OIG | OFFICE of the INSPECTOR GENERAL

Published in May 2024

Amarik K. Singh
Inspector General

Neil Robertson
Chief Deputy
Inspector General

Independent
Prison Oversight

As part of the Office of the Inspector General's statutory authority, we monitor the California Department of Corrections and Rehabilitation's performance and compliance with the use of force at its 33 prisons, parole operations, and Office of Correctional Safety. This document presents four notable use-of-force incidents that the Field Investigations Monitoring Unit closed from March 8, 2024, through April 5, 2024.

Incident Number
24-00010-UOF

Reason for Monitoring
Potential Misconduct

Incident Summary

On December 5, 2023, officers observed two incarcerated people striking a third incarcerated person, one of whom used an inmate-manufactured weapon, during medication distribution. Officers gave orders to the incarcerated people to stop their attack and get down on the ground, but were ignored. A control booth officer fired two less-lethal rounds;[1] one round inadvertently struck one incarcerated person on the chest. The force had its desired effect as the incarcerated people complied with officers' orders to get on the ground.[2] The control booth officer had failed to secure the housing section doors, which allowed the incarcerated people to move freely between the housing unit and subsequently attack each other. Both incarcerated people were sent to an outside hospital for a higher level of care.

Incident Disposition

The Institutional Executive Review Committee identified that the control booth officer failed to secure the housing unit section doors, resulting in one incarcerated person entering another section of the housing unit and repeatedly stabbing a second incarcerated person. Afterward, the second incarcerated person with the assistance of a third incarcerated person entered the first incarcerated person's housing section and repeatedly stabbed him in retaliation. The hiring authority recommended training to address the officer's failure to secure housing unit doors. The OIG disagreed with the hiring authority's decision to provide training and recommended that the hiring authority refer the officer's failure to secure the section doors for investigation. The hiring authority agreed with our recommendation and referred the matter for an investigation.

---

1. Impact munition are less-lethal projectiles. Sponge rounds are highly accurate, spin-stabilized, direct-fire munitions, and they should not be deployed from any distance under 10 feet. Zone 1 of the body (which consists of all areas of the legs and buttocks) is the only authorized zone at which officers can aim a weapon. Officers are instructed to never aim at a person's head, wrists, or groin areas unless deadly force criteria have been met. Sponge rounds can be fired in the housing unit from appropriate designated distances.

2. During a subsequent review of the institution's audio-video surveillance system recording, the incident commander identified that the attacker in the incident observed was a victim of a stabbing in an earlier incident that had gone unnoticed.

10111 Old Placerville Road, Suite 110, Sacramento, California 95827 ❋ Telephone: (916) 288-4233 ❋ www.oig.ca.gov

Incident Number
24-00011-UOF

Reason for Monitoring
Potential Misconduct

Incident Summary

On November 15, 2023, two Investigative Services Unit (ISU) officers were assigned to conduct a cell search. The two ISU officers approached the cell, removed two incarcerated people, and each conducted a clothed body search of one incarcerated person. Afterward, one ISU officer proceeded to escort one of the incarcerated people to the shower to perform an unclothed body search. While the second ISU officer was waiting to conduct an unclothed body search of the second incarcerated person, that incarcerated person removed a metal weapon from his waistband. The ISU officer ordered the incarcerated person to place his hands behind his back. The incarcerated person ignored the order and attempted to kick the weapon under a cell door. The ISU officer and two additional officers used physical force to get the incarcerated person to the ground, where they placed him in restraints.

Incident Disposition

The Institutional Executive Review Committee (IERC) identified that one officer who observed force failed to write and submit a report prior to being relieved from duty. The hiring authority provided training to the officer to address this deficiency. However, the OIG raised concerns related to how a trained officer assigned to the ISU failed to identify a large metal weapon nearly 7 inches long affixed to the front waist band of the incarcerated person's boxer shorts. Additionally, the video footage shown was incomplete and did not provide committee members with sufficient information to determine whether the ISU officer's actions or omission of actions may have contributed to the use of force. The OIG questioned why the staff of the various levels of review failed to identify, investigate, or review the video footage prior to the use of force to determine whether the ISU officer conducted a thorough clothed body search of the incarcerated person. The hiring authority responded and disclosed there were policies and union contract agreements in place that prevented management from viewing video footage other than the actual use-of-force. However, the use-of-force policy allows institutional staff the discretion to determine how much video footage the IERC is allowed to review.

The OIG responded by requesting a copy of the full video footage to review independently. The hiring authority refused to provide a copy, stating this request would serve as a potential conflict because any policy violations discovered by the OIG and reported to the warden would result in the warden having to take appropriate action. The hiring authority referred the OIG's request to an associate director who agreed to release the video footage to the OIG.

The OIG requested a copy of the video footage five times between January 17, 2024, and March 25, 2024, but the department did not provide the video footage. On March 27, 2024, the prison notified the OIG that the video footage was no longer available, as the time to retain it had passed the 90-day retention period despite the OIG requesting the video footage on multiple occasions prior to the elapse of the 90 days.

Based on the hiring authority's refusal to further review the ISU officer's actions and refusal to provide the OIG with any video footage regarding this case, the OIG was unable to thoroughly review this case and determine whether potential staff misconduct had occurred.

10111 Old Placerville Road, Suite 110, Sacramento, California 95827 ❄ Telephone: (916) 288-4233 ❄ www.oig.ca.gov

Incident Number
24-00015-UOF

Reason for Monitoring
Potential Misconduct

Incident Summary

On July 24, 2023, an incarcerated person was placed under direct observation by a medical provider because he expressed suicidal intentions to department staff. A medical technician was assigned to continuously observe the incarcerated person while the incarcerated person was on suicide watch. An officer arrived at the cell to provide the incarcerated person with a meal and observed the incarcerated person was agitated, and he yelled at officers for assistance. The incarcerated person then began to cut his right wrist area with a small, sharp metal object. The incarcerated person ignored the officer's orders to stop cutting himself. The officer deployed a chemical agent, and the incarcerated person complied with the officer's orders to stop harming himself. A second officer arrived on scene and secured the incarcerated person in hand restraints prior to transporting him to a triage and treatment area at the prison. The incarcerated person inflicted a serious bodily injury to his wrist, which required six sutures.

Incident Disposition

The hiring authority identified potential staff misconduct for the medical technician assigned to observe the incarcerated person and who witnessed the force officers had used, but did not submit an incident report. Despite their initial identification of potential staff misconduct, the Institutional Executive Review Committee declined to refer the matter for investigation. The OIG recommended on several occasions that the hiring authority refer the matter for investigation, yet the hiring authority declined to do so. An OIG supervisor contacted the associate director who supervised the hiring authority and expressed the OIG's concern that this incident had not been referred for investigation. The associate director assured the OIG that the matter would be referred for investigation. The hiring authority finally referred the incident for investigation five months after the incident occurred.

10111 Old Placerville Road, Suite 110, Sacramento, California 95827 ❄ Telephone: (916) 288-4233 ❄ www.oig.ca.gov

Incident Number
24-00016-UOF

Reason for Monitoring
Potential Misconduct; Other

Incident Summary

On November 22, 2023, two officers observed two incarcerated people fighting in a housing unit dayroom. The incarcerated people ignored the officers' orders to stop fighting. Officers used pepper spray and baton strikes to stop the incarcerated people from fighting and ordered them to take prone positions on the ground. Responding officers escorted both incarcerated people to holding cells, where they received medical evaluations.

Incident Disposition

Prior to the meeting by the Institutional Executive Review Committee, the hiring authority identified that the first officer used unnecessary force when the officer grabbed the chain between the handcuffs and pulled the incarcerated person to his feet, while the second officer watched the first officer, but failed to document in his incident report all the force he observed. The hiring authority issued a letter of instruction to the first officer for using unnecessary force and a letter of instruction to the second officer for failing to report the unnecessary force. The OIG recommended that the hiring authority refer the matters of allegations of misconduct for both officers for investigation. The hiring authority disagreed and stated the letter of instruction for the first officer was sufficient because the officer used poor judgment, but did not engage in misconduct. The hiring authority stated he would not refer the second officer's failure to report the force he observed for an investigation because there was no evidence the officer had observed the unnecessary force, which contradicted the letter of instruction issued to the second officer.

10111 Old Placerville Road, Suite 110, Sacramento, California 95827 ❄ Telephone: (916) 288-4233 ❄ www.oig.ca.gov