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 during June 2024.

Incident Number
24-00024-UOF

Reason for Monitoring
Potential Misconduct

Incident Summary
On March 31, 2024, two officers transported an incarcerated person back to the prison from an outside hospital. As the officers began the process of removing the incarcerated person from the transportation van, the incarcerated person pulled a makeshift weapon from his clothing and ran at the officers. The officers ordered the incarcerated person to put the weapon down, but the orders were ignored. An officer struck the incarcerated person in the arm with a baton, and the incarcerated person stopped the attack and got down into a prone position on the ground. The officers then searched the incarcerated person for weapons. As they started to assist the incarcerated person up from the ground, the incarcerated person spat at an officer. The officers used physical force to get the incarcerated person back to the ground. The officers completed the escort without further incident.

Incident Disposition
The hiring authority failed to identify any potential staff misconduct. The OIG identified potential staff misconduct for a lieutenant who observed force, but did not submit his report until five days after the incident. The OIG recommended that the warden refer the matter for an investigation. The OIG also recommended training for the officers who failed to search the incarcerated person prior to departing the outside hospital and transporting him back to the prison. The hiring authority declined to refer the matter for investigation and only ordered training for the lieutenant for not timely reporting the force observed, and training for the officers who failed to search the incarcerated person prior to the incident.

Incident Number
24-00025-UOF

Reason for Monitoring
Potential Misconduct

Incident Summary
On March 5, 2024, two officers directed an incarcerated person to return to his housing unit. The incarcerated person did not comply and walked freely, without permission, on a prison yard. The incarcerated person then entered a housing unit he was not permitted to enter. When a nurse exited the building, the incarcerated person forced her to the ground and attempted to sexually assault her. The nurse defended herself and struck the incarcerated person with her elbow. The incarcerated person fled the scene; however, officers were able to locate the incarcerated person and placed him in restraints without further incident.

Incident Disposition
The OIG found the actions during and following the use of force to be in compliance with departmental policy. However, the OIG identified potential staff misconduct prior to the use of force based on the officers' failure to adequately supervise the incarcerated person, which permitted him with the opportunity to access restricted areas. Moreover, the OIG identified that the two officers had failed to activate their body-worn cameras in the presence of incarcerated persons.

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	The department also did not provide the OIG with all the video footage pertaining to the incident until after the institutional executive review committee meeting. The OIG recommended that the hiring authority refer the matter for investigation. The hiring authority referred the matter for investigation for the two officers who allegedly failed to adequately supervise the incarcerated person prior to the incident, but declined to address the actions of the officers who did not activate their body-worn cameras.
Incident Number: 24-00026-UOF **Reason for Monitoring:** Potential Misconduct	**Incident Summary:** On February 9, 2024, an officer was escorting an incarcerated person in waist restraints to her assigned housing when the incarcerated person stopped the escort and retrieved food items from a cart. The escorting officer summoned a second officer, who took charge of the escort and placed both his hands on the incarcerated person's left arm. The incarcerated person was attempting to open a bag of chips and was given orders to stop, but she ignored the officer's orders. The officer then wrapped his arms around the incarcerated person's body and forced her to the ground. The incarcerated person landed on her stomach with her chin striking the concrete. The officers placed the incarcerated person in leg restraints and escorted her to a medical clinic, where an assessment was completed. Medical staff determined a higher level of care was necessary and transported the incarcerated person to a community hospital, where a physician diagnosed the incarcerated person with a fractured jaw. **Incident Disposition** The hiring authority determined that staff actions prior and during the use of force complied with policy, but that the actions following the use of force did not. The hiring authority identified that a captain and a lieutenant violated policy by failing to timely provide the incarcerated person with a video-recorded interview due to the nature of the serious bodily injury the incarcerated person had sustained. The OIG identified potential staff misconduct during the use of force based on the appearance of unnecessary and excessive use of force that resulted in serious bodily injury to the incarcerated person. The OIG recommended that this case be referred for investigation, but the hiring authority only provided training to a captain and a lieutenant to address their deficiencies. The case was then referred to the department executive review committee because the incarcerated person had sustained serious bodily injury. The department executive review committee conducted a preliminary review of the case and concurred that the officer appeared to have used unnecessary and excessive force. The department executive review committee returned the case to the prison with the recommendation that the hiring authority conduct a thorough review and refer the case to the Office of Internal Affairs. The hiring authority agreed with the department executive review committee and referred the incident for investigation.

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Incident Number
24-00027-UOF

Reason for Monitoring
Potential Misconduct

Incident Summary

On October 13, 2023, an incarcerated person and a sergeant got into a verbal disagreement. The sergeant appeared to escalate the situation by agitating the incarcerated person. The incarcerated person then clenched his fists and took an aggressive stance toward the officer. The sergeant then ordered an officer to place handcuffs on the incarcerated person. The incarcerated person resisted the officer, and as a result, the officer used physical force to place the incarcerated person on the ground. The incarcerated person was placed in handcuffs and escorted to a holding cell. He was then assessed by medical staff, who, noting no injuries, later released the incarcerated person back to his dormitory.

Incident Disposition

Prior to the institutional executive review committee reviewing this incident, the hiring authority referred the incident to the investigative services unit for an administrative review, based on potential staff misconduct by the sergeant's actions.

The administrative review determined the sergeant spoke unprofessionally to the incarcerated person, which escalated the encounter. The reviewer recommended that the sergeant be issued a letter of instruction. An associate warden disagreed with the recommendation, however, based on the lapse in time from the referral date of the administrative review in October 2023 to the month the review was completed in May 2024, the associate warden recommended on-the-job training for the sergeant in lieu of the letter of instruction. The investigative services unit lieutenant agreed with the associate warden that training would be appropriate.

The OIG met with the chief deputy warden and recommended that a letter of instruction would be more appropriate than the proposed training. The chief deputy warden agreed to accept the OIG's recommendation and issued the sergeant a letter of instruction.

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