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OIG | OFFICE *of the* INSPECTOR GENERAL

Independent Prison Oversight

August 2024

Monitoring the Use-of-Force Review Process of the California Department of Corrections and Rehabilitation

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Amarik K. Singh, *Inspector General*
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Independent Prison Oversight

Regional Offices

Sacramento
Bakersfield
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August 22, 2024

The Governor of California
President pro Tempore of the Senate
Speaker of the Assembly
State Capitol
Sacramento, California

Dear Governor and Legislative Leaders:

Enclosed is the Office of the Inspector General's report titled *Monitoring the Use-of-Force Review Process of the California Department of Corrections and Rehabilitation*. This is the Office of the Inspector General's seventh annual report, as mandated by California Penal Code sections 6126(j) and 6133(b)(1). This report addresses 730 use-of-force incidents that occurred within the California Department of Corrections and Rehabilitation (the department), and for which the department closed its review, between January 1, 2023, and December 31, 2023.

In this report, we present 14 incidents that our office monitored in which we identified significant concerns. We summarize three incidents in which officers failed to provide adequate supervision in housing units that led to murders of and assaults on incarcerated people. Included are three other incidents in which officers used unauthorized strangleholds on incarcerated people. In another two incidents, officers did not attempt to de-escalate a situation or apply controlled use-of-force procedures before resorting to the use of physical force to gain compliance. In six of the referenced incidents, officers had opportunities to either de-escalate the situation through effective communication techniques—which could have prevented use-of-force incidents—or conduct controlled use-of-force tactics, which might have reduced injury and increased the level of communication between officers and the incarcerated person involved. Finally, we provide an update on the department's response to a recommendation we made in a prior report to provide refresher training to staff on proper use-of-force tactics.

Based on concerns we identified in our monitoring, we provide five recommendations to the department: 1) to develop an improvement plan for supervising incarcerated people in housing units to reduce the number of violent incidents that occur when housing units are unsupervised; 2) to provide all custody staff with additional guidance through policy and training relating to the proper use of body-worn cameras; 3) to reevaluate departmental training and procedures regarding search practices and restraint application and removal, and to provide remedial training to all custody staff; 4) to track and monitor the different levels of the use-of-force review process and to impose progressive discipline for reviewers who fail to identify and address violations of policies, procedures, and training; and 5) to provide remedial training to custody staff, including prison management, regarding de-escalation tactics and how to better recognize when a controlled use of force is warranted.

Sincerely,

Amarik K. Singh
Inspector General

***Gavin Newsom**, Governor*

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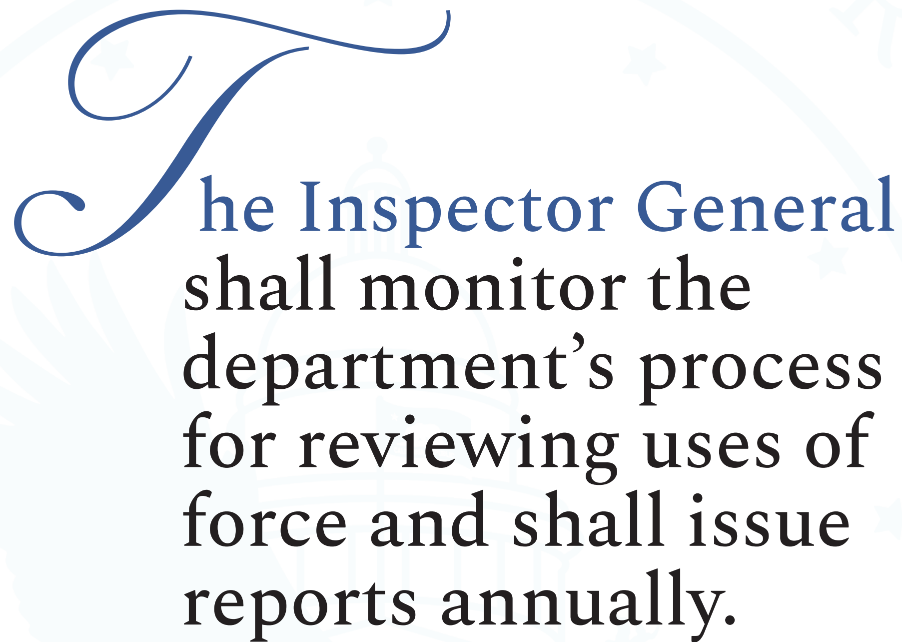

The Inspector General shall monitor the department's process for reviewing uses of force and shall issue reports annually.

— *State of California*
(Penal Code section 6126(j))

Use-of-Force Policy: Definitions of Common Terms	
Audio-Video Surveillance System	A network of cameras, monitors/display units and recorders that are designed for recording movement and activities. The cameras are fixed to buildings and objects and are not movable.
Body-Worn Camera	Video camera that is worn on clothing and used to continuously record activity in front of the wearer.
Controlled Use of Force	The force used in a prison or facility setting when an incarcerated person's presence or conduct poses a threat to safety or security, and the incarcerated person is located in an area that can be controlled or isolated. These situations do not normally involve the imminent threat to loss of life or imminent threat to prison security.
Department Executive Review Committee	The Department Executive Review Committee (DERC) is a committee of staff selected by, and including, the associate director who oversees the respective mission-based group.
Excessive Force	More force than is objectively reasonable to accomplish a lawful purpose.
Great Bodily Injury	Any bodily injury that creates a substantial risk of death.
Immediate Use of Force	The force used to respond without delay to a situation or circumstance that constitutes an imminent threat to prison/ facility security or the safety of persons.
Imminent Threat	Any situation or circumstance that jeopardizes the safety of persons or compromises the security of the prison, requiring immediate action to stop the threat. Some examples include, but are not limited to, an attempt to escape, ongoing physical harm, or active physical resistance.
Institutional Executive Review Committee	The Institutional Executive Review Committee (IERC) is a committee of executive staff at each prison tasked with reviewing all reported use-of-force incidents.
Mortality Review Report	A report that provides a review process by which medical and other disciplinary experts review the circumstances of an individual death to explore root causes and identify interventions to prevent future deaths.
Reasonable Force	The force that an objective, trained, and competent correctional employee, faced with similar facts and circumstances, would consider necessary and reasonable to subdue an attacker, overcome resistance, effect custody, or gain compliance with a lawful order.
Serious Bodily Injury	A serious impairment of physical condition, including, but not limited to, the following: 1) loss of consciousness, 2) concussion, 3) bone fracture, 4) protracted loss or impairment of function of any bodily member or organ, 5) a wound requiring extensive suturing, and 6) serious disfigurement.
Unnecessary Force	The use of force when none is required or appropriate.

Source: Article 2, Use-of-Force, Section 51020.4, "**Definitions**," California Department of Corrections and Rehabilitation, Adult Institutions, Programs, and Parole Operations Manual. The publication is commonly referred to as the department operations manual or the DOM.

Other Terms Used in This Report	
Custody Staff	Sworn peace officers at all levels within a prison or facility.
Hiring Authority	The secretary of the department, the general counsel, an undersecretary, or any chief deputy secretary, executive officer, chief information officer, assistant secretary, director, deputy director, associate deputy director, associate director, warden, superintendent, health care manager, regional health care administrator, or regional parole administrator.
Medical Staff	An organized body of licensed physicians, dentists, and other healthcare providers who are authorized by state law and by a hospital to provide quality medical care to patients.
Post Orders	Written documents that clearly outline duties, responsibilities, and expectations of officers and supervisors, regardless of their location.

Source: The department's DOM.

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Summary

This is the Office of the Inspector General's (OIG) seventh annual report, as mandated by California Penal Code sections 6126(j) and 6133(b)(1), which require the OIG to monitor the California Department of Corrections and Rehabilitation's (the department) process for reviewing its use-of-force incidents. During this reporting period, we monitored 730 use-of-force incidents that the department reviewed and closed between January 1, 2023, through December 31, 2023.

Through our monitoring methodology, we assessed staff members' actions prior to, during, and following each use-of-force incident we monitored. Not all use-of-force incidents are selected for monitoring; we only review incidents that meet our preselected monitoring criteria. Because we do not personally observe these use-of-force incidents, we monitor and assess the department's compliance with its use-of-force policies, procedures, and training by reviewing documentation and video evidence that the department maintains and makes available to us. For the 2023 reporting period, we chose to highlight a total of 14 use-of-force incidents involving departmental staff. Each highlighted incident involves multiple instances of possible staff misconduct.

With every incident in this report, the OIG seeks to bring attention to the most egregious issues our inspectors identified. Some of those issues involved failure to properly search incarcerated people; murders and assaults resulting from lapses in supervision in housing units; staff's use of unauthorized strangleholds; and staff's failure to use de-escalation techniques or controlled uses of force when immediate physical force was not necessary.

In our last report, we noted several incidents in which officers did not use de-escalation techniques prior to a use-of-force incident. Officers' failure to de-escalate these situations often led to the unnecessary use of force. Our last report also identified incidents in which officers used physical force instead of initiating a controlled use of force even though no imminent threat justified the use of physical force. In this report, we again highlight incidents in which officers should have attempted de-escalation techniques before resorting to physical force. Before 2020, the department's officer training curriculum included stand-alone de-escalation modules. However, the department abandoned this training module during the COVID-19 pandemic. In response to our recommendation to reinstate its de-escalation training, the department advised our office that the current training curriculum was adequate and that no additional training would be provided. We continue to emphasize the importance of communication and de-escalation training, and to reassert our recommendation to reinstate it.

Another important issue highlighted in this report involves the department's use of body-worn cameras and audio-video surveillance

systems, which have recently been implemented at many of the department's prisons. Body-worn cameras and fixed audio-video surveillance systems are not available at all prisons at the time of this report's publication; however, the department plans to continue installing them at additional prisons each year.[1] In our last report, we noted that supervisors and managers often failed to review and evaluate an adequate number of video recordings during their review process to determine whether staff had fully complied with policies and procedures. This issue continues to persist at several prisons. In our last report, we noted that access to an appropriate number of video recordings would assist departmental reviewers in determining whether staff attempted to communicate with the incarcerated person and resolve the situation without using force.

During the current review period, our inspectors found several additional issues involving body-worn cameras. This report discusses several incidents in which officers failed to activate body-worn cameras while in the presence of incarcerated people, thereby precluding incidents from being captured on video, and subsequently, drafted reports that did not coincide with video-recorded evidence. The department also refused to hold supervisors and managers accountable for failing to identify potential staff misconduct in their review of use-of-force incidents.

The department's policies require staff to consider using controlled force when no imminent threat is present. During a department-mandated training session we attended that was provided to in-service training (IST) representatives from each prison, training personnel emphasized that the department's operations manual only authorizes staff to use immediate force if an imminent threat is present.[2] Although the department has provided custody staff with remedial training, we continue to review incidents in which officers used immediate force instead of controlled force when no imminent threat was present.[3] No wardens, associate wardens, or captains attended this remedial training session. Because people from these classifications ultimately decide whether each use of force complied with departmental policy, their attendance at these trainings is critical.

1. In 2023, a total of 15 prisons had fixed or body-worn cameras. In 2023, the department implemented new cameras (AVSS and BWC) in six prisons.

2. The California Department of Corrections and Rehabilitation's department operations manual (commonly known as the *DOM*), Section 51020.4.

3. These two types of force are described on page *v* of this report.

Introduction

Background

Nearly 25 years ago, in the class-action lawsuit *Madrid* v. *Gomez,* the federal court found, among other things, that officials with the California Department of Corrections[4] (the department) "permitted and condoned a pattern of using excessive force, all in conscious disregard of the serious harm that these practices inflict" in violation of the Eighth Amendment of the United States Constitution.[5]

Use-of-Force Options

The department expects its officers to maintain the safe and secure operations of its prisons with minimal reliance on use-of-force options.[6] Effectively communicating with incarcerated people and using appropriate de-escalation techniques may resolve conflicts and prevent use-of-force incidents. If a use of force becomes necessary, officers are required to deploy force options according to policy guidelines and established methods of such deployment. Officers are required to remain current on all their annual training requirements related to all use-of-force options.

Our office reviews and analyzes departmental staff's use of force to determine whether staff followed departmental policy during an incident. Inspectors also verify at appropriate points during the process that the officers involved in the use-of-force incidents received appropriate training for the use-of-force option deployed. Departmental policy authorizes several force options, including chemical agents, hand-held batons, physical strength and holds, less-lethal weapons,[7] and lethal weapons (firearms). On the next page, Figure 1 shows the distribution of staff applications of force in the incidents we monitored during this reporting period.

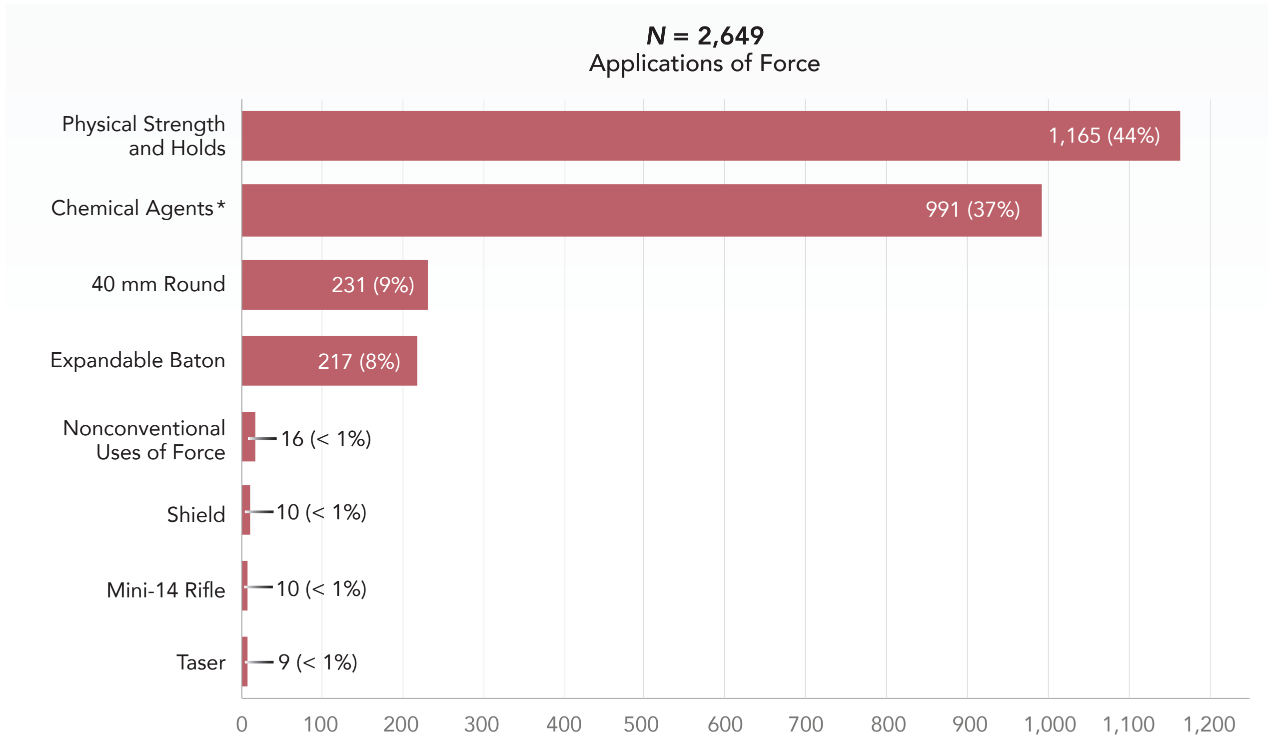
4. In 2005, the California Department of Corrections was renamed the California Department of Corrections and Rehabilitation.

5. *Madrid et al.* v. *Gomez (Cate) et al.*, 889 F. Supp. 1146 (N.D. Cal. 1995), January 10, 1995.

6. *California Code of Regulations* (CCR), Title 15, section 3268(b), and Basic Correctional Officer Academy Use-of-Force Version 4.9 Training: "It is the policy of the Department of Corrections and Rehabilitation's (CDCR) to accomplish the departmental functions with the minimal reliance on the use-of-force. Officers should attempt to use verbal commands and verbal de-escalation before resorting to the use-of-force."

7. A less-lethal weapon has the appearance of a firearm, but fires less-lethal projectiles, made of foam, rubber, or wood. A less-lethal weapon has the appearance of a firearm, but fires less-lethal projectiles, made of foam, rubber, or wood.

Figure 1. Distribution of the Applications of Force in the 730 Use-of-Force Incidents the OIG Monitored



*Chemical agents include oleoresin capsicum (OC), chloroacetophenone (CN) gas, and 2-chlorobenzalmalononitrile (CS) gas.

Note: Percentages may not sum to 100 percent due to rounding.

Source: The Office of the Inspector General Tracking and Reporting System.

Reporting and Review Requirements

The department is divided into different divisions including the Division of Adult Institutions (DAI) and the Division of Adult Parole Operations (DAPO). Until June 2023, the department also included the Division of Juvenile Justice, which housed juvenile offenders. Beginning in June 2023, the Division of Juvenile Justice transitioned its administration of youthful offenders to each corresponding California county. DAPO and DAI have similar processes for reviewing and evaluating use-of-force incidents in accordance with the department's operations manual.

Departmental policy requires that "any employee who uses force or observes a staff use of force shall report it to a supervisor as soon as practical and follow up with appropriate documentation prior to being relieved from duty."[8]

After staff complete the appropriate reporting documentation, various supervisors and managers review the reports, request any necessary corrections or clarifications, and provide a review and analysis of the force used. This review provides a critique of staff's actions prior to, during, and following a use-of-force incident based on the submitted reports and any additional evidence. Departmental policy requires that all use-of-force incidents be reviewed by the Institutional Executive Review Committee (IERC). IERC meetings are typically held on a weekly basis at each prison. The IERC is chaired by the warden or an appointee and consists of associate wardens, captains, in-service training specialists, and health care professionals. OIG inspectors also attend in a nonvoting capacity. During this final review conducted by the IERC, the hiring authority determines whether the use of force complied with policy, procedures, and training. If the committee determines that the force was not in compliance with the department's policy, procedures, and training, the hiring authority may order training or corrective action. For more serious violations, the chair may refer the matter to the Office of Internal Affairs, which reviews the relevant evidence and decides whether to initiate a formal investigation.[9]

Departmental policy requires a higher level of review by departmental executives for incidents involving a warning shot from a lethal weapon and incidents in which an incarcerated person sustains serious bodily injury that could have been caused by staff's use of force. This higher level of review is performed by the department's Department Executive Review Committee (DERC), which is chaired by the associate director of the respective mission in which the incident occurred. The DERC is required to review incidents within 60 days of the IERC's completed review.

8. DOM, Section 51020.17.

9. DOM, Section 51020.19.

Scope and Methodology

Scope

During this reporting period, we monitored a total of 730 use-of-force incidents the department reviewed and closed between January 1, 2023, and December 31, 2023. We monitored 694 incidents that occurred within the Division of Adult Institutions, 17 within the Division of Juvenile Justice (until June 2023), 12 within the Division of Adult Parole Operations, and seven involving staff from the Office of Correctional Safety.

Our inspectors reviewed nearly all the department's use-of-force incidents to select incidents that demonstrated a higher likelihood of staff misconduct or increased liability of the department. While we may select any incident to monitor, we generally select incidents that meet the criteria listed in Figure 2.[10]

Figure 2. The OIG's Established Criteria for Monitoring Use-of-Force Incidents During the Reporting Period From January Through December 2023

- Any incident with potential staff misconduct, including, but not limited to: Staff contributing to the need to use force; staff using unnecessary or excessive force; staff failing to report use of force used or observed; and staff collaborating when writing reports
- Any incident in which staff's use of force results in serious bodily injury to an incarcerated person
- Any incident resulting in serious bodily injury or great bodily injury to staff during a use-of-force incident
- Any incident in which staff may have had the opportunity to de-escalate a situation prior to using force
- Riots
- Controlled use-of-force incidents
- Any incident in which staff inadvertently strike an incarcerated person in the head with an expandable baton, less-lethal round, or other object*
- Warning shots†

* Effective December 2023, we assess and report any incident involving an inadvertent head strike through our Critical Incident monitoring.

† Effective December 2023, we assess and report any incident involving a warning shot through our Critical Incident monitoring.

Source: The Office of the Inspector General.

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10. We did not assess any incidents in which an incarcerated person alleged unreasonable force. Pursuant to the department's regulations, those allegations are investigated by the department's Allegation Inquiry Unit. The OIG's Staff Misconduct Monitoring Unit monitors a percentage of the allegation investigations and publishes those results in a separate report.

Between January 1, 2023, and December 31, 2023, our inspectors visited every adult prison and juvenile facility[11] as well as the northern and southern parole regions. We attended 613 of the department's 1,472 review committee meetings (42 percent).

Methodology

The OIG provides independent oversight of the department's use-of-force review process by reviewing documents and video evidence related to each monitored use-of-force incident; in addition, our staff attend the department's IERC meetings. Because we do not personally observe use-of-force incidents, our assessments are based on our review of staff reports, logs, and in some incidents, video-recorded evidence. We also review departmental policies and procedures, and training manuals, and attend use-of-force training sessions to better understand the department's practices and procedures. At each prison's IERC meetings, the hiring authority makes a final determination about whether staff actions complied with departmental policy. If we disagree with a hiring authority's determination of an incident, we can elevate the matter to the department's executive management for further review and consideration. Throughout this process, our office provides the department with real-time feedback and recommendations to improve the department's performance and to minimize or prevent departmental liability relating to use-of-force incidents.

11. The department currently operates 33 adult prisons. The department closed three juvenile facilities on July 1, 2023. In addition, the department closed California Correctional Center on June 30, 2023.

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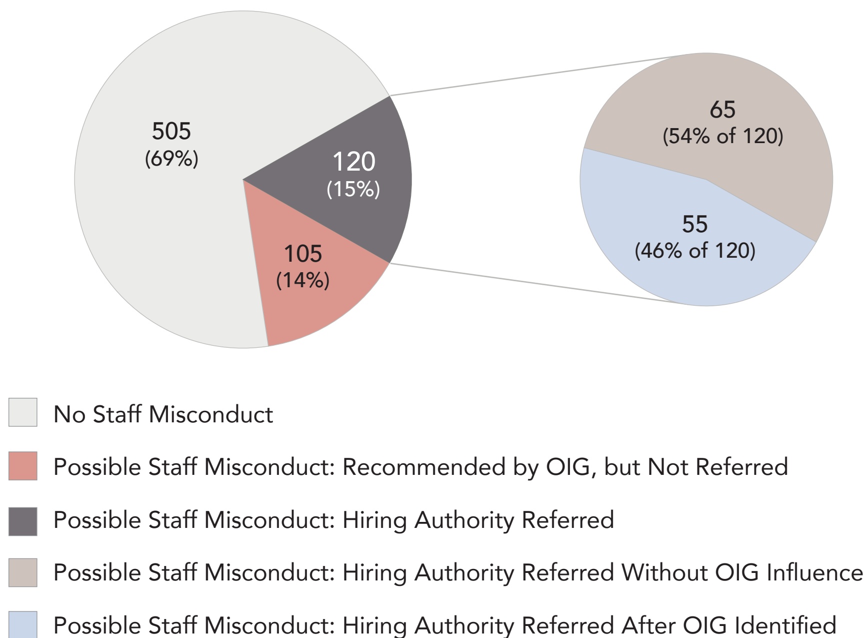
Monitoring Results

The results for this reporting period show that, overall, the department performed well in most of the incidents we monitored. Our monitoring efforts include assessing the department's performance during three stages of a use-of-force incident: prior to, during, and following the incident. This holistic approach can serve to identify deficiencies in each of these stages, as well as the department's response to any deficiencies we identify. This report provides our stakeholders and the public with a transparent assessment of the use-of-force incidents we monitored and the deficiencies we identified.

Departmental policy designates a prison's supervisors and managers as the individuals responsible for identifying potential staff misconduct that may have occurred during a use-of-force incident. Immediately following the discovery of potential misconduct, departmental policy requires that supervisors and managers notify the hiring authority of the suspected misconduct. Whenever hiring authorities have a reasonable belief that employee misconduct occurred, they must conduct a preliminary inquiry and timely refer the matter to the Office of Internal Affairs for investigation.

Figure 3. 730 Incidents Monitored by the OIG



Note: Percentages may not sum to 100 percent due to rounding.

Source: The Office of the Inspector General Tracking and Reporting System.

During this reporting period, of the 730 incidents we monitored, 225 incidents, or 31 percent, involved possible staff misconduct. Despite the requirement to refer possible misconduct to the Office of Internal Affairs, hiring authorities referred possible misconduct in only 120 of these 225 incidents, or 53 percent. In the remaining 105 incidents, we recommended a referral be made to the Office of Internal Affairs to request an investigation, but the hiring authorities disagreed with our position and took no action.

Of the 120 incidents in which the hiring authorities did refer misconduct allegations to the Office of Internal Affairs, 55, or 46 percent, were referred only after we identified the possible misconduct and recommended the referral. In the remaining 65 incidents, the hiring authorities independently identified the misconduct and referred allegations to Office of Internal Affairs.

The OIG reviews all monitored use-of-force incidents by assessing the department's actions prior to the use of force, during the use of force, and following the use of force.

Table 1. A Summary of the Phases of a Use-of-Force Incident

Phase	Description
Prior to the Use of Force	The OIG reviews the use-of-force incident package and video evidence to assess departmental staff's action prior to the use-of-force incident to determine whether staff contributed to the need to use force, used de-escalation techniques, and whether any other serious issues were identified prior to the incident.
During a Use-of-Force Incident	The OIG reviews and assesses whether departmental staff used reasonable force and applied training methods of force deployment during a use-of-force incident that were all in compliance with policy.
Following a Use-of-Force Incident	The OIG reviews departmental staff's action after a use-of-force incident, including determining whether staff provided decontamination if chemical agents were used, staff complied with medical assessments, and staff complied with proper reporting requirements related to the use-of-force incident.

Source: The Office of the Inspector General's analysis of the department's handling of a use-of-force incident.

In most of the incidents the OIG monitored, the department's actions prior to the use-of-force incident complied with departmental policy. Specifically, in 630 of the 730 incidents we monitored (86 percent), departmental staff did not contribute to the need to use force during an incident. Departmental staff used reasonable force in 648 of the

730 incidents we monitored, or 88 percent. The department complied with decontamination procedures in 90 percent of the incidents we monitored. When monitoring the department's actions following a use of force, one area we reviewed is decontamination after the use of chemical agents. The OIG also monitored the department's compliance with staff's use of body-worn cameras in those prisons that require them. During this reporting period, 82 percent of staff complied with the requirement to have their body-worn camera turned on and recording when appropriate. The use of body-worn cameras is new to the State's prison system. Accordingly, we are providing a supplemental analysis of the department's continuing efforts to introduce both body-worn cameras and fixed cameras into more prisons (see the discussion beginning on page 26), along with case examples that highlight challenges the department has faced in enforcing compliance with body-worn camera policies.

Departmental Staff Failed to Ensure Supervision of Dayrooms, Which Led to Serious Incidents and Significant OIG Concerns

By its own mandate, the department is charged with providing the incarcerated population with an appropriate living environment at each of its prisons "to facilitate the successful reintegration of the individuals in our care back to their communities . . . all in [a] safe and humane environment."[12] At times, however, the department falls short of implementing this environment. Insufficient staffing levels can hamper the effective and safe operation of facilities, and inconsistent compliance with policies and procedures may lead to breaches in safety and security. The following incidents highlighted illustrate serious departmental safety and security failures which, in some instances, led to devastating results.

An Incarcerated Person Was Murdered After Officers Did Not Adequately Supervise a Housing Unit's Dayroom, and the Department Refused to Investigate Possible Staff Misconduct Related to the Incident

In this incident, two floor officers and a control booth officer were responsible for monitoring the safety and security of staff and incarcerated people within an assigned housing unit and dayroom. Officers failed to monitor incarcerated people in the dayroom. As a result, one incarcerated person attacked another incarcerated person with a makeshift weapon. When the initial attacker slipped and fell to the floor, a second incarcerated person joined the attack and assisted with the murder. An officer attempted to end the attack by using a 40mm round from a 40mm Single Shot Launcher, which unfortunately misfired. This action stopped the attack.

12. See California Department of Corrections and Rehabilitation's website "Mission Statement."

The prison's local operating procedures for floor officers and control booth officers are as follows: "The floor officer is responsible for monitoring the safety and security of staff and inmates, within the assigned unit, and all visible areas of the institution"; and "The control booth officer is responsible for monitoring the safety and security of staff and inmates, within the assigned unit, and all visible areas of the institution."[13]

At the time of the incident, no officers had been observing or monitoring the housing unit's dayroom in which at least 15 incarcerated people were present. At the time of the incident, the two floor officers assigned to monitor the dayroom floor were neither present in the dayroom nor observing it from the observation windows. The officers were in the housing unit; however, their exact whereabouts were unknown, and the department failed to request that the officers clarify in their reports where they were at the time of the murder. The control booth officer assigned to monitor the dayroom also failed to indicate his whereabouts in his report, and clarification was not requested to determine where he was located and what he was doing at the time of the murder. The two assigned floor officers were unaware of the assault until they heard a "loud squeaking commotion" or "heard shoes squeaking coming from one of the dayrooms." The assigned control booth officer did not learn of the assault until he heard the call on his prison radio from the other assigned floor officers. During this unsupervised period, one incarcerated person attacked and murdered another incarcerated person. The control booth officer eventually responded to the control booth area of the housing unit where the attack was occurring. He attempted to fire one less-lethal round at one of the involved incarcerated people to stop the attack, but the round did not discharge. The officer then prepared to use his Ruger Mini-14 rifle; however, before he could discharge the weapon, the incarcerated attackers separated and assumed prone positions on the dayroom floor.

The mortality review report indicated that the deceased incarcerated person's cause of death was "traumatic shock" due to "multiple stab wounds." The OIG expressed concerns to the hiring authority that, based on the documentation and video-recorded evidence of the incident, this was clearly a substantial, extended, and intense attack without officers present. In fact, the housing unit's audio-video surveillance system showed the incident lasted approximately one minute and 12 seconds before an officer responded to the attack. After the one minute, 12 seconds point, the video showed officers at the door to the housing unit, but the officers did not enter the dayroom for another minute and 10 seconds. It was not until two minutes and 32 seconds after the attack began that officers entered the dayroom and rendered medical aid to the incarcerated victim. Although OIG staff raised these concerns during our

13. California Department of Corrections and Rehabilitation, Floor Officer–July 2024, Post Order No. 331431 C8 Floor Officer 1; Control Officer–July 2024, Post Order No. 331430 C8 Control Booth.

review, the hiring authority refused to refer the incident to the Office of Internal Affairs for further investigation. The hiring authority responded to the OIG's concerns—specifically those related to the lack of security—with the following statement:

> For the floor officers and the control booth officer to effectively follow the Inmate Count and movement policy there are occasions where **they must let [the] dayroom run with the only supervision being what they can hear**. (emphasis added)

In other words, at times, the only supervision that officers are able to provide to the incarcerated people in a housing unit is of an auditory nature by monitoring whatever activity can be heard, but not necessarily seen. The large number of incarcerated people present in the dayroom without any supervision, coupled with the prison's status as a high security prison, were causes for serious concern. We elevated the incident to the associate director. The associate director, unfortunately, neither acknowledged nor responded to our concerns.

Officers Failed to Supervise a Dayroom; This Failure Resulted in Incarcerated People Breaching an Unsecured Door and Attacking Members of a Security Threat Group,[14] Requiring Staff to Use Force to Stop the Attack; Departmental Officials Refused to Refer the Incident for Investigation and Instead, Only Issued Corrective Action to Staff

In this incident, two officers were assigned to observe incarcerated people in a dayroom. The control booth officer and the floor officer had both left their assigned posts without first requesting relief from other officers. After the officers left their posts, four incarcerated people breached an unlocked emergency exit door, ran across the recreational yard, and attacked five incarcerated people who were members of a rival gang. Responding officers used pepper spray and a baton strike to quell the attack, which had resulted in several incarcerated people suffering minor injuries. Officers' failure to supervise the dayroom and ensure that the emergency exit door was locked most likely contributed to the attack and the need to use force. Nevertheless, after reviewing the incident at the IERC meeting, the hiring authority decided to only issue corrective action to address those failures. The hiring authority believed the emergency fire exit door may not have been closed properly but was unable to determine who had left the door open. Although we recommended that the incident be referred to the Office of Internal

14. CCR, Title 15, Division 3, section 3315 defines a security threat group as "any ongoing informal organization, association, or group of three or more persons which has a common name or identifying sign or symbol whose members and/or associates, individually or collectively, engage or have engaged, on behalf of that organization, association, soliciting or committing unlawful acts of misconduct classified as serious." In this report, we may also use the more traditionally understood term *gang* to refer to this type of group.

Affairs for an investigation to determine all the facts regarding the incident, the hiring authority decided not to refer the incident for investigation.

The OIG elevated the incident to the executive level—an associate director—for reconsideration of the hiring authority's decision not to refer the incident to the Office of Internal Affairs. The associate director responded by stating, "I think the warden was appropriate in her handling of the situation in this incident." The associate director concluded that although the two officers violated their post orders, corrective action against the officers in the form of a letter of instruction was appropriate.

An Officer Failed to Supervise a Dayroom With 14 Incarcerated People, in Violation of the Officer's Post Orders, Which Resulted in Two Incarcerated People Battering Another Incarcerated Person for Nearly Two Minutes Before Officers Used Force and Stopped the Attack

In this incident, officers deployed three chemical-agent grenades to stop two incarcerated people from battering another incarcerated person in a housing unit dayroom. Video from a fixed audio-video surveillance system revealed that the attack was substantial, extended, and intense. The attack on the incarcerated person by two other incarcerated people, lasted approximately one minute and 48 seconds before the first officer responded to the incident. Moreover, the fixed audio-video surveillance system video showed that, at the start of the attack, no officers had been supervising the incarcerated population in the dayroom. In fact, at the time of the attack, seven officers had been monitoring the exercise yard at the entrance to the housing unit, but none had been monitoring the dayroom in the housing unit. The control booth officer also failed to supervise the dayroom. He was using the restroom at the time of the incident but had not requested that another officer monitor the housing unit in his absence.

During the IERC's review of the incident, the committee found that staff's actions prior to, during, and after the use of force were in compliance with policies, procedures, and training standards. However, the incident commander's review noted that the control booth officer's body-worn camera was deactivated during a portion of the incident because he had just exited the restroom before responding to the attack. As a result, the officer was provided training regarding proper activation and deactivation of body-worn cameras.

The OIG recommended that the incident be referred to the Office of Internal Affairs for investigation because the control booth officer failed to provide constant supervision of the dayroom, thereby causing a safety and security risk. The audio-video surveillance system showed that, at the time of the attack, about 14 incarcerated people were in the dayroom

without any officer supervision. OIG staff recommended that the hiring authority refer the matter to the Office of Internal Affairs based on the control booth officer's violation of his post orders[15] and because the control booth officer had his body-worn camera turned off. The applicable post order states the following:

> You shall provide constant observation/coverage of all activities within your area of responsibility. You act as a safeguard against attacks on staff and/or inmates.

The hiring authority did not refer the incident to the Office of Internal Affairs for further investigation.

15. California Department of Corrections and Rehabilitation, California State Prison, Los Angeles County, Local Operating Procedure No. 554.

The Department Still Needs to Improve Its Use of De-Escalation Tactics and Provide Training to Staff to Avoid Use-of-Force Incidents When Possible

The California Model "promotes positive relationships between staff and incarcerated people. This is accomplished through purposeful activities and professional, positive, and respectful communication."[16] The department attempts to accomplish this task by implementing purposeful rehabilitative programs and cultivating professional, positive, and respectful communication. Constructive communication between staff and the incarcerated population can often lead to the de-escalation of potential use-of-force situations.

During our last reporting period, we highlighted the importance of using de-escalation techniques before using force. We recommended that the department reinstate the stand-alone de-escalation training module it had used before the COVID-19 pandemic; however, the department has not followed our recommendation and stated that the current policies are sufficient. Conversely, our analysis showed that officers had the opportunity to de-escalate situations before using force in 113 of the 890 cases we monitored in 2022 (13 percent). In 39 percent of those 113 incidents, officers either failed to effectively communicate with the incarcerated person or did not adequately attempt to de-escalate the situation.

Of the 730 use-of-force incidents we monitored in 2023, we identified 137 incidents in which officers had the opportunity to use de-escalation techniques (19 percent), slight improvement, year over year. In 54 of those 137 incidents (39 percent), officers did not adequately attempt to de-escalate the situation.

De-escalation techniques can result in safer interactions between officers and incarcerated people. Public safety officials and policymakers have embraced de-escalation as a technique that promotes safer interactions between officers and subjects.[17] Per the department's guidance, an incarcerated person and an officer who can engage in effective communication techniques may eliminate the officer's need to use force and minimize the risk of injury to all parties. The following two incidents demonstrate the consequences that may result when an officer does not apply de-escalation techniques or controlled uses of force.

16. Visit the department's website to read about **The California Model – Transforming Public Safety.**

17. The United States Department of Justice, Office of Justice Programs, ***De-Escalation Training: Safer Community Safer Law Enforcement Officers***.

Officers Failed to Use De-Escalation Techniques and Implement a Controlled Use -of Force When They Needed to Take Contraband Away from an Incarcerated Person, yet the Department Refused to Refer the Officer's Potential Misconduct for an Investigation

In this incident, staff noticed that an incarcerated person housed in the short-term restricted housing unit was wearing earrings, which the department regards as contraband. A lieutenant, a sergeant, and four officers surrounded the incarcerated person, who was sitting on a chair. The sergeant ordered the incarcerated person to relinquish the earrings. When the incarcerated person refused, the sergeant ordered the officers to remove the incarcerated person's earrings. When an officer attempted to remove the earrings, the incarcerated person became agitated and resistant, and attempted to stand up. Three officers then used physical force to place the incarcerated person on the ground. The incarcerated person continued to struggle while on the ground. During the struggle with the incarcerated person, a makeshift weapon (from an unrelated prior event) fell from one of the officer's duty belts onto the floor. The officer was unaware that the weapon had fallen to the ground, and it was within reaching distance of the incarcerated person. Another officer spotted the weapon and secured it. During the struggle, the incarcerated person bit one of the officers, and after removing the earrings, swallowed them.

The OIG expressed several concerns related to the actions of the lieutenant, the sergeant, and the officers involved in the incident. Our concerns included the staff's failure to de-escalate the situation, the use of unnecessary force to remove contraband from the incarcerated person, and the inability to de-escalate the situation. The department's operations manual, Section 51020.12, states the following:

> When force is necessary but does not involve imminent threat to subdue an attacker, effect custody, or to overcome resistance, the force shall be controlled.

We informed the chief deputy warden that we believed the force used during this incident was unnecessary and unwarranted because no imminent threat was present. We also raised our concern about the threat to safety and security that emerged when the makeshift weapon fell from the officer's duty belt, and we recommended that the incident be referred to the Office of Internal Affairs for investigation. However, the chief deputy warden decided not to refer the incident for investigation.

We elevated our concerns with the chief deputy warden's decision to the department's executive level, to the attention of an associate director. As

of the publication of this report, the associate director has not responded to our concerns.

Officers Failed to Use De-Escalation Techniques and to Implement a Controlled Use-of Force to Place an Incarcerated Person in Custody; While the Department Initially Refused to Refer the Officer's Actions for an Investigation, It Later Agreed with the OIG's Recommendation

In this incident, an incarcerated person refused to enter his assigned cell, citing safety concerns with other incarcerated people in this housing unit. The body-worn camera and audio-video surveillance system recording of the incident showed the incarcerated person was standing alone in the center of a dayroom with his arms crossed. The video showed the incarcerated person had calmly explained his safety concerns to the officers. While the officers initially engaged in a respectful conversation with the incarcerated person, they did not follow the procedure that required them to escort the incarcerated person to a confidential area and contact a supervisor regarding his safety concerns. The video then showed one of the officers stating the following to the incarcerated person:

> Unless you have safety concerns that are reliable, credible, and something we can look into … other than that you are going in that house.

The officers then ordered the incarcerated person to "cuff up." One officer stated the following:

> We are giving you a direct order to cuff up and you are refusing my order, so we are going to go hands on!

At the time of the incident, the video showed the incarcerated person's hands extended over his head in a posture of surrender while he stepped slowly away from the officers. He appeared to pose no imminent threat to the officers. The officers then proceeded to use physical force to take the incarcerated person to the ground and place him in restraints.

Before the IERC meeting, the OIG met with the committee chair and the chief deputy warden. The OIG expressed concern that the officers appeared to have used force without the presence of an imminent threat and that the officers' reports did not match what was captured in the video footage. The OIG recommended that the incident be referred to the Office of Internal Affairs for an investigation; however, the chief deputy warden declined to follow the recommendation. We then discussed the case with the hiring authority, who agreed with our concerns and referred the matter to the Office of Internal Affairs for an investigation.

Despite Changes in Both California Law and the Department's Policy and Training, Officers Used Impermissible Strangleholds, and the Department Failed to Consistently Address the Violations

Effective January 1, 2021, California no longer permits law enforcement officers to use a carotid restraint or stranglehold[18] in the course of their duties. California Government Code section 7286.5 (a) (1) states, in part:

> A law enforcement agency shall not authorize the use of a carotid restraint or choke hold by any peace officer employed by that agency.

The department's regulations, policy, and training curricula also instruct officers that the use of a stranglehold or similar physical restraint is prohibited unless the situation warrants the use of deadly force. Despite these changes in State law, the department's regulations, policy, and training curriculum, some officers continue to apply these potentially deadly strangleholds on incarcerated people during use-of-force incidents in which the use of deadly force was not authorized.[19]

The following three incidents demonstrate the department's failures related to preventing the use of strangleholds. In the first incident, an incarcerated person reported to officers that he had safety concerns about another incarcerated person. Two officers proceeded to place hand restraints on the incarcerated person who had reported safety concerns regarding another incarcerated person and escorted him from the housing unit to a holding cell. The incarcerated person stepped into the holding cell and partially turned to the right as the first officer spoke to him. The officer ordered the incarcerated person to step forward into the holding cell. Then, as the incarcerated person stood still, the first officer wrapped his hand around the incarcerated person's throat, squeezed his hand, and strangled him.

After the first officer strangled the incarcerated person, the incarcerated person asked, "Why did you hit me in the throat?" The first officer responded, "I didn't hit you in the throat." Immediately following the incident, a sergeant asked the first officer what occurred during the incident. The first officer reported that the incarcerated person had resisted him but had not kicked him. However, in his report documenting the incident, the first officer reported he was justified in using force because he claimed that "without warning," the incarcerated person "kicked me, striking me in the right shin area." This statement directly

18. In this report, we use the term *stranglehold* instead of *choke hold* or *chokehold*; however, we cite verbatim the spelling of legislation per the statute's language.

19. CCR, Title 15, section 3268, "Use of Force," and DOM, Section 51020.5.

contradicted the officer's initial statement that the incarcerated person had *not* kicked him. Moreover, none of the videos of the incident depicted the incarcerated person kicking the officer. Furthermore, the second officer, who was present alongside the first officer during the entire incident, did not report that the incarcerated person had kicked the first officer. The first officer also failed to report that it was he who strangled the incarcerated person. After the incident, the first officer wrote a disciplinary report alleging that the incarcerated person had attacked him. If found guilty of the reported misconduct, the incarcerated person could have had more time added to his sentence, lost earned credit for an early release, or been assigned to a restricted housing unit.[20] In addition, because the department referred the incident to a local district attorney's office, the incarcerated person faced the possibility of criminal prosecution for allegedly kicking the officer.

The second officer, who had assisted the first officer with the escort of the incarcerated person and had been present throughout the entire incident, reported that the incarcerated person had "lunged" at the first officer; however, this was not supported by the video evidence. The video footage showed that the incarcerated person had been standing still immediately before being strangled by the first officer. The second officer also failed to report that she had observed the first officer strangle the incarcerated person. The video footage also showed that second officer used her hands to physically restrain the incarcerated person; however, this officer reported she had not used any force.

Nine days after the incident, a lieutenant, who had also served as the incident commander for this incident, identified the first officer's potential misconduct as it related to the stranglehold. Despite his identification of potential misconduct and the department's policy that any reviewer who identifies potential misconduct immediately suspend their review and request an investigation, the lieutenant did not do so and proceeded to ask the first officer clarifying questions. The assigned captain, who performed the second-level management review of this incident, agreed with the lieutenant's concerns and sent the assigned associate warden a memorandum requesting an investigation. The associate warden referred the incident to the IERC, instead of recommending an investigation. None of the reviewers identified the first and second officers' potential dishonesty or failures to report the force they had used or observed.

Before the IERC meeting, OIG staff met with the hiring authority to share several concerns about the incident, including that the first officer appeared to use excessive and potentially deadly force in the form of a stranglehold, that the officers failed to report all force they had used

20. DOM, Article 23, "Inmate Discipline." The five prisons included in the 2021 Remedial Plan include California Institution for Women; California State Prison, Corcoran; Kern Valley State Prison; California State Prison, Los Angeles County; and Substance Abuse Treatment Facility and State Prison, Corcoran.

or observed, and that the reviewing supervisors and managers did not terminate their reviews and request an investigation once they discovered potential misconduct. The lieutenant's decision to ask clarifying questions of an officer suspected of using a stranglehold, in violation of policy, also constituted possible staff misconduct. We recommended that the hiring authority refer the incident to the Office of Internal Affairs for investigation. The hiring authority agreed to refer the first officer's use of excessive force (the stranglehold), but only that concern.

In the second incident, agents from the Office of Correctional Safety, alongside local law enforcement, searched for and located a high-risk sex offender (the individual) who had allegedly failed to abide by the provisions of his parole. The agents pursued the individual on foot into a public laundromat and physically forced him to the ground. The individual struggled to escape the agents' physical restraints, but the agent lay across the individual's back, effectively pinning the individual face down on the ground. Next, that same agent reached over the individual's right shoulder and, grasping the man's throat with his right hand, strangled him. Based on our review of the video evidence of the incident, the agents' use of potentially deadly force was not justified.

In his initial incident report, the agent failed to indicate that he had strangled the individual. All levels of review, including the chief deputy of the Office of Correctional Safety, who also served as the chair for the executive review committee, failed to identify the potential misconduct. Instead, the chief deputy elected to request clarification from the agent regarding the force he had used and asked whether the agent had reviewed the body camera footage from the police department, thereby encouraging the agent to review the video footage of the incident, before the agent could respond. Eighteen days after the incident, the agent reported only that he placed his "hand at the base of [the individual's] neck. . . ." The agent did not mention having strangled the individual.

During the Field Executive Review Committee (FERC) meeting chaired by this same chief deputy, the OIG expressed concern that the agent had used unnecessary and excessive force and failed to report all the force he had used during the incident. We recommended that the incident be referred to the Office of Internal Affairs for investigation. The chief deputy stated that the agent's force was appropriate and disagreed with our recommendation to refer the incident for investigation. We elevated this incident to the chief of the Office of Correctional Safety, again recommending that the department refer the incident for investigation. Nevertheless, the chief chose not to refer the incident for investigation, stating, "After reviewing the agent's reports, the incident video, and the department policy, I do not believe the agent violated policy." Instead, the chief elected to provide general training to all Office of Correctional Safety agents. Due to the serious nature of this incident, we elevated our concerns to an undersecretary, who also elected not to refer the incident for investigation.

In another incident, an officer observed a seriously mentally ill incarcerated person in a cell that had a broken window. As the officer placed handcuffs on the incarcerated person, he reportedly observed deep scratches and blood on the incarcerated person's wrists. The officer determined that the incarcerated person had broken his cell window and had injured himself by trying to commit suicide, yet the officer elected not to activate an alarm, failed to request medical assistance, and failed to search the incarcerated person for weapons or other contraband before escorting the incarcerated person to a triage and treatment area.

The first officer and a second officer escorted the incarcerated person toward a triage and treatment area but stopped in front of a closed gate at a sally port. At that point, the incarcerated person pulled away from the first officer. The first officer then placed the incarcerated person in a stranglehold by placing his right arm around the incarcerated person's throat and neck, pulling the incarcerated person to the ground.

After the initial use of force, the first officer, along with two other officers, escorted the incarcerated person into a medical evaluation room. The officers subsequently told the incarcerated person that he had to be placed in a holding cell, so mental health staff could evaluate him. The incarcerated person did not want to leave the medical evaluation room to be placed in a holding cell because the holding cell was located in an area where other incarcerated people had been shouting obscenities and threats at him. The officers began escorting the incarcerated person out of the medical evaluation room back to the sally port holding cells, when the incarcerated person again pulled away from the officers. The first officer again reached around from behind the incarcerated person with his right arm and used another stranglehold to force the incarcerated person to the ground. The other two officers assisted the first officer in forcing the incarcerated person to the ground.

In the lieutenant's review of the incident, he excused the first officer's use of the stranglehold, reporting that it "was unintentional and was due to the inmate's erratic movement and speed of the incident." During subsequent reviews of the incident, the reviewing captain, the associate warden, and the use-of-force coordinator failed to identify the first officer's use of unnecessary and excessive force.

During the IERC meeting, OIG staff raised several concerns. These concerns included the following:

1. The first officer failed to activate his body-worn camera during the initial contact with the incarcerated person;[21]

21. The incident occurred at a prison within the High Security Mission, where officers are required to wear and activate body-worn cameras whenever they are in contact with incarcerated people.

2. Although the first officer reported that the incarcerated person had deep cuts on his wrists, the officer failed to activate his alarm; the first officer failed to request medical assistance for the incarcerated person;

3. The first officer failed to conduct a clothed body search of the incarcerated person before initiating an escort;

4. The first officer used unnecessary and excessive force when he elected to place the incarcerated person in two separate, unconnected strangleholds during the incident;

5. Two unidentified medical staff members observed force, yet failed to submit reports; and

6. None of the staff assigned to review the use of force identified the potential misconduct or other serious concerns.

We recommended that the chief deputy warden, who chaired the meeting, refer the incident to the Office of Internal Affairs for investigation. The chief deputy warden disagreed with all our concerns and closed the incident without taking any action.

After the IERC meeting, OIG staff met with the hiring authority to share our concerns about the potential staff misconduct and to again recommend an investigation. The hiring authority eventually agreed to refer the incident for investigation; however, he only referred the first officer's initial use of the stranglehold and did not address the other instances of potential staff misconduct.

Prison Staff Failed to Properly Search Incarcerated People Before Allowing Them to Enter and Exit Restricted Housing Units

Incarcerated people who are assessed as having a higher propensity for violence are assigned to restrictive housing units, where they are subjected to stricter security measures, such as more frequent and thorough searches and direct observation. The department's policy[22] requires that incarcerated people living in restricted housing units submit to an unclothed body search and be scanned with a metal detector before entering and exiting their cells. Staff's failure to conduct adequate searches at any level allows incarcerated people the opportunity to hide and transfer weapons while participating in activities beyond the confines of their secured housing. After exiting their housing units, incarcerated people also have opportunities to attack staff and other incarcerated people, which may result in the need for prison staff to use force. The following examples illustrate serious incidents in which staff failed to adequately search incarcerated people, thereby compromising the safety and security of the prison.

In one monitored incident, while an officer escorted an incarcerated person from an exercise yard to his assigned cell, the incarcerated person slipped both hands out of his restraints and aggressively ran toward an open cell that was occupied by two other incarcerated people. Multiple officers responded and used physical force to take the incarcerated person to the ground. During a subsequent clothed body search, an officer located an 8-inch metal stabbing weapon hidden in the incarcerated person's waistband.

Local operating procedures within a restricted housing unit require staff to perform an unclothed body search and pass the incarcerated person through a handheld metal detector before and after returning from out-of-cell activities. The OIG asked the hiring authority how an incarcerated person had been able to conceal an 8-inch metal weapon on his person after staff supposedly conducted an unclothed body search and passed him through a metal detector. The escorting officers did not provide sufficient detail in their reports and did not describe anything having happened before they removed the incarcerated person from the exercise yard. The officer who had escorted the incarcerated person to the exercise yard was not required to submit a report; therefore, the OIG asked whether the escorting officer searched incarcerated people prior to entering and after exiting the exercise yard. The hiring authority did not know the answers to the OIG's questions and declined to ask for further clarification.

22. DOM, Section 52050.16.5, "Unclothed Body Search of Inmates."

Based on the severity of the incident and the potential staff misconduct, the OIG recommended that the incident be referred to the Office of Internal Affairs for investigation. However, the hiring authority disagreed with the OIG's recommendation and instead ordered training for the officer. The OIG elevated the issue to an associate director, who discussed the incident with the hiring authority. The hiring authority then changed his position and referred the matter to the Office of Internal Affairs for investigation.

In another incident, an officer removed an incarcerated person from his cell within a secured housing unit. As the incarcerated person exited his cell, he turned and assaulted the escorting officer with a 10-inch-long makeshift stabbing weapon, inflicting a stab wound to the officer's shoulder. A nearby officer quelled the attack by deploying chemical agents and applying physical force. Following the incident, staff conducted a clothed body search of the incarcerated person and discovered a makeshift weapon sheath concealed near his abdomen and a handcuff key hidden inside his mouth.

OIG staff reviewed both the incident report and available video footage, identifying multiple issues leading to the assault, which likely contributed to the need to use force. Video footage showed that the escort officer had failed to perform an unclothed body search before removing the incarcerated person from his cell. The video also showed that the cell's two windows were partially covered. This covering possibly could have obstructed the officer's view of the incarcerated person before he exited the cell, and thereby preventing the officer from identifying any makeshift weapons on his person. Furthermore, when hand restraints were placed on the incarcerated person, the officer failed to check whether the waist restraints were properly secured. Video footage showed that the incarcerated person's waist restraints were not properly secured, which allowed him to freely move both arms and attack the officer.

During the IERC meeting, the hiring authority determined that the officer had violated departmental policy by not conducting an unclothed body search before removing the incarcerated person from his cell. The hiring authority also acknowledged a systematic failure by staff in the prison's restricted housing unit to perform the required unclothed body searches on incarcerated persons before they exited their cells. OIG staff reminded the hiring authority that potential misconduct should be referred to the Office of Internal Affairs for investigation; however, the hiring authority disagreed and declined to take any further action.

Body-Worn Cameras Have Been Effective in Identifying Possible Misconduct; However, Officers Often Failed to Activate Their Body-Worn Cameras, and Supervisors and Managers Failed to Hold Officers Accountable

In September 2020, a United States District Court ordered the implementation of video-surveillance cameras and body-worn cameras at Richard J. Donovan Correctional Facility to achieve compliance with the *Armstrong* Remedial Plan. The remedial plan mandated that the department draft policies and procedures regarding camera use and the retention period for video recordings obtained through the use of these cameras. In March 2021, the court ordered similar remedial measures at five more departmental prisons: California Institution for Women; California State Prison, Corcoran; Kern Valley State Prison; California State Prison, Los Angeles County; and Substance Abuse Treatment Facility and State Prison at Corcoran.

In 2023, a total of 15 departmental prisons had fixed cameras, and 10 departmental prisons used body-worn cameras (Table 2, below). Although the department has no plans to implement body-worn cameras at any additional prisons in 2024, it has indicated the intent is to implement fixed cameras at an additional 11 prisons in the future.

Table 2. Institutions With Body-Worn Cameras (BWC) or Fixed Audio-Video Surveillance Systems (AVSS) in 2023

Institution	AVSS	BWC	AVSS Installed in 2023	BWC Installed in 2023
California Correctional Institution	✓	✓	✓	✓
Central California Women's Facility	✓	✓		
California Institution of Women	✓	✓		
California Medical Facility	✓		✓	
California State Prison, Corcoran	✓	✓		
High Desert State Prison	✓			
Kern Valley State Prison	✓	✓		
California State Prison, Los Angeles County	✓	✓		
Mule Creek State Prison	✓		✓	
R. J. Donovan Correctional Facility	✓	✓		
California State Prison, Sacramento	✓	✓		
Substance Abuse Treatment Facility and State Prison, Corcoran	✓	✓		
California State Prison, Solano	✓		✓	
San Quentin State Prison	✓		✓	
Salinas Valley State Prison	✓	✓	✓	✓
Totals	**15**	**10**	**6**	**2**

Source: The California Department of Corrections and Rehabilitation's *Audio-Video Surveillance System and Body-Worn Camera Implementation Schedule.*

During this reporting period, we monitored 457 incidents captured on body-worn cameras, fixed cameras, or both. We acknowledge that an individual's ability to recall every detail may be impaired during a use-of-force incident and that there may be minor discrepancies between an officer's written report and the recordings from body-worn or fixed cameras. Therefore, when reviewing incidents captured on video, we assess whether staff reports contained material differences from the events recorded by the cameras. We focus our concerns on incidents in which there is a clear discrepancy between what is captured on video and statements included in officers' reports. Of the 457 incidents we monitored, we identified 69 incidents (15 percent) in which we believed the video recording revealed a material difference between information—or a lack thereof—presented in a written report that could not reasonably be attributed to an officer's inability to recall. We present four incidents below in greater detail.

In the first incident, officers observed four incarcerated people fighting. A responding officer arrived at the scene and ordered the incarcerated people to stop fighting and get down on the ground. The incarcerated people initially complied with the orders, but one of the involved incarcerated people stood up again and began drinking from a nearby water fountain. The officer articulated in his report that because he was uncertain of the incarcerated person's intentions, he deployed pepper spray, striking the incarcerated person in the face. The force of the spray caused the incarcerated person to stop drinking and fall to her knees.

During the department's review of this incident, the levels of review viewed the footage from body-worn cameras, which showed that the incarcerated person drank from the faucet for about four seconds while the officer gave an order three times to the incarcerated person to sit down before deploying pepper spray. The hiring authority determined that the officer allegedly used unnecessary force when he sprayed the incarcerated person in the face when no imminent threat was present.

The department referred the potential misconduct to the Office of Internal Affairs for investigation. We describe this incident to highlight the benefits of body-worn cameras and fixed audio-video surveillance systems, which can provide additional evidence of potential staff misconduct requiring investigation or evidence that exonerates an officer facing allegations of staff misconduct.

In the second incident, an officer advised an incarcerated person who was wearing a cut-off shirt exposing his abdomen that he could not go to the exercise yard with modified clothing. The incarcerated person became agitated and subsequently threw his identification card at the officer. Officers then used physical force on the incarcerated person to place him in handcuffs.

Three officers did not have their body-worn cameras activated as required by the prison's policy that cameras be activated when officers are in the presence of incarcerated people in the dayroom. Audio-video surveillance system recordings showed officers were present in the dayroom and moving among incarcerated people for a considerable length of time before the use-of-force incident occurred. The prison's policy states the following:

> With the exception of specific identified circumstances, the body-worn camera shall remain on throughout the entire shift.

We recommended that the hiring authority refer the matter of the officers' noncompliance with the prison's body-worn camera policy to the Office of Internal Affairs for investigation.

The hiring authority, however, found no fault with the officers' deactivation of their cameras and decided not to submit the incident to the Office of Internal Affairs for further review. The OIG expressed concern with this decision and mentioned that one officer might have already received a letter of instruction for camera deactivation during a previous incident, thereby making this a second policy violation for that officer. After further discussion, the hiring authority agreed to refer the incident for investigation.

In the third incident, which occurred at a prison where officers and sergeants were required to wear and activate body-worn cameras when in contact with incarcerated people, the hiring authority used at least 39 correctional academy cadets-in-training, and four academy training sergeants and officers from a nearby prison, to assist with a massive search of incarcerated people and their housing units at the prison. The hiring authority elected not to provide these academy cadets and sergeants with body-worn cameras despite the department's policy at this prison that officers and sergeants who have contact with incarcerated people be issued a body-worn camera and to activate the camera when they come into contact with incarcerated people.

During this large-scale search operation, as an officer searched an incarcerated person, the incarcerated person attempted to pull away and escape from the officer. Four officers used physical force to push the incarcerated person to the ground. Once the incarcerated person was on the ground, officers continued to use physical force to restrain the incarcerated person. At the time of the use-of-force incident, approximately 25 cadets were in the immediate area, with many of them facing in the direction of the incident.

A sergeant assigned to supervise and deliver the department's in-service training at the prison, three other prison and academy sergeants, and at least two officers, were all recorded directing the cadets to turn around

and face a wall to prevent them from observing the force, which would have necessitated their writing reports. One of the sergeants explained to the cadets that the reason for having them turn and face the wall was to reduce the number of submitted reports. The sergeant further explained that there would likely be discrepancies among reports, which would require a process to request clarification. An academy training sergeant then turned and faced the wall alongside the cadets to also avoid observing the force and being required to write a report.

Moreover, during this incident, a sergeant assigned to this prison who identified himself as the "*Armstrong* compliance sergeant," whose assignment required the sergeant to monitor the department's compliance with the *Armstrong* litigation, which requires officers at this prison to wear body-worn cameras, also failed to wear a body-worn camera during the search operation. In addition, a sergeant and an officer assigned to the prison's Investigations Services Unit and a sergeant assigned as the prison's lead trainer also failed to wear their body-worn cameras.

Before the IERC meeting, the OIG requested to meet with the chief deputy warden, who was the committee chair, but he did not respond to our request. During the IERC meeting, we raised our concerns that the involved sergeants, some of whom provide training and conduct investigations at the prison, directed the correctional academy cadets to commit potential staff misconduct by turning and facing a wall to avoid witnessing the incident. We also noted that multiple officers and sergeants failed to wear body-worn cameras during the operation. The chief deputy warden who chaired the committee disagreed with the OIG that there was potential staff misconduct and closed the incident.

We then elevated our concerns to the hiring authority, who initially stated that no staff misconduct had occurred and that he believed he had the authority to, at his discretion, permit officers, including correctional academy cadets, to *not* wear body-worn cameras when they had contact with incarcerated people despite the departmental policy requirement. However, after additional discussion, the hiring authority agreed with the OIG's recommendation and referred the incident to the Office of Internal Affairs for investigation. We also expressed concern that the academy cadets had been ordered to turn away from the incident, to which the hiring authority immediately responded that he would refer that aspect for investigation as well.

In our 2022 report on the use of force, we discussed a trend we identified at one of the prisons with fixed cameras installed, whereby medical staff failed to provide an accurate report of a use-of-force incident or any report at all, even though video footage showed that they had witnessed the incident. During this reporting period, we found that the department has been continuing to operate with this same pattern of potential staff misconduct. In this fourth incident, which was particularly egregious,

an officer contributed to the need to use force when he elected to open an incarcerated person's cell door to speak with the incarcerated person instead of speaking through the cell door or opening the cell door restraint port. Once the officer opened the door, the incarcerated person attacked the officer, who had to use physical force to stop the attack. During this incident, two medical staff members were present. The video footage showed them watching the officer use force, but they reported they did not observe any force used.

While the hiring authority agreed that the medical staff may have committed misconduct, the hiring authority failed to refer the incident for an investigation and, instead, said she would wait for the medical hiring authority to do so. The hiring authority finally referred the allegations to the Office of Internal Affairs for investigation 450 days after the incident, and 427 days after the hiring authority agreed there was potential misconduct. The Office of Internal Affairs opened an investigation into the medical staff members' statements that they had not observed staff use force during the incident. Moreover, the department failed to address the actions of the officer who had unnecessarily opened the cell door, thereby causing the need to use force. We elevated our concerns to two associate directors on several occasions and were told that the backlog of use-of-force incidents involving staff misconduct would be referred for an investigation.

In Response to Recommendations From the OIG's Most Recent Report, the Department Provided Refresher Training on Use-of-Force Tactics; However, We Continue to Review Incidents That Are Out of Policy With De-Escalation Techniques

In our prior report, we identified inconsistencies from prison to prison when following departmental policies, procedures, and training regarding use-of-force incidents.

To improve overall consistency with its use-of-force policies, procedures, and training, in August 2023, the department held a four-hour refresher course on the use of force for its in-service training (IST) staff. In attendance were senior special agents, special agents, lieutenants, sergeants, and officers from various prisons, the Office of Internal Affairs, the Division of Adult Parole Operations, and the Office of Correctional Safety. Two lieutenants from the department's training academy provided the training with assistance from an acting special agent-in-charge from the Office of Internal Affairs. Throughout this refresher course on the use of force, instructors reminded attendees that they were directly responsible for ensuring that staff understood and followed the department's use-of-force policy and training. Instructors provided several examples of incidents and explained, in some detail, the expectation that officers should attempt to de-escalate an incident to avoid using force, whenever possible.

During this training, both parties expressed concerns about the challenges that can arise when altercations erupt within the prison setting. How well or easily an officer might be able to employ techniques of persuasive communication was discussed at length. The primacy of doing so was acknowledged by both instructors and attendees. Even so, the challenge faced by those who must follow policy and procedure and bring their training to bear while in the midst of a dangerous altercation, must also be acknowledged. Ensuring safety certainly must be the ultimate priority when a fight breaks out on a yard or in the dayroom. Seconds count.

And while we appreciate the department's attempts to ensure consistent application of its use-of-force policy, we must continue to emphasize that applying certain techniques, such as de-escalation, could possibly prevent or at least reduce the need to use force. Our inspectors continue to identify numerous inconsistencies occurring among hiring authorities and their designees statewide regarding their interpretation and application of departmental use-of-force policy, procedures, and training at their respective executive review committee meetings. We agree with the department that prison trainers must be consistent when training staff on use-of-force techniques that comply with the department's

use-of-force policy. Yet we also emphasize how essential it must be for hiring authorities to share among themselves a consonant, unified understanding of the department's policy, procedures, and training—along with a steadfast willingness to apply these dictates as expected. Only then will it possible to consistently hold officers and reviewers accountable for their activities of noncompliance.

Recommendations

For this reporting period, we offer five recommendations to the department:

Nº 1. We recommend that the department evaluate and identify opportunities to improve supervision of the incarcerated population in housing units to reduce assaults and fights that may cause injuries, including death, to staff and incarcerated people. Sufficient staffing in housing units should reduce the number of use-of-force incidents and injuries to staff and incarcerated people.

Nº 2. We recommend that the department provide additional guidance and direction through policy and training to ensure that prison staff properly comply with body-worn-camera requirements, where applicable. The proper use of body-worn cameras provides valuable evidence to determine whether officers used force appropriately and identifies use-of-force deficiencies and opportunities for improvement. We identified several instances in which hiring authorities failed to properly address officers' failures to wear or activate their body-worn cameras during use-of-force incidents. We recommend that the department provide clear direction to hiring authorities regarding expectations for staff who are required to wear such devices and take appropriate corrective and disciplinary action against officers who do not comply with departmental training or policy.

Nº 3. We recommend that the department reevaluate its training and procedures regarding search practices, and restraint application and removal, and provide comprehensive remedial training to all custody staff. Staff who fail to properly perform these required tasks impact the department's ability to maintain safety and security, and frequently contribute to an officer's need to use force. When staff follow policies, procedures, and training, the number of these incidents should be significantly reduced.

Nº 4. The OIG again identified that hiring authorities categorically failed to address staff at all levels of review. The list included sergeants, lieutenants, captains, associate wardens, use-of-force coordinators, and hiring authorities, when these reviewers failed to identify violations of departmental policies, procedures, and training. We have previously recommended in our use-of-force reports that the department track and monitor staff performance at all levels of review and impose progressive discipline for reviewers who fail to complete satisfactory reviews. The department's only response to our recommendation has been it had already addressed this matter with a September 1, 2020, memorandum from one if its directors. We recommend that the department revisit and readdress this continued deficiency by imposing progressive discipline for

supervisors and managers who fail to identify and address violations of policies, procedures, and training.

Nº 5. We recommend that the department provide remedial training to custody staff, including executive staff, regarding the use of de-escalation tactics to attempt to avoid use-of-force incidents, and to recognize when the need for controlled use of force is necessary. The department is implementing the California Model, which calls for greater communication between staff and incarcerated people to reduce negative outcomes such as use-of-force incidents, and to improve rehabilitation efforts. The California Model is a new style of prison as promulgated by the department.

The Department's Response to Our Use-of-Force Report

The department received a draft of this report prior to publication and was given the opportunity to comment. The department responded to our office that it had no comment regarding the results presented herein.

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Monitoring the Use-of-Force Review Process of the California Department of Corrections and Rehabilitation

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STATE *of* CALIFORNIA
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OIG