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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 six notable use-of-force incidents that the Field Investigations Monitoring Unit closed from September through December 2024.

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**OIG Incident Number**
24-00035-UOF

**Reason for Monitoring**
Potential Misconduct

## Incident Summary

On July 26, 2024, a sergeant observed an incarcerated person waiting inside a large holding cell who was visibly upset and yelling about damage to his wheelchair. The sergeant approached the secured cell door and ordered the incarcerated person to stop his actions. The incarcerated person had detached and swung the wheelchair's footrest in the direction of the sergeant, in a motion as if he were going to throw it at the sergeant and the door grate. The sergeant deployed a single three-to-four-second burst of a chemical agent from 10 to 12 feet away, which struck the incarcerated person in the face. The incarcerated person then threw the footrest in a direction away from the sergeant, striking a nearby window. The sergeant deployed a second burst of a chemical agent, at which point, the incarcerated person got down on the ground. The incarcerated person was removed from the cell, and transported to the treatment and triage area for medical treatment.

## Incident Disposition

The hiring authority determined that the actions prior to, during, and following the use of force were in compliance with policy. The OIG identified potential staff misconduct and requested the hiring authority to review the video footage. Specifically, the responding sergeant did not appear to have used verbal de-escalation techniques, and he deployed a second application of chemical agents when there was no imminent threat and deployed chemical agents for three to four seconds, exceeding the maximum duration permitted by training and policy.

The hiring authority did not concur with the OIG's findings, emphasizing the sergeant had used de-escalation language throughout the entire time frame of the incident, and the hiring authority's opinion was the length of time the sergeant deployed the chemical agent was two to three seconds, which the hiring authority considered reasonable. Moreover, the sergeant articulated in his report that he had perceived a threat.

Although the hiring authority disagreed with the OIG's findings of staff misconduct, the department provided chemical agent training to the sergeant for having exceeded the maximum time allowed to deploy a chemical agent. The OIG recommended that the hiring authority refer the officer's alleged use of unnecessary force to the department's Office of Internal Affairs for investigation, but the hiring authority declined to take additional action.



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**OIG Incident Number**
24-00036-UOF

**Reason for Monitoring**
Potential Misconduct

**Incident Summary**
On January 27, 2024, an officer observed an incarcerated person leaving evening meal release carrying food in her hand. The officer ordered the incarcerated person to either finish eating or throw away the food. The incarcerated person returned to the dining area as if she were going to comply, but she then attempted to walk out of the dining area again, still carrying the food in her hand. The officer attempted to stop the incarcerated person from exiting the dining hall by extending his arm to block the doorway. The officer then used physical force to place the incarcerated person in restraints, but was unsuccessful as the incarcerated person resisted his attempts. The officer summoned assistance from additional staff, and on their arrival, multiple staff used physical force to take the incarcerated person to the ground.

**Incident Disposition**
The hiring authority determined that the actions during the use of force were out of compliance with policy, but those prior to and following were in compliance. The OIG identified potential staff misconduct during the use of force because the officer used immediate force when no imminent threat was present. The officer's initial report failed to articulate an immediate threat that would have required the use of immediate force. The supervisor who reviewed the incident requested that the officer clarify the nature of the imminent threat to justify having used force. The officer stated, "The inmate came into contact with me when attempting to push past me allowing me to take immediate action to stop threat [sic]." The OIG did not find that the officer's clarifying response supported the need for immediate force.

The hiring authority issued a Letter of Instruction to the officer to address the policy violation. Although the letter clearly stated that the officer had used force when there was no imminent threat, the hiring authority declined to refer the incident to the department's Office of Internal Affairs. The OIG did not agree with the hiring authority's decision.

**Incident Number**
24-00037-UOF

**Reason for Monitoring**
Potential Misconduct

**Incident Summary**
On May 27, 2023, an incarcerated person experienced a mental health crisis in a prison dayroom. Two floor officers responded to the dayroom from a nearby office. When the officers entered the dayroom, the incarcerated person was seated, completely naked, and told officers he was "homicidal, suicidal." Without incident, the officers placed the incarcerated person in restraints and began to escort the incarcerated person out of the dayroom. The first officer began the escort of the incarcerated person, while the second officer took the incarcerated person's property to the program office. A short time later, the second officer rejoined the escort, which was now on a prison yard. The incarcerated person inquired about his property, and the officers stated his property had been taken to the program office. The incarcerated person became agitated, and then slowly got down on the ground where he lay in a prone position. The officers then lifted the incarcerated person off the ground, placed him on his feet, and forced him to walk by pushing on his back, dragging and pulling him forward, and used a control hold on his arm. Once inside a sallyport, the incarcerated person pulled away from the officers, and the first officer forced the incarcerated person to the ground. After the incident, the incarcerated person was offered a medical evaluation.



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**Incident Number**
24-00037-UOF
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**Reason for Monitoring**
Potential Misconduct

**Disposition**
The institutional executive review committee reviewed this incident on April 4, 2024. During this meeting, the hiring authority told the OIG the incident was lost in the shuffle, and it was the responsibility of the associate warden at the time of the incident to ensure the incident was reviewed timely by the committee. The committee determined an officer had failed to activate his body-worn camera, and the hiring authority ordered the officer to receive a Letter of Instruction. The OIG identified potential staff misconduct based on an officer's alleged unnecessary or excessive use of force when he held the incarcerated person to the ground by pressing his arm on the incarcerated person's neck in a modified stranglehold while the incarcerated person was continuing to lie still on the ground and did not appear to resist the officer. The hiring authority disagreed and closed the case without further action. After additional review of video footage of the incident, the OIG identified still more staff misconduct. Specifically, the two officers who escorted the incarcerated person allegedly used force, when there was no imminent threat, against the incarcerated person who was observed in a video lying on the ground on a prison yard, and the officers picked him up, dragged him, and forced him to walk. The two officers did not report they had used this force. The OIG again recommended that the hiring authority refer the matter for investigation, and the hiring authority agreed.

When we followed up with the department to request a copy of the Letter of Instruction ordered for the officer who did not activate his body-worn camera, the department informed us that the letter was never issued to the officer. In addition, the prison delayed providing the OIG with video footage of this incident. As a result, OIG staff had only a portion of the available video footage to review and use in assessing this incident.

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**Incident Number**
24-00038-UOF

**Reason for Monitoring**
Potential Misconduct

**Incident Summary**
On November 22, 2023, officers observed two incarcerated people fighting on a prison yard. Officers ordered the incarcerated people to stop fighting, but the incarcerated people did not comply. Two officers deployed chemical grenades, and the incarcerated people stopped fighting. Officers offered the incarcerated people decontamination, clean clothing, and a medical evaluation.

**Incident Disposition**
Prior to the institutional executive review committee meeting, the OIG met with the custody hiring authority and recommended that he refer the matter for investigation based on the potential misconduct of a nurse who had observed the use of force, but failed to submit a report until five days after the incident. The custody hiring authority declined to refer the matter for investigation. During the institutional executive review committee meeting, the OIG again recommended that the custody hiring authority refer the matter for investigation; however, the custody hiring authority deferred and forwarded the incident to the medical hiring authority to address the potential staff misconduct, who ordered only training. Nearly 11 months later, the custody hiring authority returned the incident to the institutional executive review committee for review. The institutional executive review committee again determined the incident complied with the department's policies, procedures, and training, and only ordered on-the-job training for the nurse to address the potential staff misconduct per the medical hiring authority's recommendation. The OIG disagreed with the decision.



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**Incident Number**
24-00039-UOF

**Reason for Monitoring**
Potential Misconduct

**Incident Summary**
On June 20, 2024, officers responded to a scene in which a partially clothed incarcerated person was behaving disruptively. An officer ordered the incarcerated person to return to her cell and put a shirt on, which she refused to do. The officer announced on the radio that an incarcerated person was noncompliant with orders. Immediately afterward, the incarcerated person returned to her cell and was fully dressed, but then she refused to submit to restraints. A sergeant responded, entered her cell, and used physical force to place her in restraints.

**Incident Disposition**
The hiring authority determined the actions prior to, during, and following the use of force complied with policy. However, the OIG identified potential staff misconduct when the sergeant used immediate force when no imminent threat was present. In addition, the institutional executive review committee did not request and review all available video footage of the incident. Departmental policy requires that "all camera angles are captured" and "footage of events leading up to the event" shall be reviewed and retained. Based on the concerns the OIG raised, the hiring authority completed an additional review of the incident reports and available videos. The hiring authority acknowledged staff should have articulated the reason for placing the incarcerated person in restraints and the threat the incarcerated person posed, but ultimately determined the sergeants' actions during the incident complied with policy. The OIG disagreed with the hiring authority's decision.

**Incident Number**
24-00040-UOF

**Reason for Monitoring**
Potential Misconduct

**Incident Summary**
On September 23, 2023, officers escorted an incarcerated person experiencing a mental health crisis toward a cell in a prison hospital. During the escort, the incarcerated person dropped to the floor and refused to walk. Officers and a nurse used physical force to restrain the incarcerated person and placed him in leg restraints. The department provided the incarcerated person a medical evaluation and then placed him in a mental health crisis bed.

**Incident Disposition**
The institutional executive review committee did not identify any potential staff misconduct. The OIG identified potential staff misconduct based on an officer who reported that he and a nurse pulled the incarcerated person. However, the nurse reported they did not use force. In addition, the OIG identified another nurse who failed to clearly articulate the force observed. The OIG recommended that the custody hiring authority refer the matter for investigation. Instead, the custody hiring authority referred the case to the medical hiring authority who provided training to the nurse. The OIG did not agree with the decision.



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