OIG | OFFICE of the INSPECTOR GENERAL

Published in July 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 May 2024.

Incident Number
24-00020-UOF

Reason for Monitoring
Potential Misconduct

Incident Summary
On January 12, 2024, two officers escorted an incarcerated person back to his cell inside a prison restricted housing unit. One officer removed the hand restraints from the incarcerated person utilizing the food port in the cell door. A second officer used physical force to push the incarcerated person's hands through the food port and back into the cell, while a third officer attempted to close the food port but was unsuccessful before the incarcerated person held his arms outside the food port. The officers backed away from the cell and a sergeant responded to the cell door to help quell the incident.

Incident Disposition
The hiring authority failed to identify any potential staff misconduct. The OIG inspector reviewed video footage of the incident, and identified potential staff misconduct based on an officer who escalated the incident when he used unnecessary force and pushed on the incarcerated person's hands while another officer released the incarcerated person from hand restraints. The OIG recommended that the hiring authority refer the officer for investigation for using unnecessary force, and the hiring authority agreed with the OIG's recommendation.

Incident Number
24-00021-UOF

Reason for Monitoring
Potential Misconduct

Incident Summary
On February 25, 2024, an incarcerated person began to enter his cell when his cell mate began to punch the incarcerated person in his face and head. Two officers observed the fight and ordered the incarcerated people to stop fighting, but the incarcerated people ignored the officer's orders. To stop the fight between the incarcerated people, and prevent further injury, the officers each deployed one application of pepper spray, which struck the facial area of each incarcerated person. The incarcerated people stopped fighting, separated, and submitted to handcuffs. The incarcerated people were offered decontamination, provided with clean clothing, and escorted to be medically evaluated.

Incident Disposition
The officers' actions prior to and during the use of force were in compliance with policy. Following the use of force, the hiring authority did not identify that the two officers had used nearly identical language to describe the force used in their reports. Departmental policy prohibits staff from collaborating with each other in the preparation of reports. The hiring authority also did not identify that the associate warden had noted the identical language, but did not suspend the review and recommend an investigation as departmental policy required. The OIG brought this concern to the hiring authority's attention and recommended that the hiring authority refer the incident for investigation. The hiring authority agreed with the OIG that the two officers submitted identical reports and referred the incident for investigation.

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

Incident Number
24-00023-UOF

Reason for Monitoring
Potential Misconduct

Incident Summary

On April 6, 2024, officers removed an incarcerated person from his cell in his assigned wheelchair due to an earlier incident. As staff released the incarcerated people to the yard, the sergeant instructed officers to conduct a clothed body search of the incarcerated person. The incarcerated person refused to submit to a search and continued to place his hands in the waistband area of his shorts. The incarcerated person then lunged out of his wheelchair, landed on the dayroom floor, and refused to show his hands to officers. Two officers used physical force to place the incarcerated person into restraints. The incarcerated person was transported in his wheelchair to a holding cell. The incarcerated person was seen by medical personnel, then released back to his assigned cell.

Incident Disposition

The institution's executive review committee determined the use of force was in compliance prior to and during the use of force but out of compliance following the use of force. Specifically, two officers failed to submit a report by the end of shift as required by policy. The officer's reports were not submitted until 11 days later. The OIG recommended that the matter be referred for investigation per departmental policy. The institution's executive review committee disagreed with the OIG and ordered employee counseling records be issued for the two officers who failed to complete and submit reports prior to the end of shift.

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