward …." *See* Five Prisons Remedial Plan § I; KVSP Local Operating Procedure 217 at 2. The investigator should have noted this violation, or referred it for further investigation.

Lastly, it is worth noting that none of these instances of BWC noncompliance would have been detected by Defendants' BWC audit system, as none of the videos contain deactivations exceeding 1.5 hours.

V. DEFENDANTS FAILED TO PRODUCE ALL DOCUMENTS REQUIRED BY THE REMEDIAL PLANS

Under the Remedial Plans, Defendants are obligated to produce on a quarterly basis all documents related to allegations of staff misconduct involving *Armstrong* class members at RJD and disabled inmates at the Five Prisons. *See* RJD Remedial Plan § IV; Five Prisons Remedial Plan § V. Plaintiffs have previously reported on Defendants' failures to meet this obligation. *See* Letter from [redacted] to [redacted] & [redacted] (June 15, 2021); Letter from [redacted] to [redacted] & [redacted] (August 13, 2021); Letter from [redacted] to [redacted] & [redacted] (Apr. 19, 2022); Letter from [redacted] to [redacted] & [redacted] (June 6, 2022); Letter from [redacted] to [redacted] & [redacted] (Sept. 2, 2022).

The quality of productions has improved recently. That said, problems remain. Crucial documents were missing from the SATF and RJD productions, including OIA investigation reports and video of use-of-force incidents.

Moreover, Defendants' responses to Plaintiffs' counsel's requests to produce the missing documents and videos were seriously delayed. For example, on August 12 and 18, 2022, Plaintiffs' counsel requested documents missing from two SATF OIA investigation files. Despite a half-a-dozen reminders by Plaintiffs' counsel, Defendants did not produce the documents until October 12, 2022. It is Plaintiffs' counsel's understanding that, moving forward, Defendants have agreed to produce missing documents and video in response to our requests within seven days.

Lastly, Plaintiffs note that Defendants generally have been producing documents from SATF in a format that is different from the productions from other prisons. At the other five prisons, Defendants have been producing documents as separate files (e.g., the referral to OIA, investigation report, grievance package, and 402/403 are all produced as separate PDFs). For most of the cases at SATF, Defendants have been producing all documents for a case in one combined PDF. These combined PDFs are more difficult and time consuming to review. **Accordingly, Plaintiffs request that, if possible, Defendants produce the documents from SATF in the same manner as the documents they produce from the other prisons.**

VI. INFORMATION REQUESTS REGARDING DEFENDANTS' EFFORTS TO IMPROVE THE PERFORMANCE OF INVESTIGATORS AND HIRING AUTHORITIES

Our review of the productions indicates that serious problems with investigations, discipline, and body-worn camera policy compliance persist. All of these issues contribute to ongoing failures to hold staff accountable for violating the rights of people with disabilities.

Though Plaintiffs acknowledge that Defendants have begun to implement a number of important changes to the investigation and discipline system, many of the same investigators and Hiring Authorities will continue to play central roles. It is imperative that Defendants take all available steps to ensure that these critical staff discharge their important duties consistent with Defendants' obligations in this case.

Accordingly, Plaintiffs make the following information requests:

- The Remedial Plans require Defendants to "monitor work performance of investigators, and if warranted provide training and feedback, and take other appropriate steps consistent with existing policy," and "use available information to monitor work performance of vertical advocates and hiring authorities in the investigation and disciplinary process, and if warranted provide training and feedback, and take other appropriate steps consistent with existing policy." *See* RJD Remedial Plan at 6; Five Prisons Remedial Plan at 7. **What steps have Defendants taken to ensure that the investigators and Hiring Authorities identified in reports as performing deficiently improve their performance, complete comprehensive and unbiased investigations, and impose appropriate discipline to address disability-related staff misconduct in the future?**

- The Remedial Plans state that only locally-designated investigators ("LDIs") who have been trained by OIA will conduct local investigations/inquiries. RJD Remedial Plan at 9; Five Prisons Remedial Plan at 9. **Has this requirement of the Remedial Plans been implemented? Please provide proof that all of the LDIs conducting investigations have been trained by OIA. Please produce to us the current version of the training.**

- The Remedial Plans state that "CDCR will develop on-going training requirements for CST staff, locally designated investigator, OIA investigators, vertical advocates, and hiring authorities to ensure comprehensive and unbiased

investigations." RJD Remedial Plan at 7; Five Prisons Remedial Plan at 7-8. **What are the ongoing training requirements that have been developed? Who has received training and when? Please produce to us the current version of the training(s).**

- The Remedial Plans state "CDCR will provide additional annual training to hiring authorities on how to impose discipline, including how to review investigative reports and 402/403 memorandums, when to request additional investigation, how to weigh aggravating and mitigating factors, and how to consider past allegations or sustained findings." **Has this training been provided? Have all Hiring Authorities received it? Please produce to us the current version of the training.**

- Plaintiffs request clarification on the following issue: Under the Remedial Plans and relevant AVSS and BWC policies, the filing of a staff complaint is a triggering event requiring retention of video footage beyond 90 days. **What procedures do Defendants have in place to ensure that, even before a staff complaint is assigned to an investigator, the filing of a staff complaint results in the retention of video?**

- In Section III of this report, Plaintiffs identified numerous problems with investigators delaying in requesting video footage or requesting the wrong footage. **What training do investigators (local and OIA) receive about how quickly to request video and how much video to request?**

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VII. CONCLUSION

Pursuant to the parties' agreement, we expect to receive a response to this report from Defendants by December 8, 2022. We look forward to continuing to work with Defendants to ensure that Defendants come into compliance with the Court's orders and the RJD and Five Prisons Remedial Plans.

Sincerely,

ROSEN BIEN
GALVAN & GRUNFELD LLP

/s/ [redacted]

By: [redacted]

cc: [redacted]