OIG | OFFICE of the INSPECTOR GENERAL

Published in June 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 three notable use-of-force incidents that the Field Investigations Monitoring Unit closed during the month of April 2024.

Incident Number
24-00017-UOF

Reason for Monitoring
Potential Misconduct

Incident Summary
On December 16, 2023, two officers were escorting an incarcerated person who suddenly stopped the escort and refused to go into his newly assigned cell. The officers ordered the incarcerated person to go into the cell, which the incarcerated person refused to do. One officer ordered the incarcerated person to submit to handcuffs, which the incarcerated person also refused to do. The officer announced via his radio that he was dealing with a disruptive incarcerated person and requested additional support. Additional officers arrived and ordered the incarcerated person to get down, which he also refused to do. An officer advised the incarcerated person he was going to place him in restraints and for the incarcerated person not to move. The officer reached for the incarcerated person's wrist, and the incarcerated person pulled away and resisted the officer. Four officers used physical force to gain control of the incarcerated person, while another officer used his baton and jabbed the incarcerated person three times in the abdomen. The force that the officers used was effective, and the officers were able to force the incarcerated person to the ground and place him in restraints.

Incident Disposition
The institution's executive review committee failed to identify potential staff misconduct. The OIG identified unnecessary force was used by officers to force the incarcerated person to the ground when no imminent threat was present. Furthermore, while reviewing the video footage, it was unclear whether the incarcerated person understood the orders that the officers gave to him. The OIG recommended that the hiring authority refer the matter for investigation. The hiring authority declined to refer the incident for investigation. As a result, the OIG elevated the issue to the associate director for his review and response. The associate director did not respond to our request, and we closed this incident without the department accepting our recommendation to refer the incident for investigation.

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

Incident Number
24-00018-UOF

Reason for Monitoring
Potential Misconduct

Incident Summary

On February 14, 2024, two incarcerated people were observed fighting on a main corridor near their housing unit door. Officers ordered the incarcerated people to get down, but they continued striking each other in the upper torso and facial area. One officer deployed one burst of pepper spray to quell the incident. The incarcerated people then separated and submitted to handcuffs. The incarcerated people were offered decontamination, provided with clean clothing, and then escorted to be medically evaluated and rehoused without further incident.

Incident Disposition

The institution's executive review committee determined that the use of force was compliant prior and during but out of compliance following the use of force. During a review of the audio-video surveillance system, the department identified that a registered nurse observed the officer use force during the incident, but did not submit an incident report prior to the end of the registered nurse's shift per departmental policy. The registered nurse did not submit a report until 11 days thereafter. The late reporting policy violation was referred to the healthcare chief executive officer for administrative review. This review resulted in the registered nurse receiving documented training. The OIG disagreed, finding the documented training to be insufficient, and recommended that the hiring authority refer the incident for investigation; however, the hiring authority declined to refer the matter. In addition, the first-level reviewer identified that both the response supervisor and the incident commander failed to identify that the registered nurse observed force and then failed to submit a timely report. The hiring authority issued training to both the response supervisor and the incident commander, and the OIG concurred with the decision.

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

Incident Number
24-00019-UOF

Reason for Monitoring
Potential Misconduct

Incident Summary

On July 18, 2023, an incarcerated person became resistive while being escorted to his assigned cell. Escorting officers gave him multiple verbal orders to stop resisting with negative results. One officer pushed the incarcerated person, which caused him to fall to the ground. Once on the ground, the incarcerated person stopped resisting. The incarcerated person was then helped to his feet, escorted, and placed in a holding cell. While in the holding cell, the incarcerated person wrapped his State-issued shirt around his neck and began to strangle himself in an attempt to commit suicide. One officer deployed one burst of pepper spray into the holding cell to stop the incarcerated person's actions. The incarcerated person ceased his activity and removed the clothing from around his neck. The incarcerated person was removed from the holding cell, afforded the opportunity to decontaminate, and provided with clean clothing. The incarcerated person was medically evaluated and moved to the correctional treatment center.

Incident Disposition

The institution's executive review committee determined that the use of force was compliant prior and during but out of compliance following the use of force. Specifically, one sergeant observed the officer deploy pepper spray to stop the incarcerated person from committing suicide, but the sergeant did not submit a report by the end of his shift as policy required. The sergeant's report was not submitted until three days later, also in violation of departmental policy. The OIG recommended that the matter be referred to the Office of Internal Affairs for investigation of the policy violation. The Institutional Executive Review Committee disagreed with the OIG and ordered a Letter of Instruction for the sergeant who failed to complete and submit a report prior to the end of his shift.

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