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 July 2024.

**Incident Number**
24-00028-UOF

**Reason for Monitoring**
Potential Misconduct

**Incident Summary**
On March 21, 2024, several officers placed an incarcerated person in restraints and attempted to escort him from a housing unit to complete his transfer to another prison. The incarcerated person soon stopped the escort by dropping to his knees. Officers' body-worn camera footage provided evidence of this act of passive resistance. Four officers then used physical force, with each officer taking hold of the incarcerated person by his arms and legs. They carried him out of the housing unit and across the yard to the mental health building, where medical staff performed an evaluation prior to his transport from the prison.

**Incident Disposition**
The department determined that the use of force was compliant prior to and during the incident, but out of compliance following the use of force. Three officers observed physical force, but they did not create and submit their reports until 47 days thereafter, which was a significant amount of time from the date the incident occurred. The OIG also found that the officers use of force was unnecessary, as the incarcerated person did not present an imminent threat. The OIG recommended referring the matter to the Office of Internal Affairs for investigation for the policy violation. The institutional executive review committee disagreed with the OIG and only ordered a Letter of Instruction for the officers who had observed force and submitted late reports, but the committee declined to address the potential unnecessary force the officers had used on the incarcerated person.



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

**Incident Number**
24-00030-UOF

**Reason for Monitoring**
Unreasonable Force, Potential Misconduct

**Incident Summary**
On May 2, 2024, officers observed two incarcerated people punching a third incarcerated person in the face and upper torso on an exercise yard. An officer activated an alarm and ordered all incarcerated people to get down, but the two incarcerated people continued their attack on the third incarcerated person. Two officers each deployed one burst of pepper spray at the incarcerated people, but they continued their attack. A third officer used an expandable baton, aiming for and striking the first incarcerated person who had instigated the fight on "the lower right side of [his] back." The officer next struck the second incarcerated person who had instigated the fight with the expandable baton two times, aiming for and striking the incarcerated person's buttocks area. The baton strikes had the desired effect, and the incarcerated people stopped their attack. Officers offered the incarcerated people decontamination, and two nurses conducted medical evaluations, noting minor injuries on the three incarcerated people.

**Incident Disposition**
Neither supervisors nor managers at the prison identified any violations during their review. Prior to the meeting of the institution's executive review committee, we discussed our concerns with the warden regarding the officer who had aimed at and struck the incarcerated person's lower back with an expandable baton. The department's expandable-baton training manual includes a "trauma chart" that identifies different areas of the body with green, yellow, or red target areas, based on the severity of the physical trauma that may result from a baton strike. The department designates the entire lower back as a "red target area," specifically identifying the spine, tailbone, and kidneys. The training manual states that "in order to strike the 'red area,' the deadly force criteria must be present. You will not target a red zone area with the baton unless deadly force is authorized." We believed the officer may have used unreasonable force when he aimed for and struck a "red target area" when there was no justification for deadly force. The warden agreed with our concerns and referred the matter for investigation.



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**Incident Number**
24-00031-UOF

**Reason for Monitoring**
Potential Misconduct

**Incident Summary**
On April 30, 2024, five officers escorted an incarcerated person from a cell in a restricted housing unit to a transportation van. Reaching through the cell door's food port, one officer placed the incarcerated person in hand restraints and then released the incarcerated person from the cell. As officers began to escort the incarcerated person from his cell toward a transportation van, the incarcerated person struck one of the escort officers with his arm. Five officers then forced the incarcerated person to the ground and held him down to stop the attack. A sergeant placed a spit hood on the incarcerated person to prevent him from spitting on staff. Afterward, a nurse examined the incarcerated person, and officers transported the incarcerated person to a court hearing without further incident.

**Incident Disposition**
The institution's executive review committee identified that an officer failed to properly secure the incarcerated person in the correct type of hand restraint prior to releasing the incarcerated person from his cell. The committee recommended on-the-job training for the officer. The hiring authority failed to identify any potential staff misconduct. The OIG identified potential staff misconduct based on video recordings of the incident that depicted another officer had been present during the incident and appeared to observe the force used by other officers, yet failed to submit a report until he was directed to do so by a lieutenant 11 days after the incident had occurred. In addition, the OIG identified officers did not conduct a clothed body search of the incarcerated person, did not properly secure him in leg restraints prior to the escort, failed to document whether constant supervision was maintained while the incarcerated person wore a spit mask, and did not document when the spit mask was removed. The OIG recommended that the hiring authority refer the matter for investigation. While the hiring authority agreed to refer the matter for investigation, he only did so for the officer who had failed to timely report the force observed. The hiring authority declined to address the other significant issues that were associated with this case.



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**Incident Number**
24-00032-UOF

**Reason for Monitoring**
Officer's Action Contributed to the Incident

**Incident Summary**
On June 17, 2024, two incarcerated people were observed fighting in a dayroom. Officers ordered the incarcerated people to get down, but they continued to fight. One officer deployed one burst of pepper spray to quell the incident. The incarcerated people then separated and submitted to being handcuffed. Officers provided the incarcerated people with decontamination and a medical evaluation without further incident.

**Incident Disposition**
The institution's executive review committee identified that an officer had failed to properly secure an incarcerated person's cell prior to the incident, which permitted the incarcerated person to exit his cell and walk out, and to attack a second incarcerated person. The committee also identified a sergeant who had responded to the incident, but who did not adequately manage the incident scene by ensuring the incarcerated people got down on the ground. The committee ordered a Letter of Instruction for the officer and on-the-job training for the sergeant.



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