STATE *of* CALIFORNIA

OIG | OFFICE *of the* INSPECTOR GENERAL

***Roy W. Wesley**, Inspector General*
***Bryan B. Beyer**, Chief Deputy Inspector General*

Independent Prison Oversight

Monitoring the Use of Force

The California Department of Corrections and Rehabilitation's Process for Reviewing Staff Use of Force Is Thorough, but It Must Address Low Compliance Rates With Its Policies and Procedures

July 2018

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Roy W. Wesley, Inspector General
Bryan B. Beyer, Chief Deputy Inspector General

Independent Prison Oversight

Regional Offices
Sacramento
Bakersfield
Rancho Cucamonga

July 16, 2018

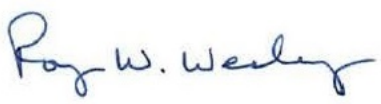
Dear Governor and Legislative Leaders,

Enclosed is the Office of the Inspector General's report titled *The California Department of Corrections and Rehabilitation's Process for Reviewing Staff Use of Force Is Thorough, but It Must Address Low Compliance Rates With Its Policies and Procedures*. This review covers use-of-force incidents we monitored for which the California Department of Corrections and Rehabilitation (the department) completed a review between July 1, 2017, and December 31, 2017.

This report concludes that the department thoroughly reviewed incidents after its staff used force. Based on its own assessments, however, the rate at which staff complied with departmental policies and training was relatively low. Specifically, the department concluded that only 52 percent of the incidents in this period fully met the standards set forth in its policy, while finding some sort of violation had occurred in the remaining 48 percent. After finding these policy violations, the department prescribed training to staff involved in the majority of the incidents. A few incidents, however, resulted in higher forms of progressive discipline, including formal counseling and adverse actions. While we concurred with the vast majority of these policy determinations, we also identified some instances of noncompliance that the department's review committees had not considered.

As part of its reviews, the department found that officers did not always justify their need to use force and, in a few instances, their actions may have contributed to the need to do so. We pointed out that these types of problems were relatively infrequent compared with the number of instances during which force occurred. Nevertheless, we believe that unnecessary force is a serious issue and could increase tension between staff and inmates and, ultimately, expose the department to legal liability. We also found that officers did not consistently follow departmental policies for video recording inmate interviews, which may have weakened the department's ability to support, or refute, certain allegations of unnecessary or excessive force. Finally, we found that officers did not always follow policies when they used controlled force, a type of force used when the inmate did not pose an imminent threat and was isolated in a confined setting.

Sincerely,



Roy W. Wesley
Inspector General

10111 Old Placerville Road, Suite 110
Sacramento, California 95827
Telephone: (916) 255-1102
www.oig.ca.gov

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Contents

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Summary

Within its statutory mandate, the Office of the Inspector General (OIG) monitors the California Department of Corrections and Rehabilitation's (the department) process for reviewing and evaluating uses of force by departmental staff and reports its findings. This report contains our evaluation concerning the use-of-force incidents for which the department completed reviews during the period from July 1, 2017, through December 31, 2017.

Any departmental employee who uses force, or observes another employee use force, is required to prepare a written report of the incident prior to being relieved from duty at the end of the working shift. These reports are then subjected to a multitiered review process culminating with an executive review committee's evaluation. The OIG's monitoring process included having its inspectors visit every adult and juvenile institution, headquarters, and the northern and southern parole regions to attend 778 of the 825 executive review committee meetings (a 94 percent attendance record), during which time, hiring authorities reviewed and evaluated every use-of-force incident to assess compliance with departmental policy and training.

As part of our oversight process for this six-month period, our inspectors reviewed and analyzed 4,001 separate instances, including 3,709 use-of-force incidents and 292 allegations of excessive or unnecessary use of force. OIG inspectors reviewed all written reports and documentation and, where applicable, viewed all related video recordings of incidents and interviews, independently determining whether staff actions were reasonable under the circumstances and in compliance with the department's policy and training. As part of this process, our inspectors provided real-time feedback and recommendations to the review committee chairs and provided each institution's warden with monthly reports summarizing all incidents we reviewed, including the names of involved staff members and the frequency of use-of-force incidents for each member.

Statistics Regarding the Use of Force During the Period From July 1, 2017, Through December 31, 2017

- Approximately 92 percent of the use-of-force incidents (3,405 of 3,709) occurred at the state prisons and contract facilities housing adult inmates, with the remainder involving the juvenile facilities (269), parole regions (29), and the Office of Correctional Safety (6).

- Approximately one-third of the incidents we reviewed occurred at only five state prisons: California State Prison, Corcoran; California State Prison, Sacramento; Kern Valley State Prison; California Correctional Institution; and Salinas Valley State Prison.

- The 3,709 incidents we monitored involved 11,046 "applications" of force—for example, two baton strikes count as two "applications" during a single incident. The use of chemical agents accounted for 5,121 (46 percent) of total applications, while physical strength and holds accounted for 3,662 (33 percent). The remaining 21 percent of applications comprised force options such as less-lethal projectiles, baton strikes, tasers, and firearms.

Highlights

The department's process for evaluating use-of-force incidents works well to identify instances in which its staff members' actions varied from departmental policy and training, but the department determined that just over half of the incidents were in full compliance.

The department subjects use-of-force incidents to several levels of review, which culminates with an executive review committee's evaluation. This process has proven effective in identifying instances of noncompliance with departmental policies and procedures governing the use of force. For example, while the department found that 52 percent of the incidents in this period fully met policy standards, it identified policy violations by its staff in 48 percent (1,774 of 3,709) of the incidents that we monitored during this six-month period. We agreed with the vast majority of the department's determinations of compliance, yet we also identified some instances of noncompliance that the department's review committees had not considered.

Officers did not always articulate their need to use force, and in some instances, their own actions may have contributed to the need to use force.

The department's policy for the use of immediate force requires that its officers' reports articulate their reasoning for using force; for example, in response to a threat against the life of another or to prevent great bodily injury or escape. Despite this requirement, officers did not adequately articulate an imminent threat in 68 of the incidents we monitored during this six-month period, leading us to question whether the use of force was necessary. While the number of such instances is relatively small in comparison to the totality of all use-of-force incidents in the period, the negative impact of any such incident involving unnecessary force can be quite significant in its potential to create tension between the inmate population and staff members, and in exposing the department to legal liability.

The department continues to experience low compliance with its procedures for video recording interviews with inmates.

The department requires video-recorded interviews of inmates who allege unnecessary or excessive force, or who sustain serious or great bodily injury possibly from the use of force. Policy requires that staff record these interviews within 48 hours of discovery of the injury or inmate allegation and that a supervisor who neither used nor observed force during the incident conduct the interview. We noted that the department's compliance rate with its own standards was only 57 percent during this six-month period. Although the department recently prescribed statewide training concerning this issue, it must explore additional measures to improve compliance.

Controlled uses of force are another area in which the department experiences a high rate of noncompliance with its policies.

The department deploys "controlled force" when an inmate's presence or conduct poses a threat, yet the inmate is located in an area that can be controlled or isolated. This application requires advance planning and organization, the presence and authorization of a management-level staff member, involvement of medical and mental-health staff, and that institutional staff video record the incident.

Of the 61 controlled use-of-force incidents we monitored during our six-month review period, the department's executive review committees found that staff violated one or more departmental policies in 46 of the incidents (75 percent). Most of these violations occurred when staff did not have required safety or medical equipment on hand, did not assign an officer to observe the inmate during the post-incident cool-down

period, or did not include key information (dates, identities of staff members, etc.) on the video recordings of such incidents.

Summary of Recommendations

We recommend that the department pursue the following actions:

- To optimize the use of the department's recently implemented use-of-force tracking system, the department should:
    - Determine which types of use-of-force management reports best suit its executive staff and local hiring authorities' needs,
    - Routinely analyze the use-of-force data at the headquarters' level for trends,
    - Monitor staff who frequently use force or who were found to have frequently violated use-of-force policies, and
    - Track the corrective or adverse actions hiring authorities impose on their staff.
- To increase the overall rate of compliance with use-of-force policies and procedures, the department should:
    - Focus its training curriculum on the most common and serious types of violations identified from the new tracking system,
    - Consider stronger progressive discipline for staff who repeatedly violate use-of-force policies, and
    - Hold supervisors and managers accountable when their staff repeatedly violate use-of-force policies.
- To ensure that staff understand how to properly carry out video-recorded inmate interviews during the course of their job duties, the department should reevaluate the training it offers to them on the correct procedure to follow when conducting these interviews.
- To ensure that staff adhere to policies that pertain to the controlled use of force, the department should reevaluate its training curriculum, provide additional training to staff, and select for participation in controlled use-of-force incidents only those who have completed additional training.

Introduction

Background

In the class-action lawsuit *Madrid* v. *Gomez,* the federal court found, among other things, that officials with the Department of Corrections and Rehabilitation (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.[1]

As a result of those findings, in 2007, the Office of the Inspector General (OIG) began monitoring the department's use-of-force internal review process. In 2011, after significant improvements to reform the department's use-of-force review and disciplinary processes, the federal court dismissed the case. The OIG, however, has continued monitoring these processes. This report presents our analysis and conclusions concerning how the department treats use-of-force incidents in accordance with the department's own policies and training.

Use-of-Force Policy: Force Concepts Defined and Force Options

Throughout this report, we use a number of terms and concepts specific to the use of force. For clarity, we present the department's policy definitions[2] for the following terms:

- **Reasonable force** – the force that an objective, trained, and competent correctional employee, if 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.
- **Unnecessary force** – the use of force when none is required or appropriate.
- **Immediate use of force** – the force used to respond without delay to a situation or circumstance that constitutes an imminent threat to institution or facility security or to the safety of persons.

[1] *Alejandro Madrid et al.* v. *James Gomez et al.*, 889 F. Supp. 1146 (N.D. Cal. 1995), January 10, 1995.

[2] Article 2, Use of Force, 51020.4 "Definitions," *California Department of Corrections and Rehabilitation, Adult Institutions, Programs, and Parole Operations Manual* (Sacramento: State of California, 2018), p. 326, Chapter 5, Adult Custody and Security Operations.

- **Imminent threat** – any situation or circumstance jeopardizing the safety of persons or compromises the security of the institution that requires immediate action to stop the threat. Some examples include an attempt to escape, ongoing physical harm, or active physical resistance.

- **Controlled use of force** – the force used in an institutional or facility setting when an inmate's presence or conduct poses a threat to safety or security, and the inmate 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 institution security.

- **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.

- **Great bodily injury**[3] – any bodily injury that creates a substantial risk of death.

When determining the best course of action to resolve a particular situation, staff must evaluate the totality of the circumstances, including the inmate's demeanor, mental health status and medical concerns (if known), and the inmate's ability to understand and comply with orders. Departmental policy states that staff should attempt to verbally persuade when possible, to mitigate the need for force. When force becomes necessary, staff must consider specific qualities for each force option when choosing which option to deploy, including the range of effectiveness for the force option, the level of potential injury, the threat level presented, the distance between staff and inmate, the number of staff and inmates involved, and the inmate's ability to understand. Departmental policy includes a number of force options, such as:

- Chemical agents

- Hand-held baton

- Physical strength and holds[4]

[3] California Penal Code section 198.5 defines "great bodily injury" as a significant or substantial physical injury. For the purpose of this review, however, we have displayed the definition contained in the department's policy.

[4] Refers to an officer using any part of his or her body as force.

- Less-lethal weapons[5]
- Lethal weapons

Statewide Training and De-escalation Techniques

In July 2017, to further its goal of accomplishing custodial and correctional functions with minimal reliance on the use of force, the department deployed the multiple interactive learning objective (MILO) simulator. All custodial and noncustodial staff use this training to improve their communication skills and learn when to apply de-escalation techniques. The goal is to gain voluntary compliance through verbal persuasion rather than by force. In addition, the training assists staff in learning to recognize signs and symptoms of mental illness or developmental disability.

MILO training consists of numerous prison-based, interactive scenarios conducted by certified instructors who direct the scenario based on the participant's verbal interaction with it, which is projected on a 12-foot screen. The scenarios do not initially present the participant with an imminent threat. However, depending on the participant's ability to employ de-escalation techniques, the scenario may present a threat that requires the participant to deploy a use of force.

MILO training has been implemented statewide and is now included in the department's required annual use-of-force training. The OIG has observed the MILO simulator at several institutions, and our staff were encouraged by both the instructional level and participant interaction. Following each scenario, meaningful discussion occurred between participants and instructors, which included both custodial and mental health staff.

Levels of Use-of-Force Review – Adult Institutions

Institution Executive Review Committee: This is the primary level of review for use-of-force incidents involving the Division of Adult Institutions. For each adult institution, an institution's executive review committee reviews every use of force, except those involving deadly force. This committee is chaired by the warden (or his or her designee, such as a chief deputy warden). The committee also includes an institution's associate wardens, captains, and health care representatives. Committees

[5] Less-lethal weapons are those not intended to cause death when used in a prescribed manner; they include the following: 37mm or 40mm launchers used to fire rubber, foam, or wooden projectiles, and electronic control devices.

at each institution meet regularly, depending on the volume of use-of-force incidents, to discuss the merits of the force used, and to determine whether staff followed policies and procedures when using force. The department's policy generally requires the committees to review each incident within 30 days of occurrence. On average, these committees evaluated about five use-of-force incidents at each meeting.

Department Executive Review Committee: This is a committee of staff selected by—and that includes—the headquarters' associate director of the respective mission in which the force occurred. This committee reviews incidents during which staff used deadly force, but wherein the force did not meet the criteria for review by the Deadly Force Review Board (e.g., warning shots), and incidents in which serious bodily injury, great bodily injury, or death could have been caused by the use of force by staff. It may also review incidents referred to it by an institution executive review committee. To reduce the duplication of work, this committee will not review incidents for which the Office of Internal Affairs has completed an investigation. The department's policy allows this committee up to 60 days to complete its review.

Levels of Use-of-Force Review – Juvenile Facilities[6] and Adult Parole Operations

Force Review Committee: For each of the juvenile facilities, a force review committee reviews every use of force. The review committee is a multidisciplinary team at each facility tasked with evaluating use-of-force incidents to identify effective and noneffective intervention techniques with the goal of reducing the use of force. The committee is chaired by the superintendent (or his or her designee, such as an assistant superintendent or chief of security), and includes program administrators, treatment team supervisors, a training officer, and health care representatives. As with the adult committees, the juvenile committees meet regularly to ensure each incident is reviewed within 30 days of occurrence, as required by policy.

Division Force Review Committee: The Division Force Review Committee is a headquarters-based multidisciplinary team of representatives whom the director of the Division of Juvenile Justice designates to ensure employees act in accordance with the crisis prevention and management policy. This committee reviews a minimum of ten percent of all use-of-force incidents that the Force Review Committee at each facility

[6] The Division of Juvenile Justice has different use-of-force policies, procedures, and training from those of the Division of Adult Institutions.

evaluates to provide another level of review and ensure employees act in accordance with the department's policies, procedures, and training.

Field Executive Review Committee: For the two parole regions, a field executive review committee reviews every use of force and is chaired by the regional parole administrator (or his or her designee, such as a chief deputy). Normally, the committee consists of the chair, one other manager, a supervising training coordinator, and a use-of-force coordinator. The department's policy generally requires the committees to review each incident within 30 days of occurrence.

Levels of Use-of-Force Review – Deadly Force (Statewide)

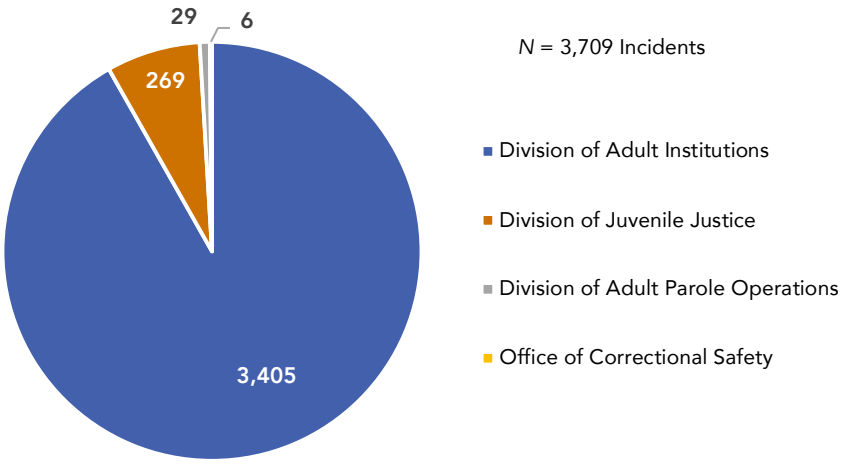
Deadly Force Investigation Team: Trained investigators from the Office of Internal Affairs conduct criminal and administrative investigations for every use of deadly force (except for certain types of warning shots inside of an institution) and every death or great bodily injury that could have been caused by a staff use of force. The OIG monitors these types of investigations as part of its discipline monitoring function and reports on the results semiannually.

Deadly Force Review Board: The board is responsible for conducting a full and complete review of all incidents involving a use of deadly force (except for certain types of warning shots) and every death or great bodily injury that could have been caused by a staff use of force, regardless of whether the incident occurred in an institutional or community setting. The board consists of at least four members, three of whom are law enforcement experts outside of the department and another high-ranking official from the department. The OIG monitors all incidents reviewed by the board as part of its discipline monitoring function and reports on the results semiannually.

Number of Use-of-Force Incidents and Type of Force Applied

As Figure 1 on the following page illustrates, the vast majority of force incidents we monitored occurred within the adult institutions. However, we also monitored use-of-force incidents in juvenile facilities, privately operated facilities contracted by the department to house adult inmates, and in the communities where offenders were on parole. Finally, we monitored the few instances of force applied by the department's Office of Correctional Safety which, among other things, acts as a liaison with other law enforcement entities and apprehends fugitives in the community. In total, we monitored 3,709 use-of-force incidents for which the department completed its review between July 1, 2017, and December 31, 2017.

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



Source: Office of the Inspector General's Tracking and Reporting System for the period July 1, 2017, through December 31, 2017.

As part of the 3,709 use-of-force incidents that we monitored, officers used 11,046 "applications" of force, defined as separate force actions. For instance, when an officer uses two bursts of oleoresin capsicum (commonly known as pepper spray or OC), each burst counts as a separate application of force. Likewise, if an officer strikes an inmate with a baton multiple times, we count each strike as a separate application of force. Thus, several applications of force can occur in each use-of-force incident.

Table 1 on the following page summarizes the number of incidents and applications of force, as well as the number of staff and inmates involved. Because of the relative size of the Division of Adult Institutions, the vast majority of incidents—about 89 percent—occurred at the adult institutions (3,307 out of 3,709). The next highest frequency of incidents occurred at the juvenile facilities. Comparatively, far fewer incidents occurred at the contract locations, parole regions, and the Office of Correctional Safety. For a more detailed examination of this data, including a breakdown of each location, refer to Appendix A.

Table 1. Numbers of Use-of-Force Incidents Involving Staff, Inmates, Wards, or Parolees

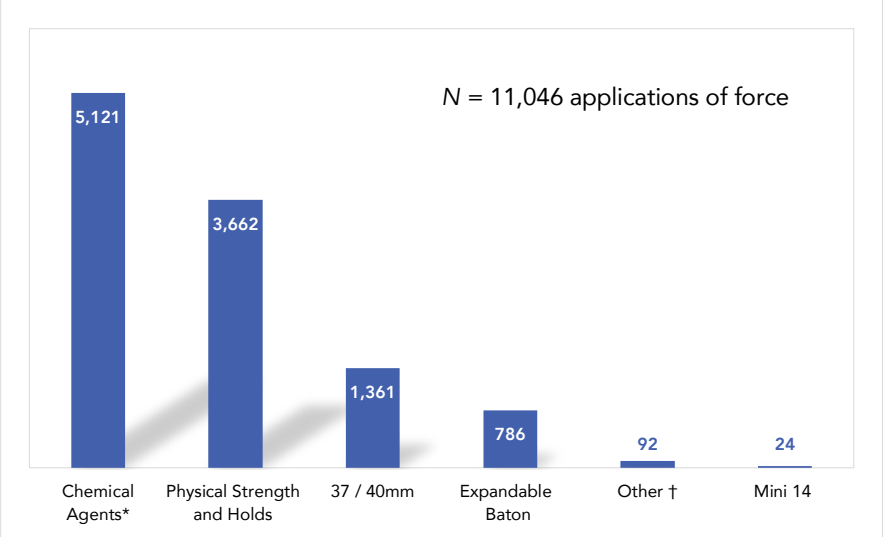
Institution	Number of:			
	Use-of-Force Incidents	Applications of Force	Staff Who Applied Force*	Inmates, Wards, or Parolees Force Applied to*
Adult Institutions	3,307	9,900	7,647	5,986
Contract Beds: Community Correctional Facilities (in California)	39	90	62	71
Contract Beds: Out of State	59	202	107	168
Juvenile Facilities	269	766	481	703
Parole Regions	29	77	73	29
Office of Correctional Safety	6	11	10	6
Totals	**3,709**	**11,046**	**8,380**	**6,963**

* The OIG counted the name of each staff member and inmate every time they were involved with a use-of-force incident. Therefore, we counted several of the staff and inmates more than once.

Source: Office of the Inspector General's Tracking and Reporting System for the period July 1, 2017, through December 31, 2017.

For all incidents we monitored, officers used about three applications of force per incident. When staff used force during this period, the most prevalent method of force entailed the use of chemical agents—predominantly pepper spray. As illustrated in Figure 2 on the following page, staff used chemical agents in 5,121 of the 11,046 applications of force (46 percent). Physical strength and holds (referring to when an officer uses any part of his or her body as force) were the next most common use, with 3,662 applications. Officers used other methods with less frequency, such as the use of deadly force (Mini 14 rifle).

Figure 2. Distribution of the Applications of Force in 3,709 Incidents



* Chemical agents include oleoresin capsicum (OC) (4,738), CN (240), pepper ball launcher (135), and sting ball grenades (8).

† Other includes the use of a shield (54), nonconventional uses (29), and a taser (9).

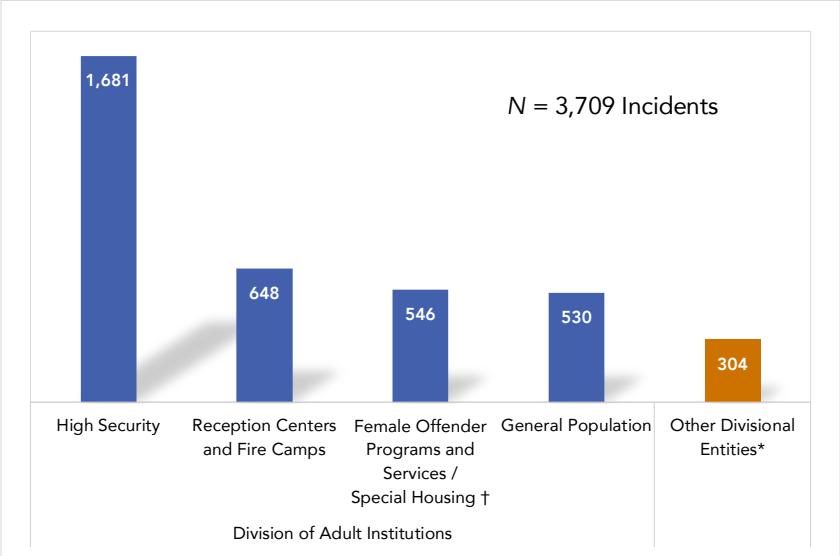
Source: Office of the Inspector General's Tracking and Reporting System for the period July 1, 2017, through December 31, 2017.

Institutions With the Highest Frequency of Force Incidents

On the next page, Figure 3 compares the distribution of the 3,709 use-of-force incidents among the department's institutional missions and with the other divisional entities. All but a few hundred occurred within the adult institutions and contract facilities. Not surprisingly, the largest portion of the incidents—1,681 of the 3,709 (45 percent)—took place within the institutions in the department's high-security mission group, wherein the department houses the most violent and dangerous male offenders.[7] On further analysis, the data reveal that within this same mission group, five prisons—California State Prison, Corcoran (304); California State Prison, Sacramento (271); Kern Valley State Prison (207); California Correctional Institution (207); and Salinas Valley State Prison (204)—account for nearly one-third of the 3,709 incidents. For additional detail, refer to Appendix A.

[7] The department groups the institutions into one of four mission-based disciplines: (1) reception centers and camps, (2) general population, (3) female offender programs and services/special housing, and (4) high security. The department organizes contract facilities in the female offender programs and services/special housing mission.

Figure 3. Use-of-Force Incidents, by Mission Within the Division of Adult Institutions and by Other Divisional Entities



* Other Divisional Entities include the Division of Adult Parole Operations, the Division of Juvenile Justice, and the Office of Correctional Safety.

† The mission encompassing the category of female offender programs and services/special housing facilities includes contract facilities that are located both in- and outside of California.

Source: Office of the Inspector General's Tracking and Reporting System for the period July 1, 2017, through December 31, 2017.

Table 2, on the following page, lists the most common locations in which use-of-force incidents occurred. As expected, locations within the high-security mission experienced the most activity. Facility B at California State Prison, Sacramento, topped the list with 51 incidents, followed by Facility A at California Correctional Institution with 38 incidents. Facility A at Mule Creek State Prison, which housed inmates with mental health conditions (as identified by the department), had 33 incidents. Several institutions had more than one location on the list, including California State Prison, Sacramento; California Correctional Institution; and California State Prison, Los Angeles County. One of the department's juvenile facilities, the O. H. Close Youth Correctional Facility, made the list with 28 incidents. All of these locations, with the exceptions of Mule Creek State Prison and the O. H. Close Youth Correctional Facility, are part of the department's high-security mission.

Table 2. The Most Common Locations of Force for Incidents We Monitored

Institution	Location	Number of Use-of-Force Incidents
California State Prison, Sacramento	Facility B	51
California Correctional Institution	Facility A	38
Mule Creek State Prison	Facility A	33
California Correctional Institution	Facility B	32
Kern Valley State Prison	Facility D	31
Salinas Valley State Prison	Facility D	30
California State Prison, Sacramento	Facility C	29
O. H. Close Youth Correctional Facility	School Area	28
California State Prison, Los Angeles County	Facility B	27
California State Prison, Los Angeles County	Facility C	27

Source: Office of the Inspector General's Tracking and Reporting System for the period July 1, 2017, through December 31, 2017.

Scope and Methodology

In this report, the OIG presents its evaluation of the use-of-force incidents we monitored and for which the department completed a review from July 1, 2017, through December 31, 2017. To evaluate the effectiveness of the department's process of handling use-of-force incidents and its compliance with policies and procedures, our staff carefully reviewed various laws, rules, and regulations relevant to use-of-force practices. We also reviewed the department's use-of-force policy and related training modules, and other applicable operational policies.

To determine whether institutions properly assessed use-of-force compliance, OIG inspectors visited every adult and juvenile institution as well as the northern and southern parole regions, and attended 778 of the 825 (94 percent) review committee meetings held during this period. Our inspectors reviewed and analyzed 4,001 separate incidents and allegations concerning the use-of-force (3,709 use-of-force incidents and 292 allegations of unnecessary force). For each of these incidents, our inspectors reviewed all written reports and documentation and, when applicable, viewed all video recordings of both related incidents and interviews. We then independently determined whether staff actions

were reasonable under the circumstances and were within the bounds of the department's policy and training. Finally, although OIG inspectors served as "nonvoting" attendees at a review committee meeting, they did provide real-time feedback and recommendations on compliance-related matters to committee chairs, when necessary.

The department conducted inquiries into the 292 allegations of unnecessary force and found that in two instances, officers made inappropriate contact with an inmate, and that both instances warranted corrective action. In one instance, an officer tapped an inmate on her shoulder with a flashlight in an attempt to get her attention, and in the other instance, an officer tapped an inmate's foot to get her attention. In 13 of the 292 allegations, the department determined the officers' actions to be inadvertent, did not consider them to be use-of-force incidents, and took no action. Inmates withdrew their complaints in 32 of the 292 allegations, and in the remaining 245 allegations, the department found insufficient evidence to support a reasonable belief that misconduct had occurred and took no further action concerning the allegations of unnecessary force. For three of the allegations, we did not believe the inquiry was thorough enough for the respective warden to make a determination and voiced our concerns to the wardens at the review committee meeting; however, the wardens disagreed with our position. We plan to explore the inquiry process in more depth in future reports.

To determine whether the department executive review committees (for adult institutions) and the department force review committees (for juvenile facilities) properly assessed force incidents, inspectors attended all meetings (11 and 6, respectively) about which the committees notified us during the six-month period.

To evaluate the implementation of statewide de-escalation training, inspectors observed the MILO simulator at several institutions. The OIG was impressed with the techniques offered as part of this training simulator and was pleased with the level of participation from departmental staff.

To ensure the department had information to monitor trends in a timely manner, inspectors provided monthly reports that drew from the data we collected to each warden summarizing all incidents involving staff who used force that we reviewed. The summary data included the name of each staff member who used force, the frequency of force used by that staff member, and whether the force resulted in injuries. We provide another report to the wardens indicating the locations within the institution concerning use-of-force incidents and their relative frequency.

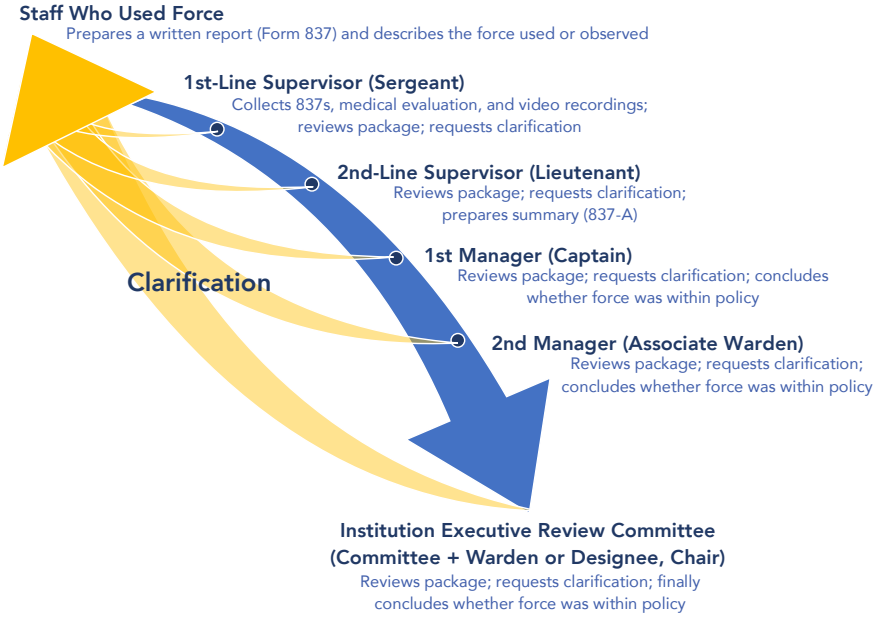
To understand the department's recently developed system for tracking uses of force, called the Incident Report Tracking SharePoint (the tracking system), inspectors met with various departmental officials to obtain a brief overview of its functionality. According to the department, it implemented the tracking system on October 1, 2017. OIG inspectors collected and reviewed sample reports from the system; however, we did not utilize or rely on any part of it for the purpose of this review. We plan to monitor the department's efforts to identify and analyze use-of-force trends in future reports.

Monitoring Results

Overall, the Department Performed Well in Self-Assessing Compliance With Its Use-of-Force Policy, yet the Rate of Noncompliance It Found Remains a Concern

The department's use-of-force policy requires staff to complete a thorough, multistep process to review and evaluate all uses of force. The review process involves a minimum of five levels of supervisory and managerial review and, on those occasions when staff use deadly force or cause serious injuries, another review at the department's executive level. This review process may involve more than a dozen individuals for every incident. The department generally requires that the review process be concluded within 30 days of the incident, given the critical nature of these issues and the severity of the potential negative outcomes. Figure 4 presents a general illustration of the steps the Division of Adult Institutions takes in its review process.

Figure 4. Flowchart Depicting the Division of Adult Institutions' Use-of-Force Review Process



Source: The Office of the Inspector General's analysis of the California Department of Corrections and Rehabilitation's processes.

The review process for the Division of Adult Institutions begins following any use of force: departmental policy requires that staff who use or observe force submit a written report prior to being relieved from duty at the end of the working shift. In general, reports should include a description of the inmate(s) actions and the officer(s) perception of the threat leading to the use of force, a description of the specific force used or observed, and a description of the inmate(s) level of resistance. The policy also requires that medical personnel evaluate and assess the extent of any injuries sustained during the event and thoroughly document their medical evaluation.

The incident response supervisor (who is typically a first-line supervisor, such as a sergeant) is responsible for collecting all the reports from staff who may have used or observed force. In this first level of review, the supervisor determines whether the reports contain the necessary information, then forwards the reports—including any medical assessments—to the next level of review.

At the second level of review, the incident commander (who is typically a second-level supervisor, such as a lieutenant) must review all of the reports for quality, accuracy, and content. The incident commander may ask staff to submit additional information if he or she determines the initial staff reports were not clear or complete in their descriptions. The incident commander is also responsible for providing an overall summary of the incident based on all reports submitted by staff and then analyzing their actions taken during the use of force to determine whether such actions complied with policy and training. The incident commander then moves the incident package along to the next reviewer.

At the third and fourth levels of review, managers who are at the captain and associate warden levels, respectively, review the incident package for content and sufficiency, and may request that staff clarify their individual reports, if needed. Each of these reviewers, in turn, independently determines compliance with both policy and training, and moves the reports along to the next level of review.

The fifth level of review occurs at the institution executive review committee meeting, which is chaired by the warden or chief deputy warden, or superintendent or assistant superintendent. Typically, institutions hold these meetings once every week. Other institutional managers also attend these meetings, in addition to a health care representative, and under certain circumstances, a mental health practitioner. The institution executive review committee reviews every reported use of force to determine whether each application of force was reasonable under the circumstances and whether staff complied with departmental policies and training. This committee also reviews every

allegation of unreasonable or unnecessary force, which may arise either directly in connection with use-of-force incidents or via inmates reporting on a separate basis.

During these meetings, if the institution executive review committee determines that staff reports remain unclear—even after the four previous levels of review—it may request additional clarifications from respective staff or conduct an internal fact-finding inquiry and re-review the incident at a subsequent meeting. Ultimately, the institution executive review committee chair determines whether the force used and the staff's actions were within policy.

If the chair determines staff actions were out of policy, he or she may order corrective action, which could include training, a letter of instruction, or counseling. For more serious policy violations (or repeated violations), the chair may refer the matter to the department's Office of Internal Affairs for an investigation or request to impose adverse action directly.

The Department's Self-Assessment of Compliance With Its Use-of-Force Policy

Between July 2017 and December 2017, the OIG reviewed and analyzed 3,709 staff-reported use-of-force incidents. These incidents predominantly occurred in a prison setting, but some occurred in the juvenile facilities or in a community setting.

The OIG groups policy determinations into three primary categories:

1. "Actual force" that refers to the force itself.
2. "Apart from the actual force" that refers to the department's policies and training encompassed within the use-of-force policy, excluding the force itself. Common examples of this include the completion of medical assessments and assessment forms, the timely completion of forms following an incident, requirements with video recording interviews, and various protocols leading up to a controlled use of force.
3. "Non-use of force" that refers to actions covered by departmental policy, unrelated to the use-of-force policy or use-of-force training. Examples include procedures related to using holding cells, escorting prisoners, and responding to alarms.

Source: Office of the Inspector General.

Overall, the department determined that its staff completely followed policy in only 1,935 out of 3,709 incidents (52 percent) that we monitored during this period, as depicted in Table 3. On the one hand, the OIG agreed with the vast majority of the review committees' decisions in these incidents. On the other hand, in the OIG's opinion, some type of policy violation was present for 46 of the incidents for which the department concluded its staff did follow policy. Nevertheless, we are pleased that the overall rate of concurrence between the department and the OIG is so high.

When evaluating force in relation to departmental policy, the OIG groups decisions into three primary categories (see box, previous page): (1) *actual force*, referring to the force itself; (2) *apart from the actual force*, referring to requirements encompassed within the use-of-force policy, but not the force itself; and (3) *non-use of force*, referring to actions covered under departmental policy, unrelated to the use-of-force policy or use-of-force training. These categories help provide some measure of context to overall compliance rates.

Table 3. Number of Incidents a Review Committee Determined Were in or out of Policy Compliance

Category	Number of Incidents Deemed In Policy by Committee	Number of Incidents With at Least One Policy Violation	Percentage of Incidents Deemed In Policy by Committee	Percentage of Incidents With at Least One Policy Violation	Number of Incidents Where the OIG Did Not Concur with Committees' In-Policy Decision
Actual Force	3,612	97	97%	3%	26
Apart From Force	2,328	1,381	63%	37%	41
Non-Use of Force	3,076	633	83%	17%	8
Overall*	**1,935**	**1,774**	**52%**	**48%**	**46**

* The values in the overall row represent unique incidents. Several of the values in the three categories overlap; therefore, to account for unique incidents, we counted an incident only once.

Source: Office of the Inspector General's Tracking and Reporting System for the period July 1, 2017, through December 31, 2017.

The department determined that it followed policy with the *actual force* requirements in 97 percent of the incidents, which represents nearly all of the incidents. The OIG predominantly agreed with the department's review committees' decisions, but determined 26 of the 3,612 incidents had at least one policy violation relevant to this category. In addition, the department determined that it followed policy with the *apart from the*

actual force requirements in 63 percent of the incidents, the lowest compliance rate of the OIG's three categories. Again, the OIG agreed with most of these determinations, but determined 41 of the 2,328 incidents had at least one violation of policy relevant to this category. Finally, the department determined that it followed policy with the *non–use-of-force* requirements in 83 percent of the incidents. The OIG mostly agreed, but determined 8 of the 3,076 incidents had at least one policy violation relevant to this category. Many of the incidents had more than one policy violation within a particular category, and some incidents had policy violations in more than one category. For additional detail, see Appendix B.

The Department Most Often Prescribed Training for Policy Violations, but, in Some Instances, It Took Additional Forms of Corrective and Adverse Actions

Overall, the department identified policy violations in 1,774 of the 3,709 incidents (48 percent); however, in general, it determined that staff required additional training for the deficiencies it identified. In fact, it required training for the staff involved with at least 1,685 of the 1,774 out-of-policy incidents, or 95 percent.

Furthermore, the department took other corrective action by counseling staff in 111 of the 1,774 out-of-policy incidents (6 percent). Finally, the department took disciplinary action for staff misconduct in 16 of the 1,774 incidents (about 1 percent), while referring another 18 incidents (about 1 percent) to the Office of Internal Affairs for consideration of further investigation. The OIG monitors and reports on the investigations conducted by the Office of Internal Affairs, including any resulting disciplinary determinations, semiannually.

The Department Recently Implemented a Statewide Use-of-Force Tracking System

According to the department, it began tracking the use of force in a statewide data system in October 2017. Prior to that date, the department did not have a data collection process comparable to that used by the OIG. We met with departmental officials about the tracking system and obtained a basic understanding of its functions. The system, called the Incident Report Tracking SharePoint (the tracking system), periodically receives an upload of data from another data source, the department's daily information reporting system, which serves as a repository for all reportable incidents occurring at each institution. Staff from each institution can enter supplemental data pertaining to incidents into the

tracking system by using a standardized input process, although each institution can view only its own data. The system can display force incident-related information concerning individual staff members and inmates, the type of force used, the results of the use of force, and corrective action taken (if applicable). According to the department, the tracking system will provide it with the ability to identify trends, create reports, and provide real-time data to its users. We believe this is a helpful start for tracking incidents, and we will monitor how wardens and executive staff use this information.

Officers Did Not Always Articulate a Threat That Necessitated Force, and in Some Instances, Their Own Actions May Have Contributed to the Need to Use Force

The department allows officers to use immediate force when an imminent threat jeopardizes the safety of persons or compromises the security of the institution. Its policy further requires that officers clearly articulate in their use-of-force reports the threat that necessitated their actions. Despite this requirement, officers did not adequately articulate an imminent threat in 68 incidents (1.8 percent), leading us to question whether the force actions were necessary. Although this is a very low percentage in relative terms, any instance of unnecessary force could represent a critical issue for staff, inmates, and the department. When officers engage in unnecessary force, it can increase tension between staff and inmates. Officers' failure to articulate their need to use force may also expose the department to legal liability.

Some Officers Did Not Articulate a Threat That Necessitated Force

The department self-identified unnecessary force in 44 of these 68 incidents and took a number of actions to address the issues, ranging from training to formal discipline. We found another 24 instances of potential unnecessary force and raised our concerns during the review committee meetings. We recognize the difficulty of making split-second decisions in these types of incidents; it is much easier to second-guess staff members' actions after the fact. Yet these events serve as a reminder of how dangerous it can be to work in a prison setting, how quickly situations can escalate, and how important it is for staff to remain vigilant and aware at all times.

In one example, an inmate refused an officer's orders to hand over a piece of paper that he received from another inmate. Despite being told to relinquish the piece of paper, the inmate instead walked to his cell and attempted to flush the paper down the toilet. The officer then sprayed the inmate with pepper spray. This initial force action did not stop the inmate from his attempt to flush the toilet, so the officer used physical force and a second burst of pepper spray to prevent the inmate from flushing the toilet. The warden determined there was no imminent threat to the safety of persons or the security of the institution and imposed formal discipline on the officer for his unnecessary use of force.

In a second example, an inmate refused an officer's request to provide his identification and turned to walk away from the officer, while making a derogatory comment. The inmate refused the officer's order to stop walking, resulting in the officer grabbing the inmate from behind and forcing him to the ground. The warden determined there was no imminent threat to the safety of persons or the security of the institution and imposed formal discipline on the officer.

One incident resulted due to a difference of opinion between an inmate and a sergeant. The inmate was located in an inmate-restricted area and refused the sergeant's order to provide identification. The inmate walked away, cursing at the sergeant, but after a yard alarm sounded, the inmate stopped walking and sat down on the ground. The inmate continued to yell at the sergeant while on the ground and, according to the officer, "flared her arms and body around while screaming (at the sergeant)." The sergeant grabbed the seated inmate's wrist to apply handcuffs and then forced the inmate to a prone position on the ground when, according to the sergeant, the inmate attempted to stand. The OIG opined that the inmate, sitting on the ground, albeit yelling and flailing her arms, neither presented an imminent threat to the sergeant or to other persons, nor any threat to the security of the institution. We suggested to the committee chair that the sergeant had options to de-escalate the situation and that the initial force of grabbing the inmate to apply handcuffs was unnecessary. The prison's management requested further information from the sergeant, ultimately concurred that the use of force was unnecessary, and prescribed training for the sergeant.

In another case, a 76-year-old, mobility-impaired inmate with a walker had just been in an altercation with another inmate. Officers used pepper spray and a baton on the other inmate, stopping the fight and causing the other inmate to get down on the ground. An officer wrote in his report that he ordered the elderly inmate to "get down," to which the inmate replied, "What did I do?" The officer further stated that because the inmate "was just involved in a physical confrontation and had not yet complied with any orders to get down, I felt he was still a threat to [the other inmate] as well as a threat to my partners," he sprayed the inmate with pepper spray. Another officer wrote that he observed the first officer spray the elderly inmate to "effect custody," so he simultaneously pepper sprayed the elderly inmate, but did not articulate in his report any threat. The executive review committee reviewed a surveillance video recording of the incident, which indicated the elderly inmate was in the process of getting down when officers sprayed him.

We suggested, based on the video and the officer's reports, that there was no imminent threat to the safety of persons or the security of the institution. The committee chair disagreed with our position that the force was unnecessary and determined the officers' actions were in policy. The OIG requested a higher-level review with department executives, but that request was also denied.

In another case, an inmate argued with an officer and walked away after the officer informed the inmate that he was being moved to a different cell. The officer followed the inmate, who placed his back against a wall and placed his arms behind his back, while refusing the officer's orders to submit to handcuffs. The officer wrote, "After repeatedly disobeying direct orders, I reached for his right bicep in an effort to turn him around to handcuff him." In this case, the officer's report did not articulate that the inmate's refusal constituted an imminent threat to anyone's safety or the security of the institution, nor did it articulate any efforts to de-escalate the situation. The committee chair disagreed with our position and determined the officer's force was within policy.

In a Few Instances, Officers May Have Contributed to the Need for Using Force

Moreover, the actions of officers in 47 of the 3,709 (1 percent) incidents unnecessarily contributed to the need to use force. Although this is a very low percentage of occurrences, these instances could have had potentially serious consequences. While we recognize that results from these actions could not have been easily foreseen, the department should examine these types of events so that it can train staff to better recognize warning signs before harmful events materialize. Even though these officers may not have intended to use force at the time of their initial actions, their actions were nevertheless contributing factors to the outcome. The review committees identified most of these cases and took actions ranging from training to disciplinary action.

In one incident, for example, an officer prematurely released an unrestrained inmate from a medical holding cell after the inmate had been cursing and yelling at the officer and other inmates. The inmate attacked the officer, requiring physical force and chemical agents to stop the attack. The inmate and two officers sustained minor injuries, and the inmate alleged the officer used unreasonable force during the incident. The warden did not sustain the allegation of unreasonable force, but imposed discipline on the officer for unnecessarily removing the agitated, unrestrained inmate from the holding cell. The officer should have recognized that, based on the inmate's demeanor, releasing him from his cell unnecessarily endangered himself and others.

In another incident, a control booth officer failed to ensure the dayroom of the housing unit was clear of inmates prior to releasing an inmate from his cell. Another inmate—whom the control booth officer did not see on the dayroom floor—attacked the inmate as he exited his cell, resulting in the control booth officer using a form of less-lethal force to stop the fight. This force did not result in any injuries to the inmates, but the victim did sustain minor injuries resulting from the attack. The warden provided corrective action to the control booth officer due to his failure to follow policy requiring close supervision and coordination of inmate movement on the housing unit floor.

We identified two additional incidents as part of our real-time monitoring efforts and recommended to the respective wardens that they provide additional training to those staff who were involved. In the first incident, an officer determined an inmate's necklace was contraband and asked the inmate to relinquish it; the inmate refused. The officer proceeded to search the inmate and tried to remove the necklace from the inmate's neck. The inmate turned on the officer and took a fighting stance. The officer used physical force to gain control of the inmate. We suggested that the officer's actions prior to the use of force likely contributed to the need for force and that he had options to de-escalate the situation. The warden agreed with our position and ordered training for the officer.

In the second incident, an inmate kicked his cell door and cursed at an officer while demanding to be released to the yard. Instead of notifying a supervisor, the officer opened the door, resulting in a confrontation with the inmate that required physical force. The OIG concluded the officer should have recognized the inmate's hostile behavior and the potential danger and notified a supervisor instead of releasing an agitated inmate from his cell. The warden agreed and provided training to the officer.

Furthermore, the OIG believed that officers contributed to the need to use force in two other cases, but the review committee disagreed with our determination. In one incident, officers observed an inmate on a mobile phone in his cell and opened the cell door to confront the inmate and retrieve the phone. The inmate's cellmate approached one of the officers with clenched fists, requiring physical force to gain control of the inmate. The OIG concurred that the force was appropriate to gain control of the inmate, but suggested that the officers contributed to the need to use force by unnecessarily opening the cell door. The warden disagreed and took no action.

In the second incident, while awaiting a decision for a controlled use of force, an officer positioned himself outside of an inmate's cell while the inmate held his arm outside of the food port. Twice, the inmate threw a cup of toilet water, striking the officer. The third time the inmate retrieved water from the toilet, the officer moved closer to the cell and sprayed the inmate with chemical agents through the food port. Based on the officer reports and the housing unit video recording, the OIG asserted that the officer positioned himself in a manner that jeopardized his own safety and that he should have moved away from the front of the cell to wait for the controlled use-of-force team. Additionally, the officer could have closed the food port. The warden disagreed with our conclusions and took no action.

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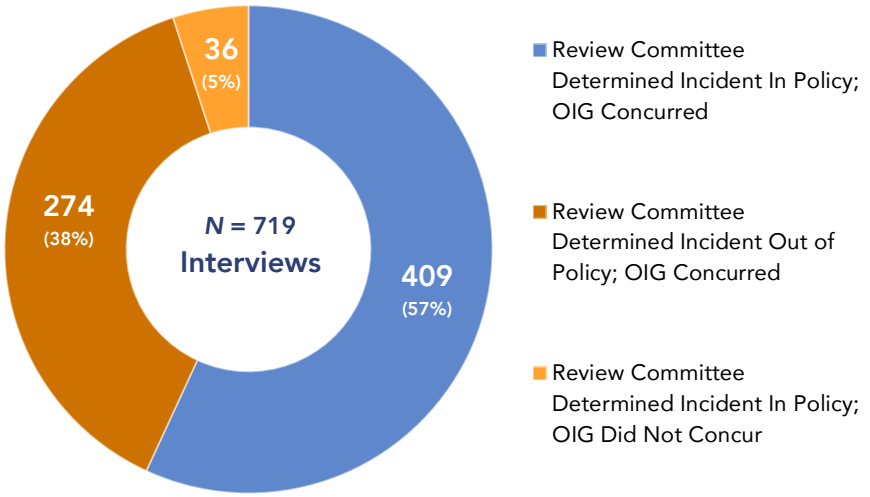
Officers Did Not Always Adhere to Policy When Conducting Video-Recorded Interviews of Inmates

The department requires staff to video record an interview with inmates who allege unnecessary or excessive force or who sustain serious or great bodily injury possibly due to the use of force. The department's policy requires staff to conduct the interview as soon as possible, but no later than 48 hours from the date of discovery of the injury or allegation. The policy further requires that any visible or alleged injuries be documented on the recording and specifies that the interviews be conducted only by custodial supervisors—such as sergeants or lieutenants—who did not themselves use or observe the force during the incident. The policy also requires supervisors not inhibit or discourage the inmate from providing relevant information.

Figure 5, on the next page, displays the number of interviews the review committees found in- and out-of-compliance with video-recording policies along with the opinion of the OIG. The department's review committees found that staff actions in only 445 of the 719 video-recorded interviews we monitored fully complied with policy.[8] This represents a compliance rate of only 62 percent. The review committees found at least one instance of noncompliance in each of the remaining 274 interviews. The OIG determined from its review that an additional 36 interviews had at least one policy violation; however, the review committees did not agree with our conclusions. After factoring the additional instances of noncompliance that we identified, the department's overall compliance rate effectively dropped to 57 percent (409 of 719). The most common types of violation resulted from untimely interviews and the failure to document the inmate's injuries on the video recording. Staff's failure to document evidence in a timely manner that could support, or refute, the inmates' allegations ultimately impairs the department's ability to take prompt action.

[8] Of the 719 video-recorded interviews, 292 of them arose from allegations of unnecessary force that were not associated with a staff-reported use-of-force incident.

Figure 5. Departmental Compliance With Video-Recorded Interviews



Source: Office of the Inspector General's Tracking and Reporting System for the period July 1, 2017, through December 31, 2017.

The OIG has presented this concern in past reports, but the issues we raised have not been fixed. In March 2017, after we published the low video-recording compliance rate of 61 percent for the July-through-December-2016 period, the department directed additional training for all custodial supervisors and managers on the video-recording requirements. However, the timing of this training did not help the department's compliance rate for the next six-month period. Specifically, during the period covering January through June 2017, the compliance rate continued to drop, falling another three percentage points, to 58 percent. Even after allowing for enough time to pass so that institutional supervisors and managers could complete the necessary training, the compliance rate did not materially improve. We believe the department should take additional measures to track violations and consider progressive discipline for staff who repeat their mistakes.

The Department Identified Many Policy Violations Involving Controlled Uses of Force

The department defines the controlled use of force as "the force used in an institutional or facility setting when an inmate's presence or conduct poses a threat to safety or security, and the inmate 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 institution security."[9] A controlled use of force involves advance planning, staffing, and organization; it also requires both the authorization and the presence of a first- or second-level manager (or an administrator-of-the-day during nonbusiness hours), and a video recording of the incident.

A common example of when an institution might authorize a controlled use of force is when an inmate refuses to exit his or her cell after being told he or she is transferring to another institution. Policy allows officers to use controlled force to remove the inmate from a cell to facilitate a transfer. Officers may also use controlled force when staff must administer medications, provide medical treatment, or complete mandated testing. Compared with immediate uses of force, controlled uses of force occur very infrequently.

During this reporting period, the OIG monitored 61 controlled use-of-force incidents. More than 93 percent of these incidents involved an inmate who, at the time of the incident, was participating in the department's mental health services delivery system. The department's review committees found staff violated policy in 46 of the 61 incidents, a 75 percent rate of noncompliance. The review committees found all 46 of the incidents out of compliance with elements "apart from the actual force" and also found three incidents among the 46 out of compliance during the actual application of force.

In one incident, staff conducted a controlled use of force during which they entered a cell because an inmate refused to take court-ordered medication. Officers used physical force to restrain the inmate while medical staff administered the medication. The review committee identified that an officer was not assigned to monitor the inmate during the cool-down period, the mental health practitioner did not adequately address the inmate's mental health issues during the cool-down period, nursing staff failed to note a review of the inmate's health record during

[9] Article 2, Use of Force, *California Department of Corrections and Rehabilitation, Adult Institutions, Programs, and Parole Operations Manual*, p. 326.

The most frequent types of policy violations the review committees found included the following:

- Not properly identifying on the video recording all staff involved in the controlled use of force (24 incidents).
- Not having required staff safety or medical equipment present during the incident (15 incidents).
- Not identifying on the video recording the type of chemical agents used (11 incidents).
- Not including the date and time on the video recording of the incident (9 incidents).
- Not assigning an officer to observe the inmate during the cool-down period (9 incidents).

Source: Office of the Inspector General.

the cool-down period, the incident commander did not articulate the tactical plan for the entry, the camera operator did not ensure that the date and time appeared on the video recording, and the camera operator inappropriately recorded the medical evaluation following the incident. The warden ordered training for staff whose actions fell short of expectations.

In another incident, an inmate who was a participant in the mental health services delivery system refused to leave a shower area. A sergeant used two applications of pepper spray during the incident to compel the inmate to comply. The review committee identified that the sergeant and lieutenant were not wearing required safety equipment during the incident and ordered training for them. The OIG identified additional deficiencies, including not posting an officer near the shower area to monitor the inmate once managers had determined the necessity of a controlled use of force, not ensuring that the date and time appeared on the video recording, failing to provide the required admonishment to the inmate that custody would use force to complete the extraction, and failing to remain at the shower and monitor the inmate after staff had deployed pepper spray. In addition, OIG inspectors identified that a nurse disagreed with the strategies to remove the inmate, but the captain did not elevate the disagreement to the appropriate managers for input. The warden agreed with the OIG and ordered training for the involved staff.

Recommendations

We are encouraged that the department has recently implemented the new tracking system and anticipate that departmental staff will be able to utilize its capabilities to improve overall compliance with departmental use-of-force policies and standards.

We are also pleased with the department's use of the MILO training to improve correctional officers' communication skills and de-escalation techniques as a means of curtailing use-of-force incidents.

We recommend that the department pursue the following actions:

- To optimize the use of the department's recently implemented use-of-force tracking system, the department should:
    - Determine which types of use-of-force management reports best suit its executive staff and local hiring authorities' needs,
    - Routinely analyze the use-of-force data at the headquarters' level for trends,
    - Monitor staff who frequently use force or who were found to have frequently violated use-of-force policies, and
    - Track the corrective or adverse actions hiring authorities impose on their staff.
- To increase the overall rate of compliance with use-of-force policies and procedures, the department should:
    - Focus its training curriculum on the most common and serious types of violations identified from the new tracking system,
    - Consider stronger progressive discipline for staff who repeatedly violate use-of-force policies, and
    - Hold supervisors and managers accountable when their staff repeatedly violate use-of-force policies.

- To ensure that staff understand how to properly carry out video-recorded inmate interviews during the course of their job duties, the department should reevaluate the training it offers to them on the correct procedure to follow when conducting these interviews.

- To ensure that staff adhere to policies that pertain to the controlled use of force, the department should reevaluate its training curriculum, provide additional training to staff, and select for participation in controlled use-of-force incidents only those who have completed additional training.

Appendices

Appendix A: Detail of Use-of-Force Incidents

Facility	Number of:			
	Use-of-Force Incidents	Applications of Force	Staff Who Applied Force*	Inmates, Wards, or Parolees Force Applied to*
Adult Institutions	**3,307**	**9,900**	**7,647**	**5,986**
Avenal State Prison	21	40	34	45
California City Correctional Facility	22	56	41	58
Calipatria State Prison	127	325	254	289
California Correctional Center	53	204	129	103
California Correctional Institution	207	738	507	490
Central California Women's Facility	134	291	265	204
Centinela State Prison	65	198	136	139
California Health Care Facility	141	506	451	156
California Institution for Men	27	50	34	66
California Institution for Women	68	200	158	100
California Men's Colony	84	204	172	125
California Medical Facility	77	249	226	96
California State Prison, Corcoran	304	897	719	490
California Rehabilitation Center	18	36	24	46
Correctional Training Facility	12	34	24	18
Chuckawalla Valley State Prison	5	10	9	8
Deuel Vocational Institution	69	193	144	141
Folsom State Prison	28	94	74	52
High Desert State Prison	148	529	389	348
Ironwood State Prison	30	88	62	45
Kern Valley State Prison	207	586	456	409
California State Prison, Los Angeles County	197	615	471	315
Mule Creek State Prison	152	538	417	228
North Kern State Prison	85	173	145	150
Pelican Bay State Prison	25	105	66	53
Pleasant Valley State Prison	42	98	92	76
Richard J. Donovan Correctional Facility	119	293	248	177
California State Prison, Sacramento	271	838	648	493
California State Prison and Substance Abuse Treatment Facility	96	233	176	154
Sierra Conservation Center	22	72	52	44
California State Prison, Solano	57	225	137	100

Continued on next page.

Facility	Number of:			
	Use-of-Force Incidents	Applications of Force	Staff Who Applied Force*	Inmates, Wards, or Parolees Force Applied to*
California State Prison, San Quentin	75	288	166	145
Salinas Valley State Prison	204	638	509	438
Valley State Prison	19	38	33	27
Wasco State Prison	96	218	179	158
Contract Beds Unit: Community Correctional Facilities (California)	**39**	**90**	**62**	**71**
Central Valley Modified Community Correctional Facility	0	0	0	0
Delano Modified Community Correctional Facility	19	40	28	34
Desert View Modified Community Correctional Facility	0	0	0	0
Golden State Modified Community Correctional Facility	1	6	4	1
McFarland Female Community Reentry Facility	1	1	1	1
Shafter Modified Community Correctional Facility	16	41	27	33
Taft Modified Community Correctional Facility	2	2	2	2
Contract Beds Unit: Out of State	**59**	**202**	**107**	**168**
La Palma Correctional Center	31	115	55	102
Tallahatchie County Correctional Facility	28	87	52	66
Juvenile Facilities	**269**	**766**	**481**	**703**
N. A. Chaderjian Youth Correctional Facility	128	388	246	297
O. H. Close Youth Correctional Facility	93	243	130	269
Pine Grove Youth Conservation Camp	1	13	4	28
Ventura Youth Correctional Facility	47	122	101	109
Parole Regions	**29**	**77**	**73**	**29**
North	15	30	29	15
South	14	47	44	14
Office of Correctional Safety	**6**	**11**	**10**	**6**
Grand Total	**3,709**	**11,046**	**8,380**	**6,963**

* The OIG counted the name of each staff member and inmate every time they were involved with a use-of-force incident. Therefore, we counted several of the staff and inmates more than once.

Source: Office of the Inspector General's Tracking and Reporting System for the period July 1, 2017, through December 31, 2017.

Appendix B: Detail of Policy Violations as Determined by the Department, Grouped by OIG Category

Facility	Number of Incidents	Number of Incidents Out of Policy: Apart From Use of Force	Out of Policy: Apart From Use of Force (%)	Number of Incidents Out of Policy: Actual Use of Force	Out of Policy: Actual Use of Force (%)	Number of Incidents Out of Policy: Non-Use of Force	Out of Policy: Non-Use of Force (%)
Adult Institutions	**3,307**	**1,209**	**37%**	**68**	**2%**	**587**	**18%**
Avenal State Prison	21	7	33%	1	5%	3	14%
California City Correctional Facility	22	17	77%	2	9%	15	68%
Calipatria State Prison	127	41	32%	4	3%	11	9%
California Correctional Center	53	27	51%	2	4%	17	32%
California Correctional Institution	207	49	24%	3	1%	37	18%
Central California Women's Facility	134	61	46%	5	4%	24	18%
Centinela State Prison	65	8	12%	0	0%	7	11%
California Health Care Facility	141	37	26%	3	2%	2	1%
California Institution for Men	27	7	26%	0	0%	5	19%
California Institution for Women	68	19	28%	5	7%	14	21%
California Men's Colony	84	72	86%	0	0%	19	23%
California Medical Facility	77	50	65%	0	0%	15	19%
California State Prison, Corcoran	304	173	57%	11	4%	83	27%
California Rehabilitation Center	18	5	28%	0	0%	2	11%
Correctional Training Facility	12	3	25%	0	0%	3	25%
Chuckawalla Valley State Prison	5	1	20%	0	0%	0	0%
Deuel Vocational Institution	69	17	25%	1	1%	35	51%
Folsom State Prison	28	7	25%	2	7%	2	7%
High Desert State Prison	148	29	20%	4	3%	26	18%
Ironwood State Prison	30	3	10%	1	3%	5	17%
Kern Valley State Prison	207	67	32%	0	0%	18	9%
California State Prison, Los Angeles County	197	49	25%	1	1%	23	12%
Mule Creek State Prison	152	73	48%	4	3%	21	14%
North Kern State Prison	85	25	29%	0	0%	15	18%
Pelican Bay State Prison	25	4	16%	0	0%	2	8%
Pleasant Valley State Prison	42	9	21%	2	5%	5	12%
Richard J. Donovan Correctional Facility	119	26	22%	3	3%	21	18%
California State Prison, Sacramento	271	79	29%	3	1%	74	27%
California State Prison and Substance Abuse Treatment Facility	96	45	47%	5	5%	24	25%
Sierra Conservation Center	22	17	77%	0	0%	5	23%
California State Prison, Solano	57	32	56%	0	0%	5	9%

Continued on next page.

Facility	Number of Incidents	Number of Incidents Out of Policy: Apart From Use of Force	Out of Policy: Apart From Use of Force (%)	Number of Incidents Out of Policy: Actual Use of Force	Out of Policy: Actual Use of Force (%)	Number of Incidents Out of Policy: Non-Use of Force	Out of Policy: Non-Use of Force (%)
California State Prison, San Quentin	75	55	73%	2	3%	21	28%
Salinas Valley State Prison	204	53	26%	4	2%	17	8%
Valley State Prison	19	9	47%	0	0%	6	32%
Wasco State Prison	96	33	34%	0	0%	5	5%
Contract Beds Unit: Community Correctional Facilities (California)	**39**	**8**	**21%**	**1**	**3%**	**7**	**18%**
Central Valley Modified Community Correctional Facility	0	0	N/A	0	N/A	0	N/A
Delano Modified Community Correctional Facility	19	1	5%	0	0%	2	11%
Desert View Modified Community Correctional Facility	0	0	N/A	0	N/A	0	N/A
Golden State Modified Community Correctional Facility	1	1	100%	0	0%	0	0%
McFarland Female Community Reentry Facility	1	0	0%	0	0%	1	100%
Shafter Modified Community Correctional Facility	16	5	31%	1	6%	3	19%
Taft Modified Community Correctional Facility	2	1	50%	0	0%	1	50%
Contract Beds Unit: Out of State	**59**	**36**	**61%**	**19**	**32%**	**22**	**37%**
La Palma Correctional Center	31	18	58%	9	29%	11	35%
Tallahatchie County Correctional Facility	28	18	64%	10	36%	11	39%
Juvenile Facilities	**269**	**121**	**45%**	**9**	**3%**	**17**	**6%**
N. A. Chaderjian Youth Correctional Facility	128	62	48%	3	2%	2	2%
O. H. Close Youth Correctional Facility	93	33	35%	4	4%	5	5%
Pine Grove Youth Conservation Camp	1	0	0%	0	0%	0	0%
Ventura Youth Correctional Facility	47	26	55%	2	4%	10	21%
Parole Regions	**29**	**7**	**24%**	**0**	**0%**	**0**	**0%**
North	15	3	20%	0	0%	0	0%
South	14	4	29%	0	0%	0	0%
Office of Correctional Safety	**6**	**0**	**0%**	**0**	**0%**	**0**	**0%**
Grand Totals	**3,709**	**1,381**	**37%**	**97**	**3%**	**633**	**17%**

Source: Office of the Inspector General's Tracking and Reporting System for the period July 1, 2017, through December 31, 2017.

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Monitoring the Use of Force

OFFICE *of the* INSPECTOR GENERAL

Roy W. Wesley
Inspector General

Bryan B. Beyer
Chief Deputy Inspector General

STATE *of* CALIFORNIA
July 2018

OIG