ROSEN BIEN
GALVAN & GRUNFELD LLP

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

[redacted]
Email: [redacted]

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**PRIVILEGED AND CONFIDENTIAL**

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VIA ELECTRONIC MAIL ONLY

[redacted]

[redacted]

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

Dear [redacted]:

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

The cases below illustrate the same types of accountability failures that Plaintiffs' counsel have pointed out in their prior quarterly reports. These problems include failures to conduct complete and unbiased investigations and to hold staff accountable and issue appropriate discipline when evidence of staff misconduct exists.

Plaintiffs have organized the discussion of cases into three sections based on the type of misconduct presented: (1) failures to provide disability accommodations, (2) use-of-force policy violations, and (3) other serious instances of misconduct.

The parties are actively engaged in negotiations aimed at improving the accountability system. The cases discussed in this report demonstrate that more must be done to improve the quality of investigations, to oversee the work of investigators in order to ensure that relevant evidence is preserved and included in inquiry/investigation reports, and to improve the reports themselves to aid disciplinary decision makers. **As has been discussed, Defendants' current proposed reforms do not go far enough to improve the quality of investigations.**

**It is also time for Defendants to take action to address the clear shortage of investigative staff, which Plaintiffs' counsel has reported on for years.** Defendants let the statute of limitations for imposing discipline lapse in multiple cases discussed in this report. Three such cases discussed below involved very serious allegations of staff misconduct, including two use-of-force cases. Further, as described in Section I.A.4 below, Defendants mismanaged valuable investigative resources convening strike teams at RJD and LAC to review hundreds of less serious, older, backlogged cases. In many of these cases, video had already been destroyed and the statute of limitations for imposing adverse action had expired. The parties have already reached preliminary agreement regarding modifications to the system that will address some of the workload issues faced by CDCR. **However, it remains clear to Plaintiffs' counsel that Defendants simply do not have enough resources to adequately handle the large number of staff complaints in the system.** Defendants must better manage existing resources to focus attention on cases, especially those raising allegations of serious staff misconduct that are still within the statute of limitations. And, as has also been discussed, Defendants should take action to extend the length of time that video evidence is preserved in order to ensure meaningful investigations.

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Plaintiffs' counsel remain hopeful that Defendants will respond to this report, especially by identifying any areas where Defendants disagree with any of the accountability failures highlighted in the cases below.

Sincerely,

ROSEN BIEN
GALVAN & GRUNFELD LLP

*/s/* [redacted]

By: [redacted]

cc: [redacted]

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

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

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

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

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

The *Armstrong* Court has found "[t]he 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 […]." Dkt. 3059 at 35. Despite multiple orders designed to improve the accountability system, Plaintiffs continue to identify many cases each quarter in which Defendants' system fails to hold staff accountable and correct failures to accommodate people with disabilities. In some cases, the investigations are so inadequate that it is impossible to know whether a violation has occurred. In other cases, Hiring Authorities fail to hold staff accountable even though the evidence shows that a failure to accommodate occurred. CDCR's ongoing failure to identify disability-related staff misconduct, to correct problems, and to hold staff accountable is alarming in light of

[1] Plaintiffs selected the cases using a variety of criteria, including, but not limited to, whether: CDCR referred the case to the OIA for investigation or direct adverse action; the AIU investigated the case; the AIMS conducted an inquiry; the case involved an allegation related to use of force or disability; the Hiring Authority sustained an allegation; and the case included video evidence. These criteria are intended to identify cases with the most serious and credible allegations of misconduct, which Plaintiffs then review to determine whether the investigations were complete and whether Defendants are holding staff accountable when the evidence shows misconduct occurred. Although Defendants have mischaracterized this approach as "cherry-picking" in the past, it is necessary to focus on cases with serious and credible allegations of misconduct to evaluate whether the accountability system is working.

multiple court orders, since 2007, to get CDCR to respect the rights of people with disabilities in prison. *See* Dkt. 1045 at 7; *Armstrong v. Brown*, 768 F.3d 975, 979 (9th Cir. 2014); *see also* Order Modifying Permanent Injunction of August 2, 2012, Dkt. 2180; Order Modifying 2007 Injunction of December 29, 2014, Dkt. 2479; Dkt. 3059; Dkt. 3060; Dkt. 3217; Dkt 3218.

Under Defendants' proposed modifications to their accountability system, a number of the cases below would be routed as routine grievances and removed from the accountability system. These cases are at the heart of *Armstrong* Court's efforts to improve Defendants' accountability system and must remain part of that system, along with the attendant court-ordered remedies, including the requirement to review camera footage and oversight by Plaintiffs' counsel and the Court Expert. The cases further illustrate how difficult it is for class members to obtain basic disability accommodations. Until Defendants' utilize the full force of their improved accountability system to identify and correct problems, ADA violations like the ones in these cases will persist.

**(a) LAC – [redacted] – Local, Not Sustained**

In this case, staff did not provide a sign language interpreter to [redacted] ([redacted]), who is deaf, during a critical interview about alleged gang affiliation.[2] Both investigations confirmed Mr. [redacted] allegation, yet the Hiring Authority failed to sustain any discipline, despite undisputed evidence that staff violated policy and Mr. [redacted] disability rights.

Mr. [redacted] reported that during an interview with the Institutional Gang Investigations unit (IGI), staff did not provide him with a sign language interpreter, even after he requested one. As a result of this failure to provide necessary communication accommodations for his disability, staff wrongly identified Mr. [redacted] as affiliated with a particular gang. *See* 602 at 4-5; 1824 at 1. Both grievances Mr. [redacted] filed were routed to local investigators, each of whom confirmed that Mr. [redacted] was not afforded a sign language interpreter for this critical due process encounter. Instead of providing him with his primary form of effective communication, staff reported that they used Mr. [redacted] secondary form of communication, which was reading lips. *See* [redacted] Inquiry at 2; [redacted] Inquiry at 5; [redacted] Exhibits at 9.

Staff were required by policy to provide a sign language interpreter for Mr. [redacted] under these circumstances, because the IGI interview implicated his due process rights, given that gang verification impacts housing and security level. In due process events like this, the *Armstrong* Remedial Plan requires staff to provide

[2] Mr. [redacted] filed two separate grievances about the incident (an 1824 and a 602), and CDCR investigated the incident twice, failing to identify the duplication and wasting investigative resources.

incarcerated persons with effective communication at a heightened standard. Under the ARP, a person's "ability to lip read should not be the sole source used by staff as a means of effective communication involving due process or medical consultations, unless the [incarcerated person] has no other means of communication." *See* Armstrong Remedial Plan at 10. Both investigations found that staff violated this provision of the ARP. Yet, the Hiring Authority did not sustain the violation that Mr. [redacted] was improperly denied a sign language interpreter. This failure is especially serious in light of Mr. [redacted] report that the interviewers reached an inaccurate conclusion regarding his status because of the lack of effective communication with him. *See* 1824 at 1; 602 at 4. Effective communication is a fundamental requirement of the ADA and the *Armstrong* case, and it was not provided in this instance, with serious consequences for Mr. [redacted] Despite this clear ADA violation and two investigations into the reported problem, CDCR failed to hold staff accountable.

The alleged failure to provide a sign language interpreter during a due process encounter is an example of a staff misconduct complaint that, under Defendants' proposal, would be routed as a routine grievance.

**(b) SATF – [redacted] – Local, Exonerated (Shower Denial), Sustained (Refusal to Provide Name)**

In this case, the Hiring Authority failed to sustain an allegation of disability-related staff misconduct despite clear video evidence of Officer [redacted] refusing to provide [redacted] ([redacted]) access to a shower following an incontinence accident.[3]

On July 31, 2023, Mr. [redacted] had an incontinence accident while housed in Building E4. He asked Officer [redacted] for permission to use the ADA shower because he had an accident. Officer [redacted] granted him permission to do so. *See* BWC 1 at 15:43:44. A few minutes later, Officer [redacted] was redirected, and Officer [redacted] began calling everyone back to their cells. Mr. [redacted] explained to Officer [redacted] that he needed to shower because he had soiled himself, and that Officer [redacted] had already given him permission to use the shower. *See* BWC 2 at 15:50:52. Officer [redacted] told Mr. [redacted] he already talked to him about the shower, said "I'm not him" (i.e., he is not Officer [redacted] and instructed Mr. [redacted] to return to his cell. *See* BWC 2 (linked above) at 15:51:05. Mr. [redacted] asked Officer [redacted] for his name, but he refused to provide it. *See* BWC 2 (linked above) at

[3] Mr. [redacted] reported similar incidents with different staff members in Building E4 on July 4 (SATF-[redacted]), August 7 (SATF-[redacted]), and September 13, 2023 (SATF-[redacted]). In addition, three other class members reported similar concerns with access to showers following an incontinence accident on Facility E this quarter. *See* SATF-[redacted], SATF-[redacted], and SATF-[redacted].

15:51:16. Officer [redacted] then threatened to write-up Mr. [redacted] if he did not return to his cell. *See* BWC 2 (linked above) at 15:51:26. When Mr. [redacted] reiterated that he was just asking when he could shower, Officer [redacted] said he had looked up Mr. [redacted] and he was not listed as incontinent, so he was not going to let him shower. *See* BWC 2 (linked above) at 15:51:30.

Per SATF Operational Procedure (OP) 403, "Upon request, an [incarcerated person] who experiences an unforeseen incontinence accident shall be offered a shower, and an appropriate amount of incontinence related supplies (i.e., clean linen and clothing) as soon as possible." *See* OP 403 Excerpt at 4. Officer [redacted] decision to deny Mr. [redacted] a shower violated this policy.

Nevertheless, the Hiring Authority exonerated Officer [redacted] on the shower denial allegation. *See* Staff Misconduct Determination Memo at 3. That decision was not appropriate and represents a failure to hold staff accountability for a clear failure to accommodate a disability.

The alleged failure to provide the class member with an incontinence shower is an example of a staff misconduct complaint that, under Defendants' proposal, would be routed as a routine grievance. This is a frequent allegation, and review of camera footage, especially BWC footage that captures the request for the accommodation and the response, is required to confirm or refute this type of allegation.

**(c) SATF – [redacted] – AIU, Exonerated**

In this case, the Hiring Authority failed to sustain an allegation of disability-related staff misconduct after Officer [redacted] provoked [redacted] ([redacted]) by insulting his disability, mental health, and custody status, and then told him not to bother asking for help in the future after Mr. [redacted] became upset. The video of the interaction is short and speaks for itself. *See* BWC. What is most discouraging is that this provocation by the officer—and the laughter of those officers observing the interaction—occurred at SATF while the prison was (and is) under court-ordered scrutiny for failing to accommodate people with disabilities. Despite this scrutiny, the Hiring Authority failed to see any problem with this interaction, and the staff member was exonerated.

BWC footage shows Mr. [redacted] walking to his room when he is suddenly stopped by Officer [redacted] who is sitting in the officers' station with two other officers in Building G3.[4] *See* BWC (linked above). Officer [redacted] says, "Hey, I got a question," and Mr. [redacted] approaches the officers' station. Officer [redacted] continues, "What do your

[4] The officers' station in G3 is in the middle of the building. Incarcerated people and staff have to walk past the officers' station to get in and out of the building and from pod to pod.

people say about you now? You just didn't go PC [protective custody], you went [redacted] and you went to the damn walker." Mr. [redacted] responds, "What's wrong with that?" Officer [redacted] tells him, "Man, it's all bad." Mr. [redacted] then gets upset and angrily asserts that he is not PC. Officer [redacted] says Mr. [redacted] to "calm down, clam down before you get more time," "don't ask me for more favors," and then, when he continues to be upset, "we'll see next time you need a bed move."

The interaction is troubling on a number of levels. First, there was no legitimate reason for Officer [redacted] to make these comments to Mr. [redacted] The inference is therefore that Officer [redacted] initiated the conversation to insult Mr. [redacted] based on his disability, mental health status, and placement on a non-designated programming facility. Second, Officer [redacted] suggestion that Mr. [redacted] friends will disapprove of his mental illness and need for a walker speaks volumes about how CDCR staff view people with disabilities and perpetuate these discriminatory ideas in prison. Confronted with such an environment, people with disabilities are understandably less likely to request accommodations from staff when needed. Third, Officer [redacted] comment that Mr. [redacted] should not ask for any favors, coupled with his comment implying that he would not help him with a bed move, exemplify why many class members report they are not safe and do not believe they can turn to staff for help. Fourth, Officer [redacted] made these comments in a common space within earshot of other incarcerated people and staff, potentially endangering Mr. [redacted] safety with regard to his disability-based vulnerabilities and his past protective custody status. Fifth, Officer [redacted] increased the likelihood of an incident with Mr. [redacted] by gratuitously provoking him regarding his disabilities and custody status.

The Hiring Authority should have sustained the allegation and, at a minimum, found Officer [redacted] responsible for discourtesy and harassment and discrimination on the basis of disability. Discipline should have been considered for the other officers who stood by and did nothing during this encounter.

**(d) SATF – [redacted] – AIU, Not Sustained**

In this case, the Hiring Authority failed to sustain an allegation of staff misconduct despite video evidence showing that Officer [redacted] made comments to antagonize and mock [redacted] ([redacted]) disability-related victimization concerns.

On February 27, 2023, Officers [redacted] and [redacted] were trying to find a cell in which to house an incarcerated person. They both acknowledged that, ideally, they would not place the person in Mr. [redacted] cell because he is [redacted]. *See* BWC at 9:29:06. They then talked cell-front with Mr. [redacted] who explained that his incontinence causes safety concerns and places him at risk of victimization and that another officer (Officer [redacted] intentionally leaves him single-celled. *See* BWC (linked above) at 9:29:30. Officer [redacted] then was dismissive of his concerns, asking Mr. [redacted] repeatedly whether he was going to beat up a cell mate and, when Mr. [redacted] became upset and accused him

of acting like this was a game, the officer stated that he was "going to put the big guy in here with you. A big guy." *See* BWC (linked above) at 9:29:46. Mr. [redacted] described in his 602, filed one day after this interaction, that he felt Officer [redacted] was "terrorizing" and "threatening" his safety by "exploiting the fact that I am 100% defenseless and absolutely a target for physical and sexual victimization." *See* 602 at 2.

Officer [redacted] comments were disrespectful and dismissive of the legitimate disability-based safety concern raised by Mr. [redacted] Interactions like this one make class members less willing to ask staff for much needed help related to their disabilities. Despite clear video evidence of the discrimination and both officers admitting to the investigator that the comment about putting "a big guy" in Mr. [redacted] cell was inappropriate, *see* IR at 4-5, the Hiring Authority found no violation.

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

In this case, the investigator failed to recognize a clear ADA violation, established by the evidence, that staff assigned and housed [redacted] on an upper tier, notwithstanding his housing restrictions. The Hiring Authority then failed to sustain the allegation. The investigation report confirms that, at the time of the incident, Mr. [redacted] required a lower bunk, lower tier, and no stairs. *See* IR at 3. The housing unit's log book, attached as Exhibit 13 to the investigation report, confirms that Mr. [redacted] was assigned to an upper cell, 221, in violation of his no stairs restriction. *See* Logbook at 34. The investigator failed to connect these pieces of evidence and also does not appear to have scoped the investigation to include the alleged ADA housing violation at the heart of the claim. *See* IR at 2, (failing to mention that Mr. [redacted] was inappropriately housed, causing a fall, as an allegation). The investigator also failed ask three officers interviewed as part of the investigation why Mr. [redacted] was assigned to an upper bunk. The investigator also failed to explore Mr. [redacted] allegation that he was injured when he had to walk up the stairs.[5] This incomplete investigation and investigation report did not adequately inform the Hiring Authority of the clear ADA violation. As a result, no one was held accountable for this failure resulting in an injury to a class member. *See* ARP § I.A.

The failure to appropriately house Mr. [redacted] on a low tier per his housing restrictions is an example of a staff misconduct complaint that, under Defendants' proposed reforms to the accountability system, would be routed as a routine grievance.

[5] Although Mr. [redacted] promptly filed a 602 after the incident, the request for BWC footage was not submitted within the 90-day retention period. *See* Clarification Memo. This prevented the investigator from investigating Mr. [redacted] other allegations that Officer [redacted] made inappropriate comments and false reports of suicidality after Mr. [redacted] went "man down."

### (f) LAC – [redacted] – Local, Not Sustained

In this case, the investigator failed to obtain and review relevant video to determine if staff failed to accommodate [redacted]). Mr. [redacted] reported that sometime on February 20, 2023, he fell on the dayroom stairs after staff ignored his request for a lower tier chrono. Mr. [redacted] alleged that after he was seen by medical, Officer [redacted] threatened to give him an RVR if he did not walk up the stairs. *See* 602 2-3. Medical records show that an alarm was activated at 7:07 PM and medical staff "witnessed I/P [redacted] lying on the floor in the dayroom approx 5 feet from the stairs." *See* Progress Note at 1 dated February 20, 2023. However, the investigator requested video from only 5:30-6:30 p.m. on the day in question. *See* Investigation Report at 1. Based on this incomplete video, which did not show the alleged interaction, the investigator improperly concluded that no misconduct occurred. The investigator should have reviewed medical records and requested video from after the fall that was documented around 7 PM. The incomplete investigation in this case made it impossible to tell whether the alleged violation occurred.

The allegation that staff disregarded a request for a housing accommodation, leading to a fall, is an example of a staff misconduct complaint that, under Defendants' proposal, would be routed as a routine grievance. It is also a disability-related staff misconduct allegation that would require the review of video to resolve it.

### (g) KVSP – [redacted] – Local, Not Sustained

In this case, the investigator failed to review relevant video to investigate [redacted] ([redacted]) allegation that an officer ignored his request for an ADA shower for an hour and a half and then failed to provide him with help accessing the shower. *See* 1824 at 1. The investigator requested only about two minutes of video of Mr. [redacted] getting in the shower from the date in question. *See* 1027/1118 at 8-9. In the video, Mr. [redacted] is visibly upset when the officer walks over to let him in the shower, and can be heard saying something about "an hour." *See* BWC. Based on this two-minute video clip, which does not include the time period before he was provided access, the investigator and Hiring Authority concluded no misconduct occurred. The investigator should have reviewed the hour and a half of video before Mr. [redacted] ADA shower to determine whether officers failed to provide Mr. [redacted] with an ADA shower despite his request for one, and whether he requested and they failed to provide him help accessing the shower. Instead, the investigator wasted investigative resources by conducting inconclusive interviews with three staff members who said only that the unit was busy that day and that, if Mr. [redacted] was requesting a shower, they were unaware.

The alleged failure to accommodate the request for an incontinence shower is an example of a staff misconduct complaint that, under Defendants' proposal, would be routed as a routine grievance. Here again, it is essential to review the footage that

captures the request for the accommodation as well as the staff member response, including over the period of time the alleged denial is taking place.

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

Plaintiffs' counsel continue to identify cases in which Defendants' accountability system has failed to confirm violations of the use-of-force policy. Some cases show that staff fail to deescalate encounters and are quick to use force when no immediate force is justified per policy. Other cases show staff using excessive force. These are not isolated examples. Plaintiffs have reported on dozens of examples of CDCR failing to confirm use-of-force violations at multiple prisons spread over years and involving multiple different decision makers, including IERCs and Hiring Authorities.

Plaintiffs previously requested that the parties meet to determine whether there is disagreement regarding the interpretation of Defendants' existing use-of-force policies. **Plaintiffs renew the request to meet regarding Defendants' ongoing failure to confirm use-of-force violations.**

#### (a) COR – [redacted] – AIMS, Not Sustained

In this case, Officer [redacted] used unnecessary and excessive force against [redacted] ([redacted]), violently slamming him to the ground, even though he was cuffed, using a walker, and did not present an imminent threat. The force was dangerous and violated policy, but neither the IERC nor the Hiring Authority found any policy violations.

On May 13, 2022, Officer [redacted] and another officer were escorting Mr. [redacted] out of the CTC and to a transport van. BWC footage shows that during the escort, Mr. [redacted] is secured in waist chains and is using a walker to ambulate. *See* BWC 1 at 11:18:59. Mr. [redacted] was initially brought to the CTC because he was having chest pains, and as he was leaving, he was upset that medical staff did not address his concerns. While being escorted to the van, he briefly stops and begins arguing with custody staff on the patio outside of the CTC. *See* BWC 1 (linked above) at 11:19:20. He then begins walking to the van, and as he walks, he continues to yell about his concerns. *See* BWC 1 (linked above) at 11:19:45. Although he is angry, yelling, and using offensive language, he is not being physically resistive.

After walking about 30 feet, Mr. [redacted] stops again to tell Officer [redacted] that he is having chest pains and that officers keep antagonizing him. *See* BWC 1 (linked above) at 11:20:00. An officer on the patio, Officer [redacted] yells to Officer [redacted] to "take him [Mr. [redacted] back to the building" where a sergeant can talk to him. *See* BWC 2 at 11:20:13. Officer [redacted] turns to listen to Officer [redacted] Mr. [redacted] yells back to Officer [redacted] and calls him several

names, then continues walking towards the transport van. *See* BWC 1 (linked above) at 11:20:13. Officer [redacted] now around 50 feet away from Mr. [redacted] yells back to the escorting officers, "Hey! Take control of the fucking escort and take the inmate back to the building!" *See* BWC 2 (linked above) at 11:20:31. Mr. [redacted] slightly turns his body and again yells profanities back at and threatens to kill Officer [redacted] Officer [redacted] then grabs Mr. [redacted] by the arms, and says, "Let's go" as Mr. [redacted] continues to yell at Officer [redacted] Mr. [redacted] turns his body back around. Officer [redacted] immediately places his hand on the back of Mr. [redacted] head and slams him head-first into the concrete, sending Mr. [redacted] toppling over his walker. *See* BWC 1 (linked above) at 11:20:41. Officer [redacted] then falls on top of Mr. [redacted] with his full body weight.

The IERC found that the force complied with CDCR policy. As part of the IERC review, Lieutenant [redacted] determined that "the force was reasonable and necessary to overcome resistance." *See* IERC at 3. In documenting that conclusion, Lieutenant [redacted] largely recycled the language from Officer [redacted] incident report. Officer [redacted] wrote that:

> Suddenly without provocation Inmate [redacted] [sic] attempted to turn his body again towards me. Due to not knowing what inmate [redacted] intentions were and his aggressive behavior, I placed my left hand on his left bicep and my right hand on the back of his upper shoulder area and utilized physical strength to force him to my left side causing us to both fall to the ground.

*See* Exhibits at 25 (Officer [redacted] Staff Narrative).

This statement was, at best, misleading, as Officer [redacted] threw Mr. [redacted] to the ground and did not attempt "to force him to [his] left side," accidentally causing them to both fall. Nevertheless, Lieutenant [redacted] credited Officer [redacted] statement that he was "was unsure of inmate [redacted] intentions and feared for his safety." *See* IERC at 3. Chief Deputy Warden. J. Bugarin, similarly concluded that Officer [redacted] had not violated policy. *Id*. at 15.

Mr. [redacted] orally made a use-of-force complaint on the day of the incident, *see* IERC documents at 11, and also filed a 602 two days later, *see* 602 at 1-2. The investigator did not interview Mr. [redacted] Officer [redacted] or any other officers who witnessed the use-of-force. Instead, the investigator summarized the incident reports, reviewed the videotaped interview of Mr. [redacted] that was conducted as part of the incident report package, and watched body-worn camera footage. The Hiring Authority did not sustain the allegations of misconduct against Officer [redacted] *See* Closure Memo at 1.

The fact that neither the IERC nor the Hiring Authority identified any issues with this use of force is deeply concerning. To begin with, Officer [redacted] did not need to use force at all. Although Mr. [redacted] was yelling at the officers, he was moving towards the transport van, where officers wanted him to go. The officer could have waited for Mr. [redacted] to finish yelling, used "verbal persuasion," and then continued along with the escort, as he had done several times in the minutes before this incident. *See* DOM § 51020.5 ("Whenever possible, verbal persuasion should be attempted in an effort to mitigate the need for force."); *see also* 15 C.C.R. § 3268(b)(1) ("Employees shall attempt to use verbal commands and verbal de-escalation, followed by a reasonable amount of time for compliance before resorting to use of force."). Officer [redacted] gave only one order—"Let's go"—before deciding to violently throw Mr. [redacted] to the ground. Moreover, Officer [redacted] increased the likelihood of force through his unnecessary provocations and escalations.

In any event, Mr. [redacted] did not present an imminent threat. *See* 15 C.C.R. § 3268(a)(5) ("An imminent threat is any situation or circumstance that jeopardizes the safety of persons or comprises the security of the institution and requires immediate action to stop the threat"). He was in waist chains and had limited mobility because of his disability. He was not in an unsecured area surrounded by other incarcerated people; rather, he was in an area of the prison where incarcerated people were only moving while cuffed and escorted. Numerous custody officers were in the vicinity. Officer [redacted] decision to use force appeared to be influenced by Officer [redacted] direction to "take control of the fucking escort" and not in response to whether force was actually necessary.

Finally, the force used by Officer [redacted] was unreasonable and dangerous. *See* 15 C.C.R. § 3268(b)(2) ("When verbal commands and de-escalation techniques do not work, or are not feasible in light of the situation, employees may use reasonable force as required in the performance of their duties, but unnecessary or excessive force shall not be used."); *see also id*. at (a)(3) (Defining "excessive force" as "[t]he use of more force than is objectively reasonable to accomplish a lawful purpose."). Grabbing any person by the back of their head and throwing them to the concrete is unsafe. But throwing a person with a mobility disability who is wearing waist chains face-first into the concrete, when they do not pose any threat, is clearly excessive. Because his hands were restrained, Mr. [redacted] had no way to brace his fall and could have been seriously injured.

The IERC's and the Hiring Authority's failure to find that this unnecessary and excessive use of force violated policy is consistent with numerous other cases reported on by Plaintiffs in prior reports, in which those entities, who are supposed to be the experts on CDCR's use-of-force policy, missed clear violations. These cases collectively demonstrate the need for substantial reform regarding how CDCR reviews allegations of excessive and unnecessary use of force.

**(b) LAC – [redacted] – AIMS, Not Sustained**

In the following two LAC cases, the Hiring Authority failed to sustain use-of-force violations. Notably, the statute of limitations had expired on both allegations so, even if violations had been sustained in these cases (and they should have been), the Hiring Authority would have been unable to impose disciplinary action.

In [redacted], Officer [redacted] the control booth officer, used unnecessary and excessive force against [redacted] ([redacted]) by unnecessarily firing a 40mm block gun at him. *See* 602 at 3; BWC 1 at 8:47:45. During the incident, Mr. [redacted] was acting erratically in the dayroom, but was surrounded by eleven officers and was beginning to comply with orders to prone out. Nevertheless, Officer [redacted] fired the block gun, hitting another officer. The use of force was objectively unreasonable and dangerous and involved "more force than is objectively reasonable to accomplish a lawful purpose." *See* DOM § 51020.4. The Hiring Authority, however, did not sustain the allegation. The statute of limitations for the February 2022 grievance expired long before the Hiring Authority closed the case in December 2023.[6] *See* Memo at 1; 602 at 3.

In LAC-[redacted], Officer [redacted] improperly used immediate force against [redacted] ([redacted]). BWC footage shows Mr. [redacted] filling a water bottle at the water fountain. Officer [redacted] orders him and several others to "take it in." *See* BWC at 10:03:40. Mr. [redacted] declines to move. Officer [redacted] then grabs Mr. [redacted] left arm and pushes him against the wall. *See* BWC 2 at 10:04:05. This leads to an extended struggle between Mr. [redacted] Officer [redacted] and another officer, with Officer [redacted] BWC being knocked off his uniform. *Id.* Once cuffed, Mr. [redacted] is visibly bleeding. In his interview, he reported injuring his hand when Officer [redacted] pulled him while he was holding the water fountain. *See* Investigation Report at 4. Medical records show Mr. [redacted] sustained multiple lacerations to the tendons in his hand and had to receive sutures and then surgery following the incident.[7] The use of force violated policy because Mr. [redacted] presented no imminent threat to security when filling his water bottle. *See* DOM § 51020.4. The Hiring Authority failed

[6] A memorandum dated February 21, 2024 states that Officer [redacted] received training "pertaining to [the] incident," but the training documents were "misplaced" and so the precise reason for the training is not clear. *See* Memo at 1.

[7] *See* Offsite Hospital Records dated May 1, 2022 at 7; RFS dated May 17, 2022 at 1; Offsite Hospital Records dated June 2, 2022 at 1-3.

to sustain any allegations. But, even if he had, adverse action would have been prohibited because the statute of limitations had expired.[8]

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

As in each quarterly report, Plaintiffs' counsel report on accountability system failures in cases where there is evidence that serious staff misconduct occurred. Defendants often object, claiming these cases are not disability related and are not relevant to the *Armstrong* case. The failure to hold staff accountable for any incident of serious misconduct – as in the cases below, where staff retaliated against a class member for submitting a declaration in support of Plaintiffs' motions in 2020 and 2021, used another incarcerated person to attack a class member, and taunted and antagonized a person with mental illness for 15 minutes – impact *all* incarcerated people. But *Armstrong* class members are uniquely impacted because, after witnessing or directly experiencing the serious harm, they still must rely on the very same staff members engaged in the misconduct to obtain needed disability accommodations. Thus, Defendants' accountability failures described below erode relationships between staff and incarcerated people and negatively impact class member access to disability accommodations from staff.

#### (a) KVSP – [redacted] – AIU, Sustained (Failing to wear required equipment, Failure to follow policy, Failure to follow BWC policy) – Corrective, LOI/Training

In this case, video footage confirmed that Officer [redacted] refused to request medical help for *Armstrong* declarant [redacted] ([redacted]), after he reportedly hurt his back when he fell while transferring from his wheelchair. Video footage also confirmed that Officer [redacted] in close temporal proximity to her refusal to help Mr. [redacted] made multiple statements to other officers that "[h]e's the one that made us get the cameras," i.e., that Mr. [redacted] participated in the staff misconduct litigation in 2020 and 2021 that resulted in BWCs at KVSP. This evidence is material to the allegation raised by Mr. [redacted] that Officer [redacted] retaliated against him for his involvement in lawsuits. However, the investigator omitted from the investigation report the statements by Officer [redacted] showing her antipathy toward Mr. [redacted] because of his legal work. The incomplete investigation report undermined accountability in this case.

There was no dispute in this case that Officer [redacted] refused to help Mr. [redacted] BWC footage showed her saying "No, we're [not] dealing with him today, he wants us to

[8] The investigation report states that Officer [redacted] and the second officer were issued training on "correctional awareness," even though no allegations were sustained. *See* Investigation Report at 3. The training documents were "misplaced." *See* Memo at 1.

hit the alarm, he wants to go talk to the Sergeant, he wants to talk to the Lieutenant, we're not doing it. He can sit out here all day [long]. We are not hitting the alarm." *See* AIU IR at 3, citing BWC at 1:13:00. The investigation report confirmed that Officer [redacted] was aware Mr. [redacted] went "man down" after he "stood up out of his wheelchair and fell to the ground."[9] *Id*. The report also indicated that Officer [redacted] much later in the footage, was observed referring to Mr. [redacted] as a "piece of shit" and saying "fuck that dude." *Id*.

Yet, the investigator omitted significant and material statements made by Officer [redacted] directly relevant to his claim of retaliation. Less than a minute after Officer [redacted] stated she would not hit an alarm, she told her colleague, "He's the one that made us get the cameras, so apparently he wants to brag about it to everybody and I'm like I don't give a f***…get on the computer and Google his name, it'll say all the lawsuits he has …." *See* BWC 1 at 1:14:10. Later, Officer [redacted] made a similar comment to an officer later, also mentioning that Mr. [redacted] was responsible for making officers wear cameras, that he has "so many" lawsuits, and that "everyone should be careful around him." *See* BWC 2 at 1:58:33. The investigator omitted these statements despite acknowledging he reviewed the portions of the footage containing the statements. *See* AIU IR at 3. The incomplete and biased investigation, omitting material evidence, prevented the Hiring Authority from considering whether or not Officer [redacted] was acting in retaliation, as alleged.

The Hiring Authority closed the case two days after the statute of limitations for imposing discipline had expired, making it impossible to impose adverse action against Officer [redacted] *See* Investigative Closure Memorandum at 1-2. The Hiring Authority did sustain other violations but imposed only corrective action including for Officer [redacted] disrespectful comments (on-the-job training), a BWC deactivation failure not discussed here (LOI), and a violation for improper equipment (LOI). *See* 402/403 at 3-6.

**(b) LAC – [redacted] – OIA, Sustained for multiple officers – Adverse for multiple officers (L9, L6, L3) and Corrective, but L3 was reduced to Training in *Skelly* Hearing and L6 was reduced to L5**

In this case, Officer [redacted] used improper immediate force on and made anti-Semitic comments about [redacted]). The Hiring Authority appropriately terminated one officer, Officer [redacted] and disciplined three other officers related to the incident. However, the investigator did not adequately investigate additional serious misconduct alleged by Mr. [redacted] and discovered during

[9] The AIU investigator did not appear to review footage of the actual incident. The case was assigned to the AIU investigator well after the 90 day video retention period. *See* AIU IR at 1.

the investigation, namely that officers encouraged an attack on Mr. [redacted] failed to respond to the attack, and then were dishonest about witnessing the attack in their AIU interviews. Despite the shortcomings in the investigation, the Hiring Authority should have, based on video evidence, disciplined three officers for failing to respond to and report the assault and two of the officers for being dishonest in their interviews.

The initial misconduct by Officer [redacted] was very serious and warranted his dismissal. As shown on video, Officer [redacted] tells Mr. [redacted] he will take him to see a sergeant to discuss a property issue and handcuffs Mr. [redacted] Officer [redacted] then takes Mr. [redacted] to his cell, rather than to speak with a sergeant. Mr. [redacted] enters the cell but refuses to return the handcuffs. Officer [redacted] enters Mr. [redacted] cell and grabs Mr. [redacted] shirt and potentially his arm. *See* BWC 1 at 11:04:55; BWC 2 at 11:04:55. Officer [redacted] did not report this force. After leaving the cell, Officer [redacted] asks Officer [redacted] in the tower to release another incarcerated person, a Men's Advisory Counsel ("MAC") representative in the unit. *See* BWC 1 (linked above) at 11:07:45. Officer [redacted] tells the other incarcerated person, "Hey before I kill this little Jew, go talk to him, cause he has my fucking cuffs and I'm gonna fucking murder him." *Id.* at 11:07:55. Officer [redacted] makes indiscernible statements as the incarcerated person begins walking toward Mr. [redacted] cell. *Id.* at 11:08:05.

The Hiring Authority terminated Officer [redacted] after sustaining charges for discourtesy, unreasonable use of force, insults to a protected class, failure to report force, and endangerment (for not wearing a mask).[10] *See* 402/403 at 1-4. The Hiring Authority also sustained a code of silence charge against Officer [redacted] (who was with Officer [redacted] on the floor) for failure to report Officer [redacted] force, 402/403 at 5-8, and against Officer [redacted] for failing to wear a mask.[11] *See* 402/403 at 12-14. These findings and the discipline were generally appropriate.

But the investigator and the Hiring Authority failed to adequately address substantial evidence that suggests that Officer [redacted] requested or encouraged that the MAC Rep attack Mr. [redacted] and that the other officers failed to respond to and report the attack once it occurred. Video shows that immediately after Officer [redacted] speaks with the MAC Rep, he walks and then runs to Mr. [redacted] cell. *See* BWC 1 (linked above) at 11:08:15. The MAC Rep shoves Mr. [redacted] into the cell and stands at the door yelling at him. *Id.* at 11:08:25. Neither Officer [redacted] nor Officer [redacted] respond to the cell, even though they are nearby and BWC footage indicates both are aware of what is transpiring. *See* BWC 1 (linked above) at 11:08:28 (showing shove); BWC 1 (linked

[10] Officer [redacted] resigned "under unfavorable circumstances" prior to the official termination. *See* [redacted] UUC Letter at 1.

[11] In addition, the Hiring Authority disciplined Lieutenant [redacted] for failing to initiate an incident package after learning about the incident. *See* 402/403 at 9-11. However, the discipline was reduced to training after a Skelly hearing. *See* [redacted] Skelly Results at 1.

above) at 11:08:28 (Officer [redacted] turning to react immediately after shove); BWC 3 at 11:08:28 (showing Officer [redacted] watching attack). Officer [redacted] also appears to witness the shove, as his BWC shows him standing at the tower window looking directly at Mr. [redacted] cell, though he quickly turns away. *See* BWC 3 at 11:08:25. None of the officers reported the assault. The Hiring Authority did not sustain any allegations related to this assault, including failure to respond to and report the assault. *See* 402/403.

The investigator's inquiry into this issue was inadequate, even though Mr. [redacted] alleged in the interview that staff use the MAC Reps "to harass or threaten inmates." *See* OIA Report at 5. Officers [redacted] and [redacted][12] claimed in their investigation interviews that they were not aware of and did not witness the assault. Their claims are not credible, because video clearly shows them looking toward and reacting to the assault. *See* BWC 2 (linked above) at 11:08:25; BWC 1 (linked above) at 11:08:25; AVSS at 11:08:25. Officer [redacted] also claimed that he asked Officer [redacted] to close Mr. [redacted] cell door so that the MAC Rep could talk to Mr. [redacted] through the mesh. Though Officer [redacted] did say "closing," that comment seems more likely to refer to closing the MAC Rep's cell. *See* BWC 1 (linked above) at 11:08:12. And even if he did take steps to try to close Mr. [redacted] cell door, he did nothing to address the assault after it began.

This evidence is consistent with Mr. [redacted] allegation that staff use MAC representatives to assault incarcerated people. Yet, the investigator did not take the most basic step necessary to assess this allegation, including speaking to the MAC Rep about his involvement, questioning the officers about their inaction during the attack, and interviewing any incarcerated witnesses to see if they could corroborate Mr. [redacted] allegation about use of the MAC Reps as enforcers. Instead, the investigator summarized at length Lieutenant [redacted] (an officer who was not present for the incident) general testimony that what is shown on officer's BWC may not represent what an officer in fact saw. *See, e.g.*, OIA Report at 6-7. And even if Lieutenant [redacted] testimony were true for some cases, the video here clearly shows (1) Officer [redacted] facing towards the assault (as viewable on Officer [redacted] BWC); (2) Officer [redacted] reacting to the assault (viewable on all BWC); and (3) Officer [redacted] looking directly at the assault and then turning away (viewable on Officer [redacted] BWC).

Ultimately, despite the investigator's failures, the video evidence supports a finding that Officers [redacted] and [redacted] all failed to respond to and report the assault and endangered Mr. [redacted] and that Officers [redacted] and [redacted] were dishonest during their investigation interviews. Despite imposing some discipline for serious misconduct in this case, CDCR fell short when investigating a serious allegation that officers initiated an assault through using MAC representatives as enforcers. And CDCR's failure to adequately investigate this allegation and hold staff accountable, if it is

[12] Officer [redacted] was not interviewed because he was no longer employed by CDCR by the time of the investigation. *See* OIA Report at 17.

occurring, will only perpetuate this dangerous practice, which poisons the culture of a prison, undermines relationships between staff and class members, and makes it more difficult for people to turn to staff for disability assistance when needed.

**(c) COR – [redacted] – AIU, Sustained – Corrective Action**

In this case, multiple officers made numerous provoking, threatening, and inappropriate comments to [redacted] ([redacted]) over the course of more than ten minutes. One of the officers eventually unholstered his OC spray and talked about manufacturing a situation so that he could spray the class member. Despite the officers' serious misconduct, the Hiring Authority only issued corrective action. As we have stated in previous reports, corrective action is not appropriate in situations, like this one, where any officer would know their behavior was wrong. *See* Plfs' May 20, 2024 Report at 27-28.

In this incident, Mr. [redacted] is in a small management yard (the walk-alone outdoor recreation cage) as three officers—Officers [redacted] and [redacted]—stand outside of the cage.[13] The officers laugh to themselves about an inaudible comment made by Mr. [redacted] *See* BWC 1 at 12:44:28. Officer [redacted] jokingly says to the other officers, "Give me that fucking 40, bro," referring to the 40-millimeter launcher potentially implying that he would like to shoot it at Mr. [redacted] *See* BWC 1 (linked above) at 12:44:49.

Mr. [redacted] then says to no one in particular, "I don't ride with no C.O." Officer [redacted] jokingly responds to the other officers, "I thought we were cool, [redacted] *See* BWC 1 (linked above) at 12:44:59. That comment starts a long conversation between the officers and Mr. [redacted] in which Mr. [redacted] becomes agitated and the officers continually escalate the situation. Mr. [redacted] challenges the officers to a fight, telling them to come into the cage with him. *See* BWC 1 (linked above) at 12:47:32. Officer [redacted] then provokes and challenges Mr. [redacted] by referring to a recent incident where Mr. [redacted] door was opened while officers were in the dayroom, but Mr. [redacted] did not take the opportunity to fight any officers. Specifically, Officer [redacted] says, "Kinda like your fucking door opened up too huh, and your bitch ass shut it. Exactly. You closed it. Hey, you stuck your little head out your fucking door that day when it opened, huh? And

[13] Office [redacted] BWC video also shows him engaging in misconduct unrelated to Mr. [redacted] Before he approaches the other officers outside of the recreation cages, he tells another officer to "go over that way" because he's "gotta do something." *See* BWC 1 at 12:42:06. He then sits down in the covered officers' station outside and makes a phone call using his smartwatch, which is a violation of policy. After making the phone call, he approaches the group of officers outside of the cages. The investigator noted Officer [redacted] use of his smartwatch and initiated another investigation into that misconduct. *See* IR at 4.

you shut it. You talk all that fucking shit and you don't do nothing." *See* BWC 1 (linked above) at 12:48:15. Mr. [redacted] becomes increasingly angry and says, "Open up the door now. Open up the door now. Let's see." *See* BWC 1 (linked above) at 12:48:28. Officer [redacted] responds, "We'll try again later." *See* BWC 1 (linked above) at 12:48:32.

Mr. [redacted] becomes angrier as he and Officer [redacted] trade insults. Mr. [redacted] calls Officer [redacted] a "bitch;" Officer [redacted] responds, "You're the little bitch walking with your head down every time." *See* BWC 2 at 12:50:10. Mr. [redacted] makes a comment about Officer [redacted] mother; Officer [redacted] responds, "After I get done with your old dirty ass bitch ass mom too." *See* BWC 2 (linked above) at 12:51:26. Mr. [redacted] calls Officer [redacted] a "hoe"; Officer [redacted] responds, "Can't be a bigger hoe than you." *See* BWC 2 (linked above) at 12:53:10. Officer [redacted] then jumps into the conversation and starts trading comments back and forth with Mr. [redacted] *See* BWC 2 (linked above) at 12:55:33. As Mr. [redacted] threatens Officer [redacted] Officer [redacted] responds, "You act like I'm scared. Scared of what? Scared of what?" *See* BWC 2 (linked above) at 12:55:43.

Ultimately, Officer [redacted] unholsters his OC spray and shakes it. *See* BWC 2 (linked above) at 13:01:21. He whispers to the other officers that he "kinda feels like walking up [to Mr. [redacted] letting them spit on [him], then spraying them." *See* BWC 2 (linked above) at 13:01:24. During his interview with the investigator, Officer [redacted] appears to have been untruthful about why he unholstered his OC spray. He claimed that Mr. [redacted] was trying to spit at officers. *See* IR at 5; Interview of Officer [redacted] at 20:55. But neither the BWC footage nor any other evidence supports that Mr. [redacted] was spitting at the officers. And the BWC footage captured Officer [redacted] statement about creating a situation that would justify him using his OC spray, which is inconsistent with his claim regarding Mr. [redacted] spitting on them. (The Hiring Authority did not sustain any dishonesty charges against Officer [redacted]

The investigator documented in his report nearly all of the officers' unprofessional conduct. Officer [redacted] and Officer [redacted] both admitted to the investigator that they made unprofessional statements. The Hiring Authority did sustain allegations of Discourtesy (D1, **1**23456) and Failure to Observe and Perform Within the Scope of Training (D26, **1**2345) against both officers. *See* 402/403 at 3, 10, 17. But then the Hiring only issued corrective action for both officers. *Id* at 1, 8, 15. The Hiring Authority also issued corrective action to the third officer present, Officer [redacted] who admitted to the investigator that he called Mr. [redacted] a "pussy." *See* IR at 6; 402/403 at 15.

Corrective action was a wholly inappropriate response to the officers' conduct. These officers, who are assigned to work in a sheltered mental health housing unit, intentionally provoked, insulted, and threatened a mentally-ill person. The conduct took place over the course of 15 minutes; it was not a one-time statement in the heat of the moment. They likely increased the risk of a future physical altercation with Mr. [redacted] and possibly with other incarcerated people who witnessed the incident. They made the prison a more dangerous environment for staff and incarcerated people, which is

especially troubling at a prison with well over 100 use-of-force cases over the last two quarterly productions.[14] And they decreased the likelihood that incarcerated people would seek from them the help or disability accommodations they may need. No officer employed by CDCR should need training to avoid interacting with incarcerated people in this obviously inappropriate, belittling, and dangerous manner. And yet, CDCR did not even impose adverse action.

**(d) LAC – [redacted] – AIU, Not Sustained**

In this case, incarcerated witness [redacted] ([redacted]) alleged that custody staff failed to take action to prevent class member [redacted] ([redacted]) from cutting his throat (Mr. [redacted] died by suicide) after Mr. [redacted] reported to clinical and custody staff that he needed help. Given the seriousness of the allegation in this case, the investigator should have exhausted all available avenues to determine what happened leading up to his death and whether staff should have done more to save his life. Instead, the investigator conducted a narrow, cursory investigation.

Mr. [redacted] died on February 4, 2023 and Mr. [redacted] filed a 602 thereafter.[15] In the 602, Mr. [redacted] alleged in part that "your staff once again allow an inmate in your eyees(sic) a piece of trash cut his throat after he asked for help and bleedout in a [redacted] building."[16] *See* 602 at 3. The AIU investigator interviewed Mr. [redacted] on April 10, 2023. In the interview, Mr. [redacted] reported that Mr. [redacted] put staff, including a clinician and officers, on notice that he was "going through something" on either the Wednesday or Thursday before his death on Saturday, February 4, 2023. *See* IR at 6. Mr. [redacted] alleged that staff simply told Mr. [redacted] to "go work it out." *Id.* According to Mr. [redacted] staff did not check on him again to see if he was OK after reporting problems until he was found dead. *Id.* Mr. [redacted] also alleged that staff "are not conducting security checks to verify if inmates are alive." *Id.*

The investigator failed to adequately follow up on these serious allegations, which required a full investigation into whether staff contributed to Mr. [redacted] death. The investigator should have attempted to confirm whether Mr. [redacted] requested help from staff in the days leading up to his death. Though Mr. [redacted] could not say for certain

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[14] The COR 2024 Q1 production had 91 use-of-force cases (out of 160 total cases), and the COR 2024 Q2 production had 37 use-of-force cases (out of 130 total cases).

[15] The 602 is dated February 3, 2023, but refers to events occurring on February 4, 2023. *See* 602 at 3-4. The investigator did not clarify with Mr. [redacted] the precise date he filed the 602, although the record shows that CDCR received the grievance on February 16, 2023. *See* Grievance Decision.

[16] Mr. [redacted] also alleged that staff picked a fight with a different incarcerated person on February 3. *See* 602 at 3.

when this happened, he stated that it was during third watch and happened a day or two before his death. *See* IR at 6. The investigator could have requested and – on hyper speed – quickly scanned the third watch AVSS footage during this time to determine if such an encounter occurred in the housing unit. Instead, the investigator appears to have only requested video from 2000-2200 hours on February 4, 2023. *See* 1118; IR at 5. And of that limited footage the investigator states that they reviewed only about 10 minutes, between 21:12:06 – 21:23:51, a snippet of footage that begins when staff discovered Mr. [redacted] was nonresponsive. IR at 5. It therefore has no bearing on Mr. [redacted] allegations that staff could have done more to help Mr. [redacted] before his death. The investigator should have, but did not, also reviewed footage leading up to Mr. [redacted] death to determine whether, as alleged by Mr. [redacted] staff failed to conduct security checks to determine whether he was alive in the hours leading up to his suicide.

Because of the incomplete investigation in this case, it is impossible to determine whether Mr. [redacted] asked for and did not receive help from staff in the hours leading up to his death or whether staff failed to conduct security checks.

**(e) RJD – [redacted] – AIU, Sustained – Adverse, L4**

In this case, Officers [redacted] and [redacted] delayed more than eleven minutes in responding to reports of suicidality and a cell fire started by [redacted] ([redacted]). Despite video evidence and both officers admitting that their conduct violated policy, the Hiring Authority sustained only one allegation against Officer [redacted] for failing to act when Mr. [redacted] reported that he was suicidal and even then, failed to impose more serious charges of endangerment. Officer [redacted] who similarly failed to respond to the cell fire, was not disciplined at all.

At 8:01 AM on November 17, 2022, BWC captures Officer [redacted] approach Mr. [redacted] cell while performing security checks. *See* BWC at 8:01:36. Mr. [redacted] reports to Officer [redacted] that there is a fire inside his cell and that he is suicidal. Officer [redacted] responds "Okay, we'll get you out in a bit" before walking away from Mr. [redacted] cell to inform Officer [redacted] about the cell fire. *See* BWC (linked above) at 8:01:42.

For the next eleven minutes, BWC[17] footage shows officers failing to respond to Mr. [redacted] report of suicidality and cell fire while they continue with security checks, prepare food for themselves, and, at one point, appear to mock Mr. [redacted] by commenting, "I'm refusing to come out. Alright, stay there." *See* IR at 4. Officer [redacted]

[17] The case file does not contain the footage from the [redacted] BWC worn by Officer [redacted] However, the investigator included a detailed description of this footage, which Plaintiffs' Counsel used for the timeline of events.

says in Spanish to another officer, "lo mandamos a la verga o hablamos un codigo?", which essentially means "Do we tell him to fuck off or call a code?" *Id.* Officer [redacted] finally uses his radio to call in the cell fire at 8:13:22, more than eleven minutes after Mr. [redacted] first alerted custody staff about the fire. *See* BWC (linked above) at 8:13:22.

The Hiring Authority sustained a charge against Officer [redacted] for failure to observe and perform within the scope of training, post orders, duty statement, department policy, or operational procedures (D26, penalty **1**2345) and imposed a Level 4 penalty for his failure to respond to Mr. [redacted] reported suicidality. *See* 402/403 at 7-8. Failing to respond to reports of suicidality can have life threatening consequences. The Hiring Authority should have sustained a more serious charge of intentional endangerment (D3, 45**6**789) and imposed a more substantial penalty. Officer [redacted] did not receive any discipline at all.

Both officers should have been disciplined for leaving Mr. [redacted] for eleven minutes in a cell with visible smoke and a reported fire. In their interviews with the investigator, both officers acknowledged that they were trained to call a code for a cell fire and to remain cell front to visually observe the individual. *See* IR at 8, 9, 12. Yet, neither officer followed this protocol. During his interview, Officer [redacted] also stated that he would notify his supervisor and medical staff if the individual refused to exit the cell during a cell fire, and potentially perform a medical cell entry to remove the individual from the cell. *See* IR at 8. However, that did not occur here, Officer [redacted] did not notify anyone if Mr. [redacted] was refusing and, instead, prepared food for himself and mocked Mr. [redacted]

In light of the video evidence and officers' admissions to failing to follow Fire and Life Safety policy, the Hiring Authority should have sustained violations against both officers for failing to act, including intentional endangerment against Officer [redacted] whose comments make clear his intent not to act.

### 4. The Failure to Adequately Manage Existing Investigative Resources and the "Strike Team" at RJD

In this quarter, Plaintiffs' counsel attempted to conduct an analysis of all cases from RJD, similar to the review of all cases for LAC during the last quarter that Plaintiffs conducted. *See* Letter from [redacted] to [redacted] and [redacted] dated April 24, 2024. This was a futile endeavor.

Due to Defendants' increasing backlog of staff misconduct cases, a significant number of the 166 RJD cases produced this quarter appear to have been resolved by a

"Strike Team."[18] **61 of the 166 cases (37.4%)[19] were closed after the statute of limitations for imposing adverse action had passed, ensuring that it would be impossible to hold anyone accountable for the alleged misconduct**. *See* RJD Q2 2024 Case Index, attached hereto as Exhibit A. Moreover, 115 of the 166 cases (or 69%) do not include video evidence, apparently because they were either not assigned to an investigator or the investigation did not request video until after the 90-day video retention period had elapsed. *Id.* In short, Plaintiffs' review of all RJD cases this quarter was futile because CDCR let these cases languish without preserving evidence, and then spent significant time and department resources convening a "Strike Team" to investigate cases after the material evidence was already destroyed and after it was too late to hold staff accountable even if violations were discovered.

Defendants actions in convening the "Strike Team" raise serious questions about their management of their limited investigation resources. Defendants have under-resourced their investigation process, but chose to ignore Plaintiffs' warnings for years and instead assert that their accountability system is failing due to the allegedly large number of non-legitimate staff complaints. Regardless of the precise reason CDCR's accountability system is failing, the decision to utilize precious and limited investigation resources on cases where evidence had already been destroyed and where it was too late to hold staff accountable makes no sense.

**If the parties are to continue negotiations, and Plaintiffs are to make concessions aimed at addressing the large investigation workload, Defendants must better manage their existing resources to resolve the large number of staff misconduct complaints in the system.**

### 5. AIU Investigations Continue to be Delayed

AIU staff are continuing to fail to complete investigations by the deadlines set in the Remedial Plans: 120 days for investigations conducted by custody supervisors

[18] Plaintiffs' counsel discovered the "Strike Team" while conducting a monitoring tour of RJD in February 2024. LDI staff at RJD reported that the "Strike Team" was convened to address a backlog of over 500 staff misconduct cases at the prison. Defendants have confirmed the use of "Strike Teams" at RJD and LAC to address backlogged cases, though few other details have been disclosed.

[19] Due to contradicting received by dates, missing documents, and duplicate grievances, Plaintiffs' counsel could not determine whether the statute of limitations for imposing discipline had passed for the following 3 cases: [redacted]; [redacted]; [redacted]. These cases were excluded from the total case count and the percentage of cases closed after the statute of limitations had passed was instead calculated with a denominator of 163.

(Sergeants and Lieutenants), who conduct nearly all AIU investigations,[20] and 180 days for investigations conducted by Special Agents. The chart below shows that, for investigations the AIU received in May 2023 to February 2024,[21] the AIU closed 26% of the investigations late. For the most recent three months of available data (December 2023 to February 2024), the AIU closed 28% of investigations late.

| | MONTH REC'D | CLOSED-ONTIME | CLOSED-PAST DUE | OPEN | OPEN-PAST DUE | TOTAL | % LATE |
|---|---|---|---|---|---|---|---|
| **2023** | **May** | 305 | 100 | 0 | 1 | 406 | 25% |
| | **June** | 322 | 127 | 2 | 2 | 453 | 28% |
| | **July** | 279 | 83 | 0 | 0 | 362 | 23% |
| | **August** | 200 | 73 | 1 | 1 | 275 | 27% |
| | **September** | 144 | 54 | 0 | 1 | 199 | 28% |
| | **October** | 184 | 47 | 0 | 3 | 234 | 21% |
| | **November** | 141 | 30 | 0 | 4 | 175 | 19% |
| | **December** | 196 | 49 | 1 | 10 | 256 | 23% |
| **2024** | **January** | 225 | 61 | 0 | 51 | 337 | 33% |
| | **February** | 161 | 21 | 2 | 40 | 224 | 27% |
| | **TOTAL** | 2157 | 645 | 6 | 113 | 2921 | 26% |

## II. CONCLUSION

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

[20] In the last thirteen months for which Plaintiffs have data (May 2023 to June 2024), the AIU assigned 4,236 of 4,307 (98%) of cases to be investigated by custody supervisors. The CST only assigned 70 (2%) cases to be investigated by Special Agents.

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