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BUREAU OF INDEPENDENT REVIEW

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SPECIAL REVIEW INTO THE SHOOTING OF INMATE DANIEL PROVENCIO ON JANUARY 16, 2005 AT WASCO STATE PRISON

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STATE OF CALIFORNIA

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EXECUTIVE SUMMARY

This report presents the results of a special review conducted by the Office of the Inspector General's Bureau of Independent Review into the circumstances surrounding the death of inmate Daniel Provencio at the Wasco State Prison-Reception Center (Wasco) and of the several investigations that followed. The incident began on January 16, 2005 when a fight broke out between two inmates who were finishing their evening meal. As officers attempted to gain control of the situation, Provencio inserted himself into the incident and was struck once in the head by a 40mm direct-impact "sponge," or rubber-like, projectile. The resulting head wound to Provencio caused him to lapse into a coma approximately 45 minutes later and caused his eventual death on March 4, 2005.

The Office of Internal Affairs of the California Department of Corrections conducted a criminal investigation into the incident and found no criminal misconduct by Wasco employees. The department's Law Enforcement and Investigations Unit also conducted a "use-of-force" investigation into the incident and subsequently determined that the actions of the correctional officer who fired the direct- impact round at Provencio complied with department policy. The findings of the Law Enforcement and Investigations Unit were also presented to an independent Deadly Force Review Board comprised of executive-level law enforcement officers from outside the department. The members of the Deadly Force Review Board determined that the officer's shooting of Provencio was reasonable under the circumstances and was in compliance with the department's policy governing the use of less-than-lethal direct-impact weapons. Warden P. L. Vazquez of Wasco also convened an "Institution-Head Review of Use-of-Force Critique and Qualitative Evaluation Analysis" Committee (the Wasco Use-of-Force Committee), which reviewed the matter and concluded there had been no employee misconduct during the incident.

Immediately following the incident, the Bureau of Independent Review became involved to ensure the timeliness, thoroughness, and objectivity of the investigations by the various entities and to identify any systemic policy or training deficiencies, procedural violations, or other factors that may have contributed to Provencio's death. In its review, the bureau examined the Wasco incident reports and attendant documents; the criminal investigative report by the Office of Internal Affairs, including more than 100 witness interviews; the "use-of-force" investigative report by the Law Enforcement and Investigations Unit; the Deadly Force Review Board findings; and the Wasco Use-of-Force Committee findings. The bureau also examined the department's relevant policies and procedures concerning safety and security, weapons deployment, emergency incident response, medical response, and crime scene management.

As a result of its review, the bureau has determined that the investigations conducted of the incident were, on the whole, thorough, objective, and timely. Furthermore, the conclusions reached by the investigative entities involved — namely, that the actions of the officer did not involve criminal misconduct, that he acted in a reasonable manner, and

that he had complied with department policy in firing the 40mm direct-impact projectile at Provencio — were supported by the weight of the evidence.

Although the bureau concurs with the findings described above, the special review did identify other issues of concern. These issues include deficiencies in the following areas: staff training in the use of direct-impact weapons; housing unit security checks and cell searches; emergency response procedures; evidence handling; and identification of responsibility for conducting administrative investigations. The bureau recommends implementation of the recommendations presented in this report at the appropriate individual, institutional, and departmental levels. The bureau will continue to monitor and report on this matter with regard to the implementation of the corrective actions described herein.

INTRODUCTION

This report presents the results of a special review conducted by the Office of the Inspector General's Bureau of Independent Review into the circumstances surrounding the January 16, 2005 shooting of inmate Daniel Provencio with a direct-impact weapon at Wasco State Prison-Reception Center (Wasco). The direct-impact 40mm sponge projectile fired during the incident struck Provencio on the side of the head, causing substantial intercranial trauma and eventually resulting in his death on March 4, 2005. The review was conducted by the Bureau of Independent Review pursuant to Penal Code section 6131, which requires contemporaneous oversight of investigations conducted by the California Department of Corrections, Office of Internal Affairs.

OBJECTIVES, SCOPE AND METHODOLOGY

The purpose of the special review was to ensure the timeliness, thoroughness, and objectivity of the investigations and to identify any systemic policy or training deficiencies, procedural violations, or other factors that may have contributed to the incident or had an impact on the effectiveness of the investigations that followed. The review also considered whether the incident revealed the need for statutory or regulatory changes, as well as staff training requirements.

In conducting the review, the bureau examined the following documents and evidence:

- 112 investigative interviews prepared by the Office of Internal Affairs.
- 30 investigative interviews conducted by the Law Enforcement and Investigations Unit.
- Numerous photographs taken of the incident scene.
- Facility incident reports and other related documents.
- Wasco post orders, housing unit logbooks, and other related documents.
- Provencio's criminal history record.
- The criminal investigative report by the Office of Internal Affairs.
- The "use-of-force" investigative report by the Law Enforcement and Investigations Unit.
- The Deadly Force Review Board findings.
- The Wasco Use-of-Force Committee findings.

- Function and performance data obtained from the testing performed by the Law Enforcement and Investigations Unit personnel on the Defense Technologies 40mm launcher used during the incident.

- The department's training materials for the use of direct and indirect-impact rounds.

- Manufacturer and industry performance material for the Defense Technologies "eXact iMpact" 40mm sponge round employed during this incident.

- The National Institute of Justice's Impact Munitions Data Base of Use and Effects.

- The personnel file and training records of the officer who fired the sponge round.

- Pertinent statutes, regulations and operational policies and procedures.

In reviewing these issues, the Bureau of Independent Review conducted the following procedures:

- Assigned two attorneys and one investigator to conduct the review.

- Viewed the incident scene at Wasco.

- Interviewed Wasco personnel, including the warden, management staff, institutional investigators and other employees.

- Consulted with special agents of the Office of Internal Affairs and the Law Enforcement and Investigations Unit.

- Contacted the Kern County District Attorney's Office.

- Attended the Deadly Force Review Board inquiry.

BACKGROUND

On Sunday, January 16, 2005, a floor officer in Facility D, Building Four, at Wasco State Prison-Reception Center (Wasco) was supervising approximately 38 inmates from the upper tier who were eating at the dining tables in the dayroom on the ground floor. At approximately 4:41 p.m., the floor officer observed an inmate dump food from his tray and strike another inmate on the head with the empty tray; the two inmates then began to fight one another. The floor officer immediately ordered all the inmates in the facility down onto the floor and activated his personal alarm device. According to witnesses, most of the inmates complied, but inmate Daniel Provencio stood up and placed himself directly between the officer and the fighting inmates. The floor officer ordered Provencio several times to get down onto the floor, but Provencio refused. Instead, Provencio became verbally belligerent and began advancing toward the floor officer in a hostile manner.

At the time of the incident, another officer was stationed in the facility's second tier control booth approximately 12-1/2 feet above the ground-floor dayroom. He, too, observed the fight between the two inmates. The control booth officer observed Provencio advancing toward the floor officer, saw the floor officer draw his baton, and heard some of the other inmates yelling hostile and provocative statements. Perceiving a serious threat to the safety of the floor officer as Provencio continued to advance, the control booth officer shouted at the floor officer to back up and then fired one XM1006 direct-impact sponge projectile from his 40mm launcher. The control booth officer later stated during an interview that he was aiming at Provencio's upper right thigh when he discharged the round. The sponge projectile struck Provencio on the left side of his forehead from a distance of approximately 53 feet. In response, Provencio knelt to the floor, bleeding from the forehead, but quickly stood up again.

In response to the floor officer's personal alarm, other correctional officers began to arrive at the unit. During this time, one of the fighting inmates crawled to Provencio and attempted to pull him down to the floor, but Provencio resisted his efforts. Several correctional officers also ordered Provencio to get down onto the floor. However, Provencio refused. During this time, it appeared to the staff that several other inmates were moving into push-up positions in an apparent attempt to ready themselves to quickly get up from the floor. Some inmates were yelling statements such as, "remember Chino" and "get that mother-fucker like they did in Chino" — apparent references to the fatal stabbing of a correctional officer by an inmate at the California Institution for Men in Chino, California on January 10, 2005, six days earlier.

At this point, a correctional lieutenant attempted to resolve the situation by approaching Provencio and offering to help him get medical attention. Provencio swung at the lieutenant as the other inmate continued to hold him. While in close proximity to Provencio, the lieutenant was able to smell alcohol on the inmate's breath. As the situation escalated, Provencio and the other inmate attempted to spit on some of the

responding staff members. Provencio eventually struck one of the responding correctional officers with food from one of the trays.

A different correctional officer responded by spraying both inmates with Oleoresin Capsicum pepper spray. That officer was then able to separate Provencio from the other inmates, and with help from the officer who was struck with food from the tray, Provencio was handcuffed. Provencio was escorted out of the building to the facility patio area and placed on a gurney. While being transported to the Wasco Infirmary, he remained combative.

Provencio arrived at the Wasco Infirmary at approximately 5:00 p.m. A registered nurse immediately examined Provencio and found a two-and-a-half-inch laceration to the left side of his forehead, which he attempted to treat. Provencio, however, continued to resist staff and attempted to spit on infirmary staff members who were attempting to assist him. A doctor also assessed Provencio's condition, but was unable to treat the laceration due to Provencio's combativeness. At approximately 5:45 p.m., Provencio lost consciousness. The doctor ordered that an ambulance be called "Code Three" (emergency) to transport Provencio to Mercy Hospital in Bakersfield, California. The ambulance was called at 5:50 p.m. and arrived at the prison at approximately 6:05 p.m. Prior to being transported to the hospital for treatment, the ambulance paramedics and the doctor performed various procedures to stabilize Provencio. At 6:35 p.m. the ambulance transported Provencio "Code Three" to Mercy Hospital. Provencio's blood alcohol concentration was tested at 7:35 p.m. and was later determined to be .152 percent. Following his arrival at Mercy Hospital, Provencio lapsed into a coma. He subsequently died on March 4, 2005. The medical examiner's report listed the cause of death as blunt force trauma to the head.

In his capacity as the Incident Commander, the lieutenant reported the incident to the facility captain at 5:30 p.m. At approximately 8:30 p.m., the lieutenant contacted the Wasco State Prison Investigative Services Unit and the Office of Internal Affairs. On Monday, January 17, 2005, the day after the incident, the Bureau of Independent Review was notified of the incident by the Office of Internal Affairs.

Wasco State Prison Incident Review

Due to the near-immediate response by the Office of Internal Affairs, the Wasco Investigative Services Unit did not investigate the incident. The Incident Commander nevertheless directed all staff members involved to write incident reports of their actions and observations, which he then reviewed. As a result, several of the inmates involved in the incident, including one of the inmates involved in the initial fight, received administrative discipline for their actions. Furthermore, all of the staff reports were provided to a special agent from the Office of Internal Affairs, and later, to another special agent from the Law Enforcement and Investigations Unit, for use in their respective investigations.

On January 20, 2005, the warden requested that the Office of Internal Affairs conduct a Category II criminal investigation of the incident. On March 8, 2005, the warden also convened a committee of Wasco administrators to conduct an "Institution-Head Review of Use-of-Force Critique and Qualitative Evaluation Analysis" (the Wasco Use-of-Force Committee). The Wasco Use-of-Force Committee reviewed all of the reports and documents previously described, as well as an advisory memorandum authored by the special agent from the Office of Internal Affairs concerning the incident. The committee also reviewed California Code of Regulations, Title 15, section 3268 concerning the lawful use of force to determine whether the staff had acted in compliance with legal requirements under such circumstances. Finally, the warden issued a "Final Executive Review" report on behalf of the committee on March 21, 2005 (Case No. WSP-FDY-05-01-0025).

The Office of Internal Affairs Investigation

The Office of Internal Affairs was notified of the incident involving Provencio on January 16, 2005, approximately three hours after it occurred. Immediately after notification was received, a special agent responded to the hospital where Provencio was receiving medical care. Another special agent responded to Wasco at the same time. Under the supervision of the latter special agent, a Deadly Force Investigations Team was assembled to determine whether the staff used excessive force during the incident. The Deadly Force Investigations Team opened its investigation into the incident the same day.

During the course of the investigation, the Deadly Force Investigations Team interviewed 112 potential witnesses (staff members and inmates) and took numerous photographs of the incident scene. The Team also received into evidence the 40mm launcher used in the incident, which had been secured earlier by a sergeant at Wasco, and two pieces of the sponge round, which had been recovered from the dayroom by the floor officer. The Office of Internal Affairs completed its investigation on February 24, 2005. (Case no. C-11-WSP-013-05-D)

The Law Enforcement and Investigations Unit Investigation

Upon notification of the incident, the Law Enforcement and Investigations Unit opened a "use-of-force" investigation into the matter and assigned it to another special agent on January 24, 2005. The agent reviewed all of the Wasco incident reports, consulted with the special agent from the Office of Internal Affairs, visited the scene, test-fired the 40mm launcher, and interviewed 30 witnesses (staff members and inmates). The Law Enforcement and Investigations Unit completed its investigation on March 10, 2005 and presented it to the Deadly Force Review Board on April 11, 2005 (Case no. OIS-WASCO-05-01-01).

FINDINGS AND RECOMMENDATIONS

FINDING 1

The Bureau of Independent Review found that the investigations into the death of inmate Provencio were thorough and objective and were completed in a reasonably timely manner. The Bureau of Independent Review also found that the conclusions reached by the investigative entities involved — namely, that the control booth officer's discharge of the 40mm launcher complied with department policy — were supported by the weight of the evidence.

All of the investigations and other reviews relating to the incident that resulted in the death of inmate Provencio were completed within approximately four months of the occurrence. The Bureau of Independent Review found no relevant issues that were ignored and identified no potential witnesses who were overlooked during the course of the investigations. None of the investigative agencies or the Wasco staff resisted or attempted to obstruct the bureau's involvement, and it did not appear from the bureau's review of the case that any institutional or personal bias existed in favor of a particular outcome by any of the entities involved.

Following is a timeline of key events:

1/16/05	Provencio is injured
1/16/05	Office of Internal Affairs began its investigation
1/17/05	Bureau of Independent Review was notified and began monitoring the investigation
1/20/05	Warden requested a Category II internal affairs investigation
1/20/05	Provencio ceased brain function
1/24/05	The Law Enforcement Investigations Unit began its investigation
2/24/05	The Office of Internal Affairs completed its investigation
3/4/05	Provencio died at 2:05 p.m.
3/8/05	Wasco Use-of-Force Review Committee convened
3/9/05	Autopsy conducted by the Kern County Coroner
3/10/05	Autopsy report completed
3/10/05	The Law Enforcement Investigations Unit completed its investigation
3/21/05	Wasco Use-of-Force Committee report released
4/6/05	Bureau of Independent Review reviewed the Wasco Use-of-Force Committee report with the warden
4/11/05	Deadly Force Review Board hearing held
4/20/05	Deadly Force Review Board report completed
4/29/05	Deadly Force Review Board report released to the Bureau of Independent Review
5/16/05	Bureau of Independent Review contacted the warden to discuss all findings

The Bureau of Independent Review monitored the Office of Internal Affairs' criminal investigation from notification through to its conclusion. The bureau noted that the special agent from the Office of Internal Affairs made the investigation his first priority and went to considerable lengths to interview everyone who might have pertinent information. He readily and willingly accepted and incorporated the bureau's suggestions into his investigation. His conclusion was based upon the totality of the circumstances, including: interviews and accounts from inmates and staff corroborating one another, physical evidence, his own training and experience, the histories and potential biases of those involved, and other information, including the autopsy findings. He processed the report through his supervisors and on to the hiring authority as expediently as possible. He also produced a memorandum outlining several administrative/training issues that needed to be addressed. Given the seriousness of this case, and in light of what the special agent accomplished in six weeks, the length of time in which he completed the investigation was commendable.

The Law Enforcement Investigations Unit investigation was somewhat duplicative of the Office of Internal Affairs investigation, but the Law Enforcement Investigations Unit did conduct many separate and independent interviews of the parties involved. The Law Enforcement Investigations Unit also went to additional lengths to diagram the scene and test-fire the weapon. The Law Enforcement Investigations Unit reviewed the Office of Internal Affairs investigation, but relied primarily on its own investigation to complete its report. It should be noted that the autopsy report by the Kern County Coroner's Office was not completed until March 10, 2005 and was necessary for the completion of the Law Enforcement Investigations Unit investigation in light of its required presentation to the Deadly Force Review Board.

The one exception with regard to timeliness in this process was the month it took to convene the Deadly Force Review Board after the Law Enforcement Investigations Unit report became final. Part of the delay is attributable to the fact that the members of the Deadly Force Review Board are all current or retired executive-level law enforcement officers from agencies outside the Department of Corrections. Consequently, the department struggles to find compatible days on which to schedule board meetings. The independence of the Deadly Force Review Board, however, helps ensure that each case referred to the board is reviewed with objectivity and a wealth of experience.

The Wasco Use-of-Force Committee did not conduct a separate investigation, but rather completed a thorough review of all the reports and investigations provided in the case. The warden also met with the Bureau of Independent Review on several occasions and discussed administrative actions and remedies for issues noted by the bureau. The warden was cooperative and objective in assessing the performance of the staff, readily conceding the need for training in certain areas.

At the conclusion of the investigations described above, the various entities involved each determined that the actions of the control booth officer complied with department policy. Specifically, the Office of Internal Affairs concluded that the actions of the

control booth officer did not involve criminal misconduct; the Law Enforcement and Investigations Unit concluded that the control booth officer complied with department policy in firing the 40mm direct-impact projectile at inmate Provencio; and the Wasco Use-of-Force Committee concluded that the control booth officer acted in a reasonable manner under the circumstances.

Of significant note, the Deadly Force Review Board considered the various statements made by officers and inmates and determined that Provencio did in fact behave in an aggressive and disobedient manner throughout the incident; that he failed to comply with orders to "get down"; and that he posed a threat to the floor officer, who was alone among numerous inmates. Based on these facts, the Deadly Force Review Board concluded that the control booth officer acted in a reasonable manner and was fully in compliance with the department's use-of-force policy when he elected to fire a less-than-lethal weapon at inmate Provencio.

Similarly, a thorough evaluation by the Bureau of Independent Review of all of the evidence developed by the various investigative entities involved found that the weight of the evidence supports the conclusion reached by those entities that the control booth officer's discharge of the 40mm launcher complied with department policy.

FINDING 2

The Bureau of Independent Review found a number of contributing factors that may have accounted for the control booth officer's inaccurate placement of the 40mm projectile, including inadequate training on the weapon and the lack of a consistent policy at Wasco for qualification with the 40mm launcher.

Inmate Provencio was struck on the forehead and killed by a projectile fired from a department-issued 40mm launcher. The 40mm Defense Technology launcher is designed to fire a less-than-lethal M1006 direct-impact sponge round. The control booth officer fired the weapon from the second-tier control booth, which sits approximately 12-1/2 feet above the ground-floor dayroom where Provencio was standing, at a distance of approximately 53 feet. The control booth officer said he fired the 40mm launcher so as to strike Provencio on the lower extremities.

According to statements by the control booth officer, the floor officer and several inmates who were present when the incident occurred, Provencio was moving toward the floor officer at the time the control booth officer fired the weapon, meaning that Provencio was moving toward the control booth officer's position at an oblique angle. Provencio's forward movement both created a moving target and increased the likelihood that the projectile would strike him in the upper body as he moved into its flight path.

The Law Enforcement and Investigations Unit tested the same weapon used in the incident and determined the weapon to be functioning properly; however, the Law Enforcement and Investigations Unit also determined that direct-impact projectiles fired

from a distance of 53 feet in a slightly downward angle tend to rise 4 to 5 inches above the point of aim. Moreover, this type of weapon has a trigger pull longer than that of many other firearms, potentially causing a shooter to unintentionally raise the point of aim (and therefore the point of impact) during the firing sequence. Moreover, it is well-established that a weapon's target zone is reduced geometrically when the weapon is fired at a downward angle. In other words, the steeper the downward angle the more likely projectiles will strike an unintended target due to the reduced sight picture and diminished target area.

In addition, it appears that the control booth officer received insufficient training on the 40 mm launcher. Wasco records reveal that the officer participated in weapons training one month before the incident, in December 2004, and that he was deemed qualified to use the 40mm launcher at that time. However, it could not be determined from the records whether the officer actually fired a 40mm round during this training event or had simply handled the weapon. Moreover, it was determined that Wasco lacks a consistent policy governing the requirements for qualification with a 40mm launcher. In fact, the Bureau of Independent Review was told that due to the high cost of the 40mm direct-impact round (approximately $20 to $25 per round), officers are rarely, if ever, given the opportunity to practice firing the 40mm launcher using live direct-impact rounds. Thus, the first time an officer may actually fire a live 40mm direct-impact projectile is during an emergency situation in which the officer is expected to quickly aim and fire, often at moving targets.

The Bureau of Independent Review also found that many of the special characteristics and limitations of the 40mm launcher discussed above are not adequately addressed in the department's "Line Staff Impact Munitions Workbook," a training guide for staff members on the proper use of approved weapons. In particular, the Bureau of Independent Review found that the workbook contains significant ambiguities concerning the use of direct-impact weapons such as the launcher from an elevated position and at a moving target.

It therefore appears likely that the combination of Provencio's forward movement, the projectile's tendency to rise from the target area when fired, the effect of the longer trigger pull on the shooter, and the reduced target zone, may have all contributed to the sponge projectile striking Provencio in the head instead of on the lower extremities. In addition to these factors, the Bureau of Independent Review found that inadequate training on the weapon with live rounds and the lack of a consistent policy at Wasco for qualification on the 40mm launcher may have also contributed to the control booth officer's inaccurate placement of the 40mm projectile.

RECOMMENDATIONS

The Bureau of Independent Review recommends that the Department of Corrections develop a more comprehensive training component covering the use of direct-impact weapons from an elevated position. In addition, the

department should develop a comprehensive training component that includes training on how to effective and safely employ the 40mm launcher against a moving target. Absent adequate training, the use of this weapon should be discontinued.

The Department of Corrections should also ensure that every officer armed with a department-issued weapon is regularly qualified with that weapon, including firing live rounds or using a realistic simulator.

FINDING 3

The Bureau of Independent Review found that the Wasco staff may not have regularly performed thorough security checks of the housing unit during shift changes, failed to conduct timely cell searches of the housing unit after the incident, and failed to properly maintain the housing unit's logbooks.

During investigative interviews conducted by the Office of Internal Affairs, four inmates stated that inmate Provencio and several of the other inmates involved in the incident were intoxicated. In particular, one inmate reported that he and Provencio had consumed a large quantity of inmate-manufactured alcohol just before the evening meal at which the incident occurred. Tests performed at the hospital confirmed that less than four hours after the incident, Provencio's blood alcohol concentration was .152 percent — almost twice the legal limit in California for driving a motor vehicle. Also, a sobriety report prepared by a senior medical technical assistant confirmed that one of the fighting inmates was found to be under the influence of alcohol shortly after the incident occurred. That Provencio and other inmates were significantly intoxicated at the time of the incident raises significant questions about the efficacy of security measures in place in Facility D, Building 4. It is clear from the evidence reviewed that the intoxication level of Provencio and the other inmates involved significantly contributed to the incident and threatened the safety of staff and inmates alike.

Regular and thorough security checks of the housing unit ordinarily deter, if not detect, activities that might result in the intoxication of inmates. The California Department of Corrections Operations Manual requires a physical count of all inmates a minimum of four times every calendar day. Furthermore, the operations manual dictates that post orders at each institution require a minimum of three cell searches in each housing unit during the second and third watches every calendar day. The Wasco post orders for Provencio's housing unit also required security checks at the beginning of each shift change.

However, the Wasco post orders do not articulate with precision the proper manner in which the security checks are to be conducted at each shift change, making it unclear whether a proper security check includes a visual inspection of each cell or a less-thorough check. Nor do the Facility D, Building Four logbooks that were prepared prior to the incident on January 16, 2005 indicate whether the security checks conducted by the

Wasco staff included a visual inspection of each cell. Had the security checks included a visual inspection of each cell, it is possible that Provencio's intoxication would have been discovered before he was released from his cell. In addition, the amount of inmate-manufactured alcohol consumed by Provencio and the other inmates involved in this incident raises serious questions about the effectiveness of security measures being taken to prevent inmates from removing and transporting fruit, sugar, and other associated alcohol-brewing ingredients from kitchens and dining areas.

The Facility D, Building Four staff also failed to conduct timely searches of the housing unit cells of all of the inmates involved in the incident immediately afterward. Again, had cell searches been conducted it is possible that additional inmate-manufactured alcohol from the batch that intoxicated Provencio and possibly four other inmates might have been discovered. Locating and collecting the inmate-manufactured alcohol was potentially important not only for its evidentiary value, but also to prevent other similarly dangerous incidents from occurring.

The bureau also noted in general that the Facility D staff failed to properly maintain the housing unit logbooks. In addition to a general lack of good record keeping, the logbooks also included one inappropriate and unprofessional remark concerning the incident. Properly and professionally maintained logbooks are essential for the efficient operation of the facility and the institution at large. Furthermore, they are a critical source of factual information for investigators in the event of a significant incident, such as occurred here. Accordingly, the failure to properly maintain the housing unit's logbooks, while perhaps inconsequential in this case, is of concern.

RECOMMENDATIONS

The Bureau of Independent Review recommends that Wasco State Prison develop clear written requirements governing security checks of housing units during shift changes, maintenance of housing unit logbooks, and timely cell searches following any significant incident at the institution.

FINDING 4

The Bureau of Independent Review found emergency notification procedures for use-of-force incidents at Wasco State Prison to be deficient.

Provencio sustained his injuries at approximately 4:41 p.m. on January 16, 2005. At approximately 5:45 p.m., he lost consciousness and was transported by ambulance to Mercy Hospital in Bakersfield. At that point it should have become reasonably evident that Provencio's injuries were significant; yet neither the Wasco Investigative Services Unit nor the Office of Internal Affairs was contacted until approximately 8:30 p.m. By the time the first special agent from the Office of Internal Affairs arrived at Wasco an hour later, only one member of the staff involved in the incident remained at the institution. The absence of all the other members of the staff prevented timely interviews

of those involved and the timely review of staff reports, which could have resulted in the loss of critical information at the outset of the investigation.

Several reasons were provided for the reporting delay. First, because Provencio was still alive (albeit unconscious) when he was taken by ambulance to the hospital, the severity of his injuries was neither immediately communicated nor appreciated by the staff at Wasco. Second, because the functions of the watch commander and the incident commander overlap, it is unclear which supervisor is required or expected to make the notifications. Third, a shift change that occurred near the time of the incident caused additional confusion on the part of the staff. And fourth, because the incident involved the use of a weapon designated by the department as less-than-lethal, the staff did not immediately comply with established procedures for incidents involving the use of deadly force. While each of these reasons may have in fact contributed to the delay, the bureau found that none of them individually, or cumulatively, excuse it.

RECOMMENDATION

The Bureau of Independent Review recommends that Wasco State Prison revise its emergency notification procedures to clarify responsibility for ordering employees to remain at their posts following significant incidents at the institution.

FINDING 5

The Bureau of Independent Review found that members of the Wasco staff improperly handled some of the evidence in this case, but that this deficiency did not affect the investigation.

In most use-of-force incidents in which serious injury or death has occurred, the clothing worn by the injured or deceased is collected as evidence. This is a sound and recommended investigative practice because clothing may contain important trace evidence (such as blood, fiber, and DNA) as well as other important forensic evidence (such as blood spatter marks and entry/exit points). The Department of Corrections recognizes the importance of crime scene preservation in general by making it a four-hour component of its basic correctional officer academy training program. Crime scene preservation and evidence preservation are also an integral part of the training program for the Wasco Investigative Services Unit.

More specifically, section 55010 of the California Department of Corrections Operations Manual requires that each warden have in effect at all times an Emergency Operations Plan. The purpose of the plan is to specify institutional procedures in the event of an emergency or inmate-initiated disturbance, such as the fight among inmates that precipitated the shooting of Provencio. Furthermore, the Emergency Operations Plan includes a supplement for crime scene preservation and preservation of evidence.

In this instance, however, collection of Provencio's clothing as evidence was overlooked when it was removed at Mercy Hospital. Apparently, the hospital janitorial staff picked up and disposed of the clothing shortly after it was removed and, unfortunately, neither of the two correctional officers who accompanied Provencio to the hospital interceded. It is unclear whether Provencio's clothing had much evidentiary value in this particular case, inasmuch as the life-threatening wound he received was sustained to the head, yet preserving the clothing would have been appropriate. As a general practice the correctional staff members who were present at the hospital should have preserved Provencio's clothing as evidence pending instructions from the appropriate investigating officials. To the staff's credit, pieces of the sponge projectile were recovered, and the weapon used in this incident was immediately taken out of service and preserved as evidence for the subsequent investigation.

RECOMMENDATION

The Bureau of Independent Review recommends that Wasco State Prison institute policies and procedures and training to ensure that all evidence related to incidents resulting in injury to staff or inmates is preserved pending instructions from investigating officials.

FINDING 6

The Bureau of Independent Review found that none of the Department of Corrections entities investigating the incident was required to conduct an administrative investigation beyond the use-of-force review to determine whether corrective or disciplinary action of all staff involved was appropriate. The Bureau of Independent Review took on this task voluntarily.

The Bureau of Independent Review determined that in use-of-force cases involving the death or serious injury of an inmate, such as this case, the department does not routinely conduct an administrative investigation of potential staff misconduct arising from the incident. For instance, following the death of Provencio, the Office of Internal Affairs was charged with the responsibility of conducting a criminal investigation of the incident to determine whether any criminal misconduct occurred and the Law Enforcement and Investigations Unit was charged with the responsibility of conducting a "use-of-force" investigation to determine whether the shooting of Provencio was within department policy. Even though the investigations by the two entities were somewhat overlapping and duplicative, it was not within the scope of either investigation to determine whether, beyond the use of force, any administrative misconduct necessitating corrective or disciplinary action occurred.

The Wasco Use-of-Force Committee did address some of the potential staff misconduct issues, but only within the context of determining whether the institutional response to the incident was adequate. Fortunately, the Office of Internal Affairs, working with the Bureau of Independent Review, identified many of the underlying administrative issues

raised by this incident and described those issues in a memorandum to the warden, who incorporated the issues into the committee's review. Nonetheless, the incident revealed a void in the department's investigative process for use-of-force incidents.

One potential solution is for the Office of Internal Affairs to conduct separate but parallel criminal and administrative investigations of all use-of-force incidents in which an inmate suffers death or serious injury, with appropriate safeguards in place to comply with the Public Safety Officers Procedural Bill of Rights Act. Another potential solution is for the Law Enforcement and Investigations Unit to conduct the criminal investigation and for the Office of Internal Affairs to conduct the administrative investigation, providing additional assurance of compliance with the Act.

RECOMMENDATION

The Bureau of Independent Review recommends that the Department of Corrections reassess the scope of work of each of its investigative entities to avoid unnecessary duplication and to ensure that administrative investigations are conducted in use-of-force incidents involving the death or serious injury of an inmate to identify potential staff misconduct.