Amarik K. Singh, *Inspector General*

Neil Robertson, *Chief Deputy Inspector General*

OIG | OFFICE *of the* INSPECTOR GENERAL

Independent Prison Oversight

July 2023

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

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STATE of CALIFORNIA
OIG | OFFICE of the INSPECTOR GENERAL

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Neil Robertson, Chief Deputy Inspector General

Independent Prison Oversight

Regional Offices
Sacramento
Bakersfield
Rancho Cucamonga

July 3, 2023

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

Dear Governor and Legislative Leaders:

Enclosed is the Office of the Inspector General's report titled *Monitoring the Use-of-Force Review Process of the California Department of Corrections and Rehabilitation*. This is the Office of the Inspector General's sixth annual report, as mandated by California Penal Code sections 6126 (j) and 6133 (b) (1). This report addresses 890 of the California Department of Corrections and Rehabilitation's (the department) use-of-force incidents that occurred, and for which the department closed its review, between January 1, 2022, and December 31, 2022.

In this report, we present six monitored incidents in which we identified significant concerns. We include our findings based on several incidents in which officers did not adequately de-escalate a situation prior to using force. We also include our findings regarding the department's use of body-worn and fixed cameras. Finally, we provide an update to recommendations made in our prior reports regarding the department's supervisors' and managers' failures to address policy violations identified during use-of-force incidents and the department's failure to implement a policy to require prisons to complete a review of incidents in a timely manner if deferred during the prison's initial review.

Based on concerns we identified in our monitoring, we provided three recommendations to the department: 1) to reinstate its communication and de-escalation training as a mandated course to be completed by all custody staff at least one time each year; 2) to impose progressive discipline for supervisors and managers who fail to identify and address violations of policies, procedures, and training as they relate to the use of force; and 3) to implement a policy that requires that all deferred use-of-force incidents be reviewed by the institution executive review committee or the department executive review committee within a specific time frame.

Sincerely,

Amarik K. Singh
Inspector General

Gavin Newsom, Governor

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

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

Use-of-Force Policy: Definitions of Common Terms	
Controlled Use of Force	The force used in an institutional or facility setting when an incarcerated person's presence or conduct poses a threat to safety or security, and the incarcerated person is located in an area that can be controlled or isolated. These situations do not normally involve the imminent threat to loss of life or imminent threat to institutional security.
Department Executive Review Committee	The Department Executive Review Committee (DERC) is a committee of staff selected by, and including, the associate director who oversees the respective mission-based group.
Excessive Force	More force than is objectively reasonable to accomplish a lawful purpose.
Great Bodily Injury	Any bodily injury that creates a substantial risk of death.
Immediate Use of Force	The force used to respond without delay to a situation or circumstance that constitutes an imminent threat to institution/facility security or the safety of persons.
Imminent Threat	Any situation or circumstance that jeopardizes the safety of persons or compromises the security of the institution, requiring immediate action to stop the threat. Some examples include, but are not limited to, an attempt to escape, ongoing physical harm, or active physical resistance.
Institution Executive Review Committee	The Institution Executive Review Committee (IERC) is a committee of executive staff at each prison tasked with reviewing all reported use of force incidents.
Reasonable Force	The force that an objective, trained, and competent correctional employee, faced with similar facts and circumstances, would consider necessary and reasonable to subdue an attacker, overcome resistance, effect custody, or gain compliance with a lawful order.
Serious Bodily Injury	A serious impairment of physical condition, including, but not limited to, the following: 1) loss of consciousness, 2) concussion, 3) bone fracture, 4) protracted loss or impairment of function of any bodily member or organ, 5) a wound requiring extensive suturing, and 6) serious disfigurement.
Unnecessary Force	The use of force when none is required or appropriate.

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

Other Terms Used in This Report	
Custody Staff	Sworn peace officers at all levels within an institution or facility.
Hiring Authority	The secretary of the department, the general counsel, an undersecretary, or any chief deputy secretary, executive officer, chief information officer, assistant secretary, director, deputy director, associate deputy director, associate director, warden, superintendent, health care manager, regional health care administrator, or regional parole administrator.

Source: The department's DOM.

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Summary

This is the Office of the Inspector General's sixth annual report, as mandated by California Penal Code sections 6126 (j) and 6133 (b) (1), which addresses the California Department of Corrections and Rehabilitation's (the department) use-of-force incidents. During this reporting period, we monitored 890 use-of-force incidents that occurred on or after January 1, 2022, and for which the department completed its review on or before December 31, 2022.

Through our monitoring methodology, we assessed staff members' actions prior to, during, and following each use-of-force incident we monitored. Because we do not personally observe the use-of-force incidents that we review, we monitor and assess the department's compliance with its use-of-force policies and procedures by reviewing documentation and other evidence the department maintains and makes available to us.

In this report, we highlight six incidents of particular concern, including incidents involving possible staff misconduct that the department failed to address; a departmental staff member who failed to provide use-of-force documentation and video recordings, which impeded our ability to effectively monitor the use-of-force process; and an incident in which a hiring authority refused to request video recordings from an outside law enforcement agency that revealed a departmental agent had used and observed force, but failed to report it.

Additionally, we identified 113 incidents in which the involved officers had the opportunity to de-escalate the situation prior to using force. In 44 of those incidents (39 percent), officers failed to effectively communicate with the incarcerated person or did not adequately attempt de-escalation strategies. In 2017, the department implemented mandated training to improve staff communication skills and further its commitment to resolving conflicts and crises at the lowest level when an imminent threat is not present. Until 2020, the department included this training in its required annual training program, but due to the novel coronavirus pandemic restrictions, the department removed this portion of the training from the mandatory training schedule. Consequently, we recommend the department reinstate its de-escalation course as mandated training for all custody staff.

We monitored 466 incidents that were captured on video recordings. The department did not add fixed or body-worn cameras to any new prisons in 2022, but it plans to add body-worn cameras at four prisons and fixed cameras at 11 prisons in 2023. We are encouraged by some of the successes of video-recording implementation. Even so, we have concerns that supervisors and managers did not always evaluate an adequate amount of video recordings during the review process to determine whether staff had fully complied with policy and procedures.

We also provide an update to two concerns and recommendations made in our last report. First, the department's supervisors and managers continue to perform poorly when reviewing use-of-force incidents and identifying policy and training violations. We identified 367 incidents (41 percent) in which one or more reviewers failed to identify policy violations. In our last report, we recommended that the department evaluate its policy to ensure supervisors and managers capture deviations. The department responded that the current policy is sufficient to identify deviations and to hold reviewers accountable when they do not. Despite the department's assurances, we identified that hiring authorities provided corrective action to supervisors and managers who failed to address the deficiencies in only 62 cases (17 percent).

Finally, the department has yet to implement a policy to ensure that use-of-force incidents which are deferred during an initial executive review committee meeting are returned to the committee in a timely manner to resolve outstanding issues and close the use-of-force incident. In our last report, we noted our concerns regarding the lack of policy to return incidents to the committee for closure, and we identified several incidents with extensive delays between initial and final reviews. To address unreasonable delays, we recommended that the department develop and implement a policy to require prisons to return deferred incidents to the committee for closure in a timely manner. The department responded, stating it has drafted a memorandum and a new policy to address deferred cases. As of the date of this report, the department has not implemented a new policy regarding time lines for deferred cases.

Introduction

Background

Nearly 25 years ago, in the class-action lawsuit *Madrid* v. *Gomez,* the federal court found, among other things, that officials with the California Department of Corrections[1] (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.[2]

As a result of those findings, in 2007, the Office of the Inspector General (the OIG) began monitoring the department's use-of-force review process. In 2011, after the department made significant improvements to reform its use-of-force review and employee disciplinary processes, the federal court dismissed the case. However, as mandated by the California Penal Code, section 6126 (j), we continue to monitor the department's process for reviewing uses of force and to issue an annual report with our findings.

Use-of-Force Options

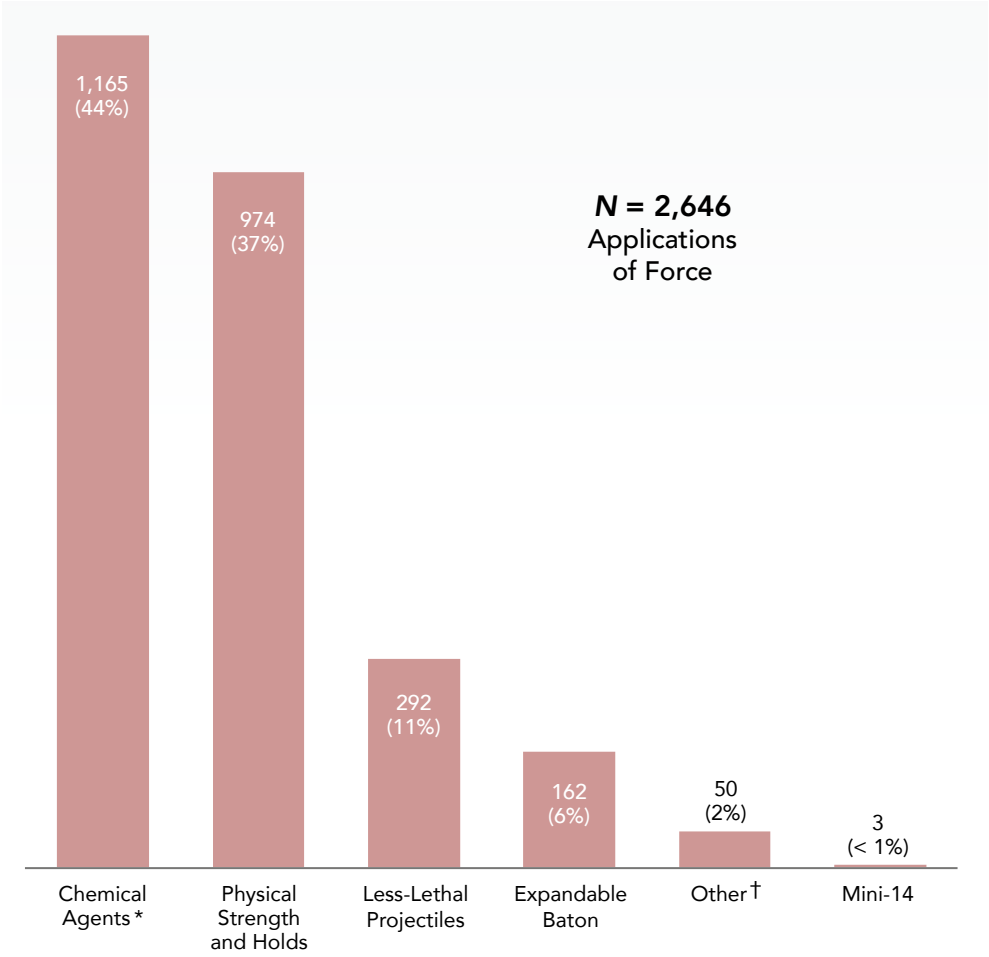
According to departmental policy, when determining the best course of action to resolve a particular situation, staff must evaluate the totality of the circumstances, including an incarcerated person's demeanor, mental health status and medical concerns (if known), and that person's ability to understand and comply with orders. Policy further states that staff should attempt to use verbal persuasion, whenever possible, to mitigate the need for force. When force becomes necessary, staff must consider the specific qualities of each force option when deciding which options to use, including the range of effectiveness of the force option, the level of potential injury, the threat level presented, the distance between staff and the incarcerated person, and the number of staff and incarcerated persons involved. Departmental policy authorizes several force options, which include chemical agents; hand-held batons; physical strength and holds; less-lethal weapons;[3] and lethal weapons (firearms). See Figure 1, next page, for the distribution of these applications for this reporting period.

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

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

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

Figure 1. Distribution of the Applications of Force in the 890 Use-of-Force Incidents We Monitored



* Chemical agents include oleoresin capsicum (OC), CN gas, and CS gas.

† Other includes the use of a shield, nonconventional uses of force, and a taser.

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

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

Reporting and Review Requirements

The department is divided into different divisions, including the Division of Adult Institutions, the Division of Juvenile Justice, and the Division of Adult Parole Operations. Although each division is distinct, the divisions have a similar process for reviewing and evaluating use-of-force incidents.

The Division of Adult Institutions' policy requires that the reporting and review process begin after any use of force. This policy requires that staff who use or observe force submit a written report prior to being relieved of duty.[4]

After staff complete their reports, a lieutenant, a captain, and an associate warden review the complete incident package for content and sufficiency. Each reviewer may request that staff clarify their respective reports if any lack clarity or detail. Each reviewer then completes a critique and independently determines whether staff complied with policy, procedures, and training. The final level of review at the prison occurs at the executive review committee meeting, which is chaired by the warden or chief deputy warden and attended by other prison managers. Ultimately, the committee chair determines whether staff complied with policy, procedures, and training. For minor violations, he or she may order corrective action to address the violation. For more serious violations, the chair may refer the matter to the department's Office of Internal Affairs for an investigation.[5]

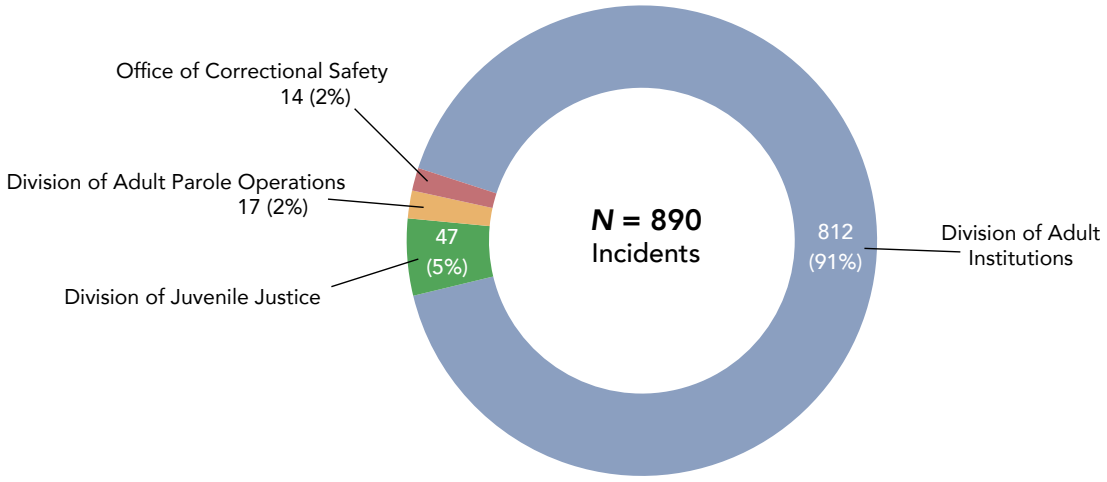
Policy requires a higher level of review by departmental executives for incidents involving a warning shot from a lethal weapon and incidents in which an incarcerated person sustains serious bodily injury that could have been caused by staff's use of force. The department's executive review committees are chaired by the associate director of the respective mission in which the incident occurred, and the committee is required to review the incidents within 60 days of the institution's completed review.

Number of Use-of-Force Incidents

We monitored 890 use-of-force incidents that occurred on or after January 1, 2022, and the department completed its review on or before December 31, 2022. Most of the incidents we monitored occurred at adult prisons (812), with a smaller share occurring in juvenile facilities (47), or within the communities where offenders were on parole (17) (Figure 2, below). We also reviewed a few incidents of force applied by the department's Office of Correctional Safety (14), which acts as a liaison with other law enforcement entities and apprehends fugitives in the community.

4. DOM, Section 51020.17.
5. DOM, Section 51020.19.

Figure 2. Distribution of the 890 Use-of-Force Incidents the OIG Monitored, by Division and Other Entities



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

Scope and Methodology

Scope

The 890 incidents that we monitored occurred on or after January 1, 2022, and were reviewed and closed by the department on or before December 31, 2022. There were 7,592 use-of-force incidents that occurred within the department during this period, but if the review and closure of a monitored incident occurred after December 31, 2022, we include our assessment of that incident in a future report.

We randomly selected 552 of the 890 incidents we monitored. In addition, our inspectors reviewed nearly all of the department's use-of-force incidents to select another 338 incidents based on their characteristics (e.g., serious bodily injury to an incarcerated person caused by force, a riot, a controlled use of force, incidents involving possible misconduct) and the workload of our inspectors.

Between January 1, 2022, and December 31, 2022, our inspectors visited every adult prison and juvenile facility,[6] as well as the northern and southern parole regions, and attended 501 of the department's 1,580 review committee meetings (32 percent).

Methodology

The OIG monitors the department's adherence to its policies, procedures, and training concerning the use-of-force and the department's subsequent review process. To evaluate the effectiveness of the department's process of handling use-of-force incidents and its compliance with policies and procedures, our staff review various rules and regulations relevant to the department's use-of-force practices. We also review the department's use-of-force policy, related training modules, and other applicable operational policies. To further understand the department's procedures, we also observe use-of-force training at some prisons.

Because we did not personally observe use-of-force incidents, our assessments relied on departmental staff's written accounts of each incident and recordings from fixed cameras or body-worn cameras, when available.[7]

6. The department currently operates 34 adult prisons and three juvenile facilities. The department closed Deuel Vocational Institution on September 30, 2021.

7. In 2022, a total of nine prisons had fixed or body-worn cameras. The department did not implement cameras at any more prisons in 2022.

Following a review of the use-of-force incident documentation, our inspectors attended the prisons' review committee meetings. Although our inspectors served as nonvoting attendees at these meetings, they provided real-time feedback and recommendations to the committees. The latter may include recommending obtaining clarifications from involved staff when the initial report is not clear, recommending corrective action for policy violations, or recommending a referral to the Office of Internal Affairs in instances in which our inspectors identified potential staff misconduct. For some cases in which we disagreed with the hiring authority's decision, we elevated the matter to the department's executive management for consideration.

Monitoring Results

While overall the department performed adequately in a majority of the 890 incidents we monitored, we expect the department to perform well in all aspects prior to, during, and following each incident, and to proactively identify and address deficiencies once realized. In this report, we provide our stakeholders with transparent assessments of incidents and issues we identified that are of significant concern.

Highlighted Incidents of Significant Concern

An Officer Used Unreasonable Force on An Incarcerated Person Who Posed No Threat to the Officer and Submitted an Inaccurate Report, Yet Department Officials Refused to Acknowledge the Existence of Potential Misconduct and Failed to Refer the Incident for Investigation

In this incident an officer did not attempt to de-escalate his initial interaction with an incarcerated person. The officer subsequently used unreasonable force against the person even though the person did not pose an imminent threat to the officer's safety. In addition, the officer's report deviated significantly from the actions captured by the officer's body-worn camera. After we raised these concerns with managers at the institutional and executive levels, the department failed to address the policy violations and apparent misconduct we brought to its attention.

This case involved an incarcerated person who was a participant in the department's mental health program in the Enhanced Outpatient Program (EOP) level of care. The incident occurred on the exercise yard of the prison's designated EOP yard. According to the officer's report, the incarcerated person reported to his job at the culinary operation, but refused the required clothed-body search. The officer ordered the incarcerated person to return to his cell, to which order the incarcerated person initially complied by starting to walk across the exercise yard toward his housing unit. The officer's report stated that the incarcerated person then began to "demonstrate odd aggressive behavior kicking his bowl onto the ground and yelling something incoherently." The incarcerated person started to walk back towards the culinary operation and that he "appeared to be angry with a strained scowl on his face." The officer stated that to "de-escalate" the situation, he instructed the officer working in the tower to "put the yard down," which is a signal to activate an audible alarm and announce over the loudspeaker that the incarcerated people should lie or sit on the ground. The initial officer reported that the incarcerated person continued to advance toward him. To effect custody, the initial officer took control of the incarcerated person's wrist and shoulder, turned the incarcerated person away from him, and then placed handcuffs on the incarcerated person (see Photos 1 and 2, following page.)

Photo 1. The incarcerated person stopped walking as officers approached.

Photo 2. The incarcerated person did not display aggressive behavior.

Our initial concern with the report involved the officer's attempt to "de-escalate" the situation by instructing the tower officer to activate the alarm and order the yard down. Activating an alarm and ordering the yard down is not a department trained de-escalation tactic to use with an incarcerated person with mental health concerns who does not pose an imminent threat. However, the more concerning issues appeared after we reviewed the body-worn camera recording from the incident, which showed significant discrepancies compared with the officer's report, including:

- The body-worn camera recording revealed that the officer was on the opposite side of the chain-link yard fence from the incarcerated person, a detail not provided in the officer's report. To engage the incarcerated person, the officer had to unlock a gate and enter the exercise yard, where the incarcerated person could have been contained if necessary.
- The incarcerated person appeared incoherent, and at one point, held his hand up to his ear, as if he did not understand what the officer was telling him. The incarcerated person did not appear to make eye contact with the officer.
- The incarcerated person stopped walking approximately 10 to 15 feet from the officer, which contradicted the officer's report that the incarcerated person "continued to advance towards me."
- The officer ordered the incarcerated person to "Get on the fucking ground! I'm not playing with you, man." This verbal order was not included in the officer's report.
- The officer's report also did not include any mention of the officer's use of physical force which he applied to push the incarcerated person against the yard fence while he applied handcuffs.

Reviewing staff did not identify any policy violations during any of the different levels of review that occurred before the incident was presented at the prison's executive review committee. During the prison's executive review committee meeting we raised the concerns noted above, but the committee chair—an associate warden—stated he had no concerns with the officer's actions and had no concerns with the differences in the officer's report compared with his body-worn camera imagery. We attempted several times to raise our concerns with the warden, who has since retired, but received no response.

We elevated the incident to the associate director of the department's High Security Mission who agreed to review the incident. Nearly one month later, we received an email that stated, "The High Security Mission has carefully reviewed [the incident] and has determined no further action will be taken." We disagreed with the associate director's

position and believe the officer's actions should have been referred to the Office of Internal Affairs for investigation.

An Officer's Body Camera Showed that the Officer Used Excessive Force and Failed to Report It, Yet the Department Refused to Refer the Officer's Actions for an Investigation

In another concerning incident, an officer reported that he used physical force on an incarcerated person during an escort, but the officer's body-worn camera revealed the officer had used excessive force that he failed to report. The officer reported that, during the escort, the incarcerated person dropped his body and thrust his body backward, toward the officer. The officer reported that he used force by placing his hand on the incarcerated person's back and pushed him toward the ground, where he and another officer "rolled [the incarcerated person] onto his stomach to stop his resistance." Based on the officer's report, the use-of-force appeared to be justified and appropriate. The officer's body-worn camera, however, revealed that after the officer pushed the incarcerated person to the ground, he grabbed the incarcerated person's face and squeezed it for approximately four seconds, which the officer neglected to report (see Photo 3, below).

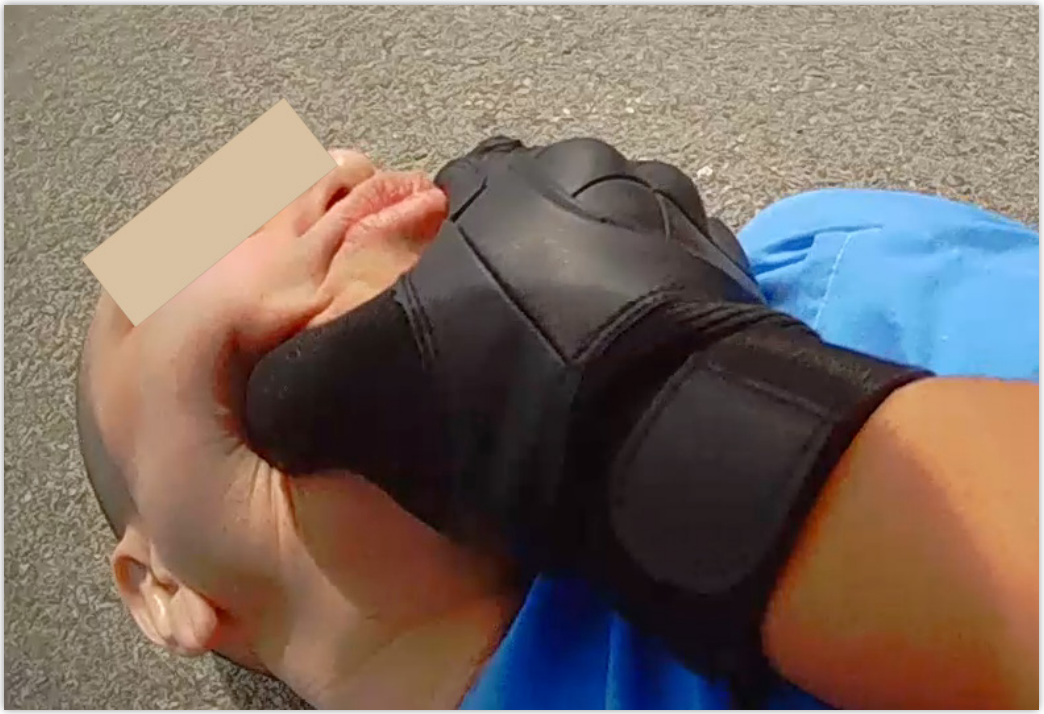


Photo 3. The officer grabbed and squeezed an incarcerated person's face, which the officer failed to report.

The first-level review at the prison (conducted by a lieutenant identified that the officer used unreasonable force when he grabbed the incarcerated person's face. During the prison's executive review committee meeting, we recommended that the officer's misconduct be referred to the Office of Internal Affairs, but we learned that the warden had already issued a nonpunitive Letter of Instruction to the officer for using unreasonable force. The Letter of Instruction did not address the officer's failure to report the force—a separate allegation of misconduct that the OIG recommended be referred to the Office of Internal Affairs, but the warden declined.[8]

We elevated the issue to the associate director of the department's High Security Mission, who reviewed the matter and returned the incident to the prison "for further review and contemplation of Administrative Review." When we contacted the acting warden for a status update—the previous warden had retired—the acting warden responded that he had not reopened the case "due to a backlog of [incidents]." We notified the acting warden that the statute of limitations to impose disciplinary action was rapidly approaching, and he responded that the previous warden made a decision and that he, as the new acting warden, was not going to take any further action.

When we relayed the acting warden's failure to address the issue to the associate director, one of the associate director's subordinates responded that the warden had "determined the [Letter of Instruction] was sufficient" and that "based on the corrective action given, the [warden] cannot complete an admin review and discipline [the officer] again. Also, the [statute of limitations] is soon to expire."

The response from the associate director's office is flawed because the warden never issued corrective action against the officer—and never disciplined him—for failing to report his unreasonable use of force. Further, the non-punitive letter of instruction did not preclude the warden from referring the allegations to the Office of Internal Affairs.

A Departmental Investigator Stopped an Inquiry and Informed the Warden that a Reasonable Belief of Misconduct Existed, but the Warden and Departmental Management Refused to Refer the Matter to the Office of Internal Affairs, Causing the Officers' Actions to Go Unaddressed

In this incident, supervisors and managers at the prison, and a departmental investigator, determined there was sufficient evidence to believe that officers used unreasonable force, yet the warden failed to refer the officers' alleged misconduct to the Office of Internal Affairs.

8. According to the department's employee disciplinary matrix, an officer's failure to report his or her own unreasonable force carries a base penalty of dismissal (DOM, Section 33030.19).

Officers escorted an incarcerated person to his cell. As the officers removed the handcuffs, the incarcerated person pushed his arm through the closed cell door's food port. Officers used physical force and chemical agents to attempt to gain control of the incarcerated person's hands and push them back through the food port. The lieutenant, the captain, and an associate warden who reviewed the incident all agreed that the officers violated policy by using immediate force, and instead, the officers should have initiated a controlled use of force.[9]

Pursuant to policy, the prison paused its review of the incident because the incarcerated person alleged the officers used unreasonable force, and referred the allegation to the department's Allegation Inquiry Management System (AIMS). The AIMS investigator, who had not yet conducted any interviews, stopped his inquiry and returned the case to the prison, concluding, "This allegation inquiry was stopped based upon the belief of the investigator that a reasonable belief of misconduct likely to result in adverse action has been reached."

An associate warden reviewed the incident and allegation during the prison's executive review committee meeting—nearly three months after the AIMS investigator determined there was a reasonable belief of misconduct—and concluded that the officers did not violate any policy.[10] We were not provided with any documentation to indicate that the warden, who has since retired, reviewed the matter after it returned from AIMS, and he did not respond to our requests to review the incident and alleged misconduct.

We elevated our concerns to the associate director of the department's High Security Mission, who reviewed the matter and returned the incident to the prison "for further review and contemplation of Administrative Review." Similar to the previous incident discussed in this report in which an officer used excessive force and failed to report it, the acting warden failed to refer the matter to the Office of Internal Affairs and allowed the statute of limitations to expire.

We notified the associate director that the acting warden took no action in response to the associate director's request that the warden review the incident further. One of the associate director's subordinate managers responded to the OIG, stating that the warden did not sustain the allegation and had closed the incident. The manager also asserted that the warden could not refer the matter again for the same allegation. This response is inconsistent with the associate director's earlier response. If the associate director believed the warden could not take

9. DOM, Section 51020.11.3, requires the officer to verbally order the incarcerated person to relinquish control of the food port. If the incarcerated person does not relinquish control, the officer shall back away and advise a supervisor of the situation. Controlled force may be initiated while custody staff continues to monitor the incarcerated person.

10. Departmental policy states that the institution head (warden) or chief deputy warden shall normally serve as the chairperson and final decision maker at the executive review committee meeting (DOM, Section 51020.19.5).

any further action, there would have been no reason to return the matter to the prison for "further review and contemplation of Administrative Review." The response is also inconsistent with information we reviewed indicating that the warden never actually reviewed the matter after the AIMS investigator returned it to the prison because of their opinion that a reasonable belief of misconduct existed. Contrary to the manager's response, the previous inquiry by AIMS did not prevent a formal investigation. In fact, when the inquiry reveals sufficient information to warrant an investigation, departmental policy requires the warden to refer the matter to the Office of Internal Affairs.[11]

Officers Failed to Supervise a Dayroom Filled with Incarcerated People, Which Provided One Incarcerated Person the Opportunity to Stab a Second Incarcerated Person *82 Times*, Killing Him

In this incident, two officers were assigned to posts that required them to be physically present on a dayroom floor and monitor the actions of the incarcerated people in the dayroom. A third officer was assigned to monitor the dayroom from a control booth. For reasons the department was unable to explain, the officer assigned to the control booth left the building, and one of the officers assigned to the floor entered an office, instead of remaining at his assigned post on the dayroom floor. The second-floor officer assigned to monitor the incarcerated population by walking the floor was reassigned to the control booth. Therefore, there were no officers physically on the floor of the dayroom to monitor the incarcerated population's activity. There were at least 22 incarcerated people in the dayroom at the time of the incident. During this period, one incarcerated person attacked and murdered another incarcerated person. While one officer remained in an office, the other floor officer who was now working in the control booth, was observing medication distribution in another housing unit when he heard yelling. That control booth officer eventually responded to the area of the attack and fired two less-lethal rounds at one of the involved incarcerated people to stop the attack. At the time of the incident, there were no officers physically on the floor of the dayroom to monitor the incarcerated population.

The medical examiner who conducted the autopsy determined that the deceased incarcerated person had been stabbed 82 times, which caused his death (on the following page, see Photo 4 for two views of the weapon used in the attack). We provided our concerns to the warden that, based on the documentation and photographs of the incident, it was clear this was a substantial, extended, and intense attack. It occurred while the two officers assigned to monitor the incarcerated population were absent from the housing-unit dayroom. One officer was reassigned and observing medication distribution in another housing unit and the other officer was inside an office. Despite these obvious concerns, the

11. DOM, Section 31140.14.

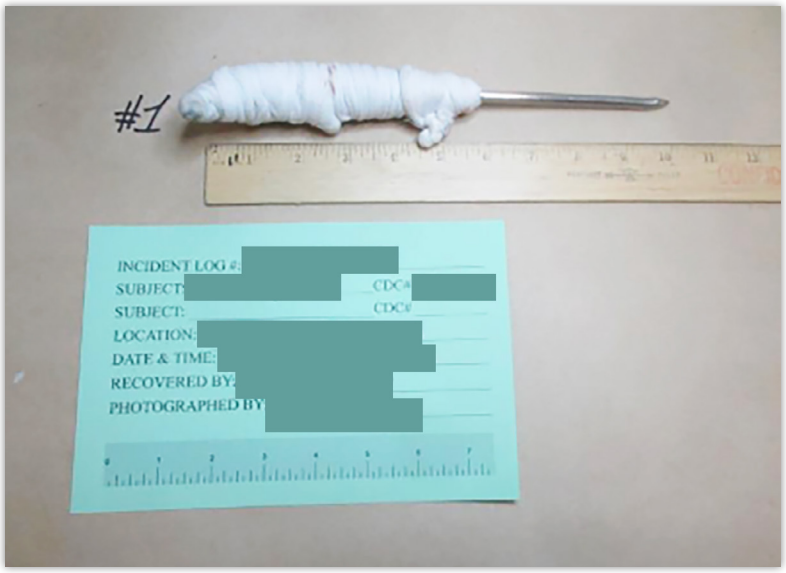
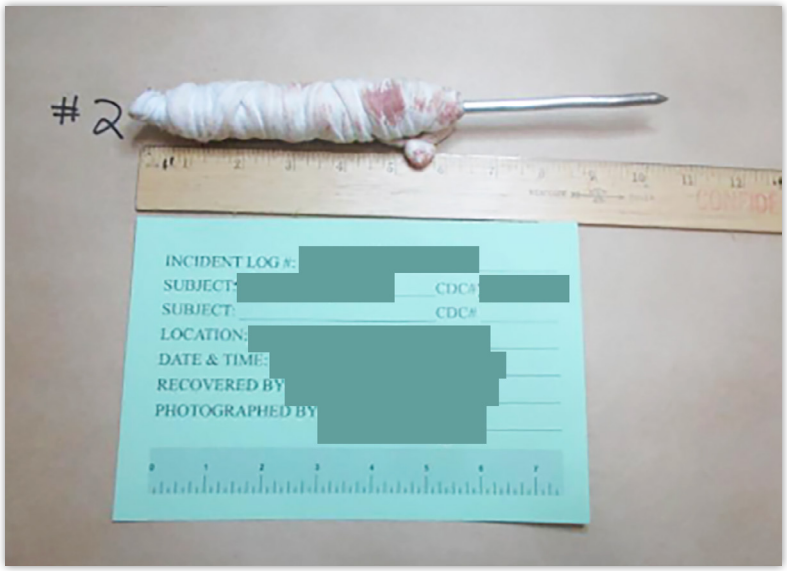


Photo 4. Two views of the weapon that was manufactured by an incarcerated person, which was used in the attack (above and right).



warden refused to consider them and chose not to take any action in response to what appears to have been a significant neglect of duty by these officers. We elevated the matter to an associate director, who acknowledged the officers were absent from the dayroom during the incident. However, the associate director, without the benefit of an investigation, concluded there was "absolutely no misconduct" on the part of the officers and refused to refer the incident to the Office of Internal Affairs for an investigation.

Staff's failure to properly supervise incarcerated persons gave one incarcerated person the opportunity to stab and murder another incarcerated person and, the department's associate director failed to address the potential misconduct.

A Warden Failed to Hold an Officer Accountable for Firing a Less-Lethal Projectile Round at a Distance That Exceeded What Department Policy Allows

In another incident, two incarcerated people attacked and stabbed a third incarcerated person on a recreation yard. To stop the attack, officers used chemical agents and fired two 40mm less-lethal sponge rounds at the attackers from an elevated post (observation tower). The rounds struck the ground without striking the incarcerated person who was the intended target. We reviewed the video recording and photographic evidence of the incident, which showed that the officer appeared to have fired the less-lethal rounds beyond the maximum distance of 105 feet permitted by the department's training, which states: "Staff shall not deploy any impact munitions beyond [their] maximum effective range,"

and "Firing a projectile beyond its maximum effective range will reduce its effect once it strikes its target and increases the likelihood of missing the target."[12]

In response to a recommendation in our 2020 report, the director of Adult Institutions issued a memorandum which directed wardens

> to complete a diagram or schematic for each of their elevated posts with markings that delineate the maximum range for each type of less–lethal rounds currently in use at their institution. This will include observation yard towers, control booths, dining halls, etc. Each completed diagram or schematic shall then be posted in each elevated post where any less–lethal ammunition is used.
>
> . . . . .
>
> Firing a projectile beyond the maximum effective range will reduce its efficacy once it strikes its target as the projectile loses its velocity and accuracy. As distance increases, the likelihood of missing the intended target increases. All approved munitions shall not be utilized outside of the guidelines of the manufacturer's recommendations.

One of our inspectors physically examined the scene of this incident with a sergeant and confirmed that the officer fired the less-lethal round many feet beyond the maximum distance of 105 feet that departmental policy allows. The inspector entered the tower and confirmed the prison had posted the schematic diagram, visible to staff assigned to the tower, which depicted the maximum distance officers were permitted to fire each type of less-lethal round. The sergeant agreed with the OIG that the round had been fired from beyond the maximum distance permitted. During the executive review committee meeting, we raised concerns about the officer firing the round from beyond the maximum distance. The warden disagreed with both the department's training and the department's memorandum reminding staff that they cannot fire a less-lethal weapon from a distance beyond the weapon's maximum range. The warden ignored these clear policy violations, closed the incident, and determined that staff acted in accordance with policy, procedures, and training.

12. California Department of Corrections, Basic Correctional Officer Academy, *Impact Munitions and Assuming an Armed Post*.

A Prison's Use-of-Force Coordinator Impeded Our Review of Use-of-Force Incidents by Failing to Provide Us With Necessary Documents in Violation of the Penal Code, and the Warden Failed to Timely Address the Misconduct

At one prison, a use-of-force coordinator failed to provide our inspector with multiple use-of-force-related documents which included staff reports that describe details of the use-of-force incident, and incarcerated people's medical information that identifies potential injuries an incarcerated person may have received during an incident. We identified more than 20 occasions in which the prison failed to provide some, or all, of the use-of-force records necessary for our inspector to appropriately monitor these incidents. When prison staff do not provide all necessary records, we cannot properly monitor use-of-force incidents and may not identify potential staff misconduct and policy violations that we would otherwise be aware of if we had all relevant documents.

California Penal Code section 6126.5 specifically identifies that the OIG has unfettered access to the department's records and requires departmental officials to grant the OIG access to its information and records. The code states:

> (a) Notwithstanding any other law, the Inspector General during regular business hours or at any other time determined necessary by the Inspector General, shall have access to and authority to examine and reproduce any and all books, accounts, reports, vouchers, correspondence files, documents, and other records, and to examine the bank accounts, money, or other property of the Department of Corrections and Rehabilitation in connection with duties authorized by this chapter. Any officer or employee of any agency or entity having these records or property in their possession or under their control shall permit access to, and examination and reproduction thereof consistent with the provisions of this section, upon the request of the Inspector General or the Inspector General's authorized representative. (c) Any officer or person who fails or refuses to permit access, examination, or reproduction, as required by this section, is guilty of a misdemeanor.

Our inspector and the inspector's supervisor contacted the warden several times in person, by email, and telephone regarding the failure to provide use-of-force related documents to our inspector. Initially, the warden failed to address the conduct of his staff. However, after further discussion with the warden, he did begin the progressive

discipline process with the use-of-force coordinator through training and corrective counseling. However, the use-of-force coordinator still failed to send all use-of-force incident packages to our inspector. We elevated our concern to an associate director, and he reported he was unable to direct a warden to take any particular action and was only able to make recommendations for the warden to address our concerns.

However, approximately nine months after we initially brought our concerns to the warden, he issued disciplinary action (salary reduction) to the use-of-force coordinator for their failure to provide us with the documents we need to perform our use-of-force reviews. Despite this issuance of the disciplinary action, the same use-of-force coordinator has again failed to provide multiple use-of-force related documents to our inspector, as recently as May 2023. This failure raises significant concern that the department is unwilling to hold its staff, including supervisors and managers, accountable for their conduct.

Even more concerning is the department's impeding our ability to carry out our statutory responsibilities. The department's failure to provide all records related to a use-of-force incident prevents us from providing transparent and independent oversight of the State's prison system. As referenced above, the penal code is very clear regarding our access to department records, and we expect departmental managers to be fully aware of our authority. The need for OIG staff to continually remind departmental staff of our authority to request and receive documents is unacceptable.

The Department Failed to Request Video Recordings From Another Law Enforcement Agency of the Department's Officers Using Force

The department's Office of Correctional Safety provides investigative, and security services for the department, and serves as a liaison for the exchange of information with other law enforcement agencies and Governor's Office of Emergency Services. The Office of Correctional Safety conducts the majority of its work outside the prisons, frequently alongside other law enforcement agencies that use and maintain video-recording technologies.

In February 2020, during an executive review committee meeting we recommended the Office of Correctional Safety request and review any video recordings, including body-worn, fixed, and in-car camera recordings that may have captured the department's staff using force. The Office of Correctional Safety agreed with our recommendation.

In March 2022, we monitored a use-of-force incident that occurred inside a local detention facility when special agents from the Office of Correctional Safety were in the process of transferring an individual to the local jurisdiction. At the local facility, the individual continually

refused to stay seated on a bench as the agents were processing the individual into the local facility. After several verbal warnings, an agent [Special Agent 2] used physical force to gain compliance of the individual. The executive review committee reviewed this use-of-force incident, and determined the agents acted within policy and training, but none of the reviewing supervisors, managers, or the hiring authority requested or reviewed the video recording of the incident. We recommended the department obtain and review the video recordings.

Not until 157 days after the incident occurred did the department request and review the video recording of this incident which depicted the actions of the Office of Correctional Safety agents. In response to the department's reviewing the video recording, the hiring authority submitted a request for an investigation based on the incident video. The deputy chief who served as the chair of the executive review committee meeting reported that

> upon review of the video it appears [Special Agent 1] may have observed some of the above-described force used by [Special Agent 2]. Also, it is possible [Special Agent 2] used his hands and body weight on the arrestee to keep him from standing up. However, the camera angle and resolution does not conclusively reveal whether [Special Agent 2] used force.

The video of the incident revealed an agent [Special Agent 2] used physical force to restrain an individual, appeared to observe the physical force used by another agent and, failed to report the force used and observed. The investigation determined a special agent [Special Agent 2] failed to report he used and observed force during this incident, and the hiring authority issued disciplinary action (salary reduction) to the special agent. However, the hiring authority failed to address the actions of the managers and the supervisor who reviewed the incident and failed to identify misconduct during their review.

The OIG Continues to Identify Many Incidents in Which Officers Failed to Use De-Escalation Techniques Prior to Using Force

The department's use-of-force policy directs staff in the following manner:

> It is the expectation that staff evaluate the totality of circumstances involved in any given situation, to include consideration of an inmate's demeanor, bizarre behavior, mental health status if known, [and] medical concerns, as well as ability to understand and/or comply with orders, to determine the best course of action and tactics to resolve the situation. Whenever possible, verbal persuasion should be attempted to mitigate the need for force.[13]

Staff are also reminded of this expectation in the department's *Communication and De-escalation* training course: "It is extremely important to reduce the need to use force by first attempting to effectively communicate with inmates," and "In order to avoid potentially violent situations when an imminent threat is not present, verbal de-escalation should be attempted."[14]

Of the 890 use-of-force incidents we monitored in 2022, we identified 113 incidents in which the involved officers had the opportunity to de-escalate the situation prior to using force. In 44 of those incidents (39 percent), officers either failed to effectively communicate with the incarcerated person or did not adequately attempt de-escalation strategies.

The de-escalation failures occurred at multiple prisons, but several cases at one prison in particular illustrate the concern. We identified 24 incidents in which officers at the prison appeared to use force on an incarcerated person without attempting to de-escalate the situation. We raised the concern to the warden, who agreed with our position and told us he would provide de-escalation training to the prison's supervisors and managers. After the conversation with the warden, we observed some improvement in the prisons' managers identifying issues and taking appropriate actions to de-escalate situations. In one instance, officers used immediate physical force on an incarcerated person who refused to leave an exercise yard, but who posed no imminent threat.

13. DOM, Section 51020.5.

14. California Department of Corrections and Rehabilitation, *Basic Correctional Officer Academy, Communication, and De-escalation Techniques.*

The reviewers found the actions out of policy, and the executive review committee ordered corrective action for the officers because they should have considered a controlled use-of-force and did not attempt to de-escalate the situation prior to using force.

Soon after, however, we identified additional deficiencies that went unaddressed by the prison's supervisors and managers. When we raised this concern to the warden, he changed his earlier position and told us that de-escalation is a "gray area" and he "can't really tell the officers how to handle those situations." We elevated several incidents to the associate director of the department's High Security Mission, all of which had included similar circumstances and involved an incarcerated person who refused to comply with an officer's orders, but posed no imminent threat. In our opinion, officers had the opportunity to de-escalate the situation prior to using force, but failed to do so.

- One case that illustrates the above concern involved an incarcerated person in the department's mental health program, a participant at the Enhanced Outpatient Program (EOP) level of care.[15] While recalling incarcerated people in a housing unit's dayroom, an officer ordered an incarcerated person to return to his cell. The incarcerated person stated, "I am not going back to my cell." The incarcerated person walked toward his cell, dropped an item of clothing near his cell door, then continued to tell officers that he would not go back into his cell. When an officer approached the incarcerated person to apply handcuffs, the incarcerated person sat on the floor next to the officers' podium. An officer could be heard on the radio, stating, "I have an inmate refusing to take it back to his cell, sitting on the floor." The officers then sounded an audible alarm and used physical force to place handcuffs on the incarcerated person. In our opinion, the officers did not adequately attempt to de-escalate the situation prior to using physical force. Furthermore, the incarcerated person posed no imminent threat to the officers to justify their use of immediate force.[16] (See Photo 5, following page.)

15. The Enhanced Outpatient Program (EOP) provides the most intensive level of outpatient mental health care within the department's Mental Health Services Delivery System (MHSDS). The program is characterized by a separate housing unit and structured activities for mentally ill inmate-patients who, because of their illness, experience adjustment difficulties in a General Population (GP) setting, yet are not so impaired as to require 24-hour inpatient care. Mental Health Services Delivery System Program Guide Overview.

16. DOM, Section 51020.4: "Immediate use of force is the force used to respond without delay to a situation or circumstance that constitutes an imminent threat to institution/facility security or the safety of persons. Immediate force may be used without prior authorization from a higher official. Immediate force may be necessary to subdue an attacker, overcome resistance or effect custody. If it is necessary to use force solely to gain compliance with a lawful order, controlled force shall be used."

Photo 5. Officers did not adequately de-escalate the situation and used physical force when the incarcerated person sat on the floor, refusing to return to his cell.

In July 2017, the department deployed the multiple interactive learning objective (MILO) simulator to improve staff communication skills and further its commitment to resolving conflicts and crises at the lowest level when an imminent threat is not present. The training consisted of numerous prison-based, interactive scenarios conducted by certified instructors who direct the scenario based on the participant's verbal interaction, which is projected on a screen in front of the participant. The scenarios do not initially present the participant with an imminent threat. However, depending on the participant's ability to use de-escalation techniques, the scenario may present a threat that requires the participant to deploy a use of force.

According to the lesson plan, the techniques are designed to prevent situations from escalating as well as aid participants in identifying incarcerated people with mental illness or cognitive impairment. The lesson plan acknowledges that failure to recognize and respond to incarcerated people who are in conflict or crisis may result in future litigation for the department.

Until 2020, the MILO training was included in the department's required annual training for correctional staff, but due to the novel coronavirus pandemic restrictions, the department removed this training module from the mandatory training schedule. In January and February 2023, we contacted several prisons and discovered that none were currently offering MILO training and that de-escalation training had not been provided to custody staff for the past three years. The training unit at the department's academy confirmed that MILO had not been reinstated as a required course even though the pandemic restrictions have been nearly eliminated. According to the lieutenant with whom we spoke, the

department intends to implement the training again later this year, but the course's reimplementation still needs final approval.

In our last report, we raised the same concern and recommended that the department evaluate its current policies and training objectives as they relate to communication and de-escalation. Unfortunately, the department declined to take any action in response to our recommendation, responding, "Currently policy is sufficient, and the department will not be making any changes to its current training and policies." In our opinion, the current policy and curriculum are not sufficient without mandated, regularly scheduled classes to train staff on de-escalation techniques.

Body-Worn and Fixed Cameras Have Been Successful in Identifying Possible Misconduct, but Supervisors and Managers Do Not Consistently Review All Relevant Video Imagery

In September 2020, a United States District Court ordered the implementation of video-surveillance cameras and body-worn cameras at the Richard J. Donovan Correctional Facility to achieve compliance with the *Armstrong* Remedial Plan. The remedial plan mandated that the department draft policies and procedures regarding camera use and the retention period for video recordings obtained through cameras. In March 2021, the Court ordered similar remedial measures at five additional prisons.[17]

In 2022, a total of nine prisons had fixed cameras, and six prisons used body-worn cameras (Table 1, below).[18] In 2023, the department plans to implement body-worn cameras at an additional four prisons, and fixed cameras at an additional 11 prisons.

Table 1. Prisons With Body-Worn Cameras or Fixed Audio-Video Surveillance Systems in 2022

Prison	Audio-Video Surveillance System	Body-Worn Camera
California Institution for Women	✓	✓
California State Prison, Corcoran	✓	✓
California State Prison, Los Angeles County	✓	✓
California State Prison, Sacramento	✓	
Central California Women's Facility	✓	
High Desert State Prison	✓	
Kern Valley State Prison	✓	✓
R.J. Donovan Correctional Facility	✓	✓
Substance Abuse Treatment Facility (Corcoran)	✓	✓

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

17. The five prisons included in the 2021 Remedial Plan include California Institution for Women; California State Prison, Corcoran; Kern Valley State Prison; California State Prison, Los Angeles County; and Substance Abuse Treatment Facility and State Prison, Corcoran.

18. Cameras were not implemented at any new prisons during our 2022 monitoring period.

We monitored 466 incidents in 2022 that were captured on body-worn cameras, fixed cameras, or both.[19] We acknowledge that the ability to recall every detail may be impaired during a use-of-force incident, and there may be minor discrepancies between an officer's written report and the recording from the body-worn or fixed camera. For example, if an officer wrote in his report that he applied pepper spray to an incarcerated person from a distance of eight feet, but the recording revealed that the officer sprayed the incarcerated person from closer to six feet, we would not take exception to the discrepancy. Rather, our assessment included whether staff reports contained material differences from the events captured on body-worn or fixed cameras. We identified several incidents in which we believed the video recording revealed a material difference that could not be attributed to a staff member's inability to recall.

One prison's response to discrepancies identified on the prison's fixed cameras was particularly alarming. We identified at least 18 incidents in which video recordings showed that medical staff were present during a use-of-force incident but either failed to report the use-of-force they appeared to observe or failed to submit a report at all.[20] In one of the incidents, an incarcerated person who was sitting on a chair in a dayroom threw water on an officer after receiving his medication. In response, the officer physically forced the incarcerated person to the ground. During the executive review committee meeting we watched the video recording that was captured by the fixed camera in the dayroom. The recording revealed several medical providers present in the dayroom who appeared to see the officer force the incarcerated person to the ground, but failed to submit a report as required by policy. None of the prison's supervisors or managers who reviewed the incident prior to the executive review committee identified this potential misconduct. We recommended the hiring authority, an acting warden, refer the matter to the Office of Internal Affairs for an investigation, as required by departmental policy. The acting warden refused to refer the case based on her mistaken belief, that she was unable to address the misconduct because medical staff do not report to the warden.[21] We elevated our concerns to an associate director and a director, each of whom assured us that the acting warden would refer all use of force cases involving potential misconduct for investigation, regardless of staff reporting structure. After 348 days of the first incident, the acting warden finally

19. The prisons in Table 1 are part of the department's implementation plan for body-worn cameras and new fixed-camera systems. The 466 incidents include incidents captured on those systems in addition to incidents captured on the department's older camera systems that exist at certain prisons, but that will eventually be replaced by the newer AVSS.

20. DOM, Section 51020.17: "Any employee who uses force or observes a staff use of force shall report it to a supervisor as soon as practical and follow up with the appropriate documentation prior to being relieved from duty."

21. DOM, Section 33030.19: To illustrate the severity of the misconduct, according to the department's disciplinary matrix, the baseline penalty for failing to report force witnessed is a 10 percent salary reduction for three to 12 months, or suspension without pay for six to 24 work days.

referred the first of the 18 use-of-force incidents described above to the Office of Internal Affairs. As of this report, the acting warden has still not referred any of the 17 remaining cases for investigation. Based on the acting warden's failure and delay in referring cases for investigation, the department risks violating the statutory time period in which it has to address potential misconduct.

Supervisors, managers, and executive review committees do not always review all relevant video recordings to determine compliance with policy and training.

The department's operating procedures for body-worn and fixed cameras instruct that when preserving recorded data, all angles should be captured and "not only footage of the actual incident but footage of the events leading up to the event or subsequent footage following the event, should be reviewed and copied to the extent that such footage provides a more thorough picture of the entirety of the incident."[22]

Our observations revealed that the incident commander (lieutenant) for each use-of-force incident has the discretion to determine the length of video recording they believe is necessary to include for each use-of-force incident. This discretion may result in only a portion of the actual incident video recording being submitted for review, as opposed to the entire video recording which depicted the actions of staff before, during and after an incident. Similarly, an executive review committee also has the discretion to watch only a portion of the incident video recording, as opposed to the entire video recording, which depicted the actions of staff. If multiple cameras captured the incident, the committee may select only one recording to watch during the meeting, without considering the content of the other video recordings.

As we have identified above, de-escalation techniques are an important process that can reduce or even avoid a use-of-force incident. Having access to an appropriate amount of a video recording will assist departmental reviewers in determining whether staff attempted to communicate with the incarcerated person and resolve the situation without using force.

We are encouraged by the department's continued expansion of surveillance cameras, and will continue to monitor progress, and provide feedback and recommendations as necessary.

22. Memorandum from the Director of Adult Institutions, June 2, 2021.

The Department Has Not Adequately Addressed Recommendations in Our Prior Report

Supervisors and Managers Continue to Fail to Identify Policy and Training Violations, and Wardens Infrequently Address the Failures

In three of our last five reports, we identified that during required review and critique for each use-of-force incident, supervisors and managers often failed to identify staff's noncompliance with departmental policy, procedures, and training. In each report, we recommended that the department evaluate its review process and ensure that supervisors and managers are held accountable.

In response to our report published in 2018, the then-acting director of the Division of Adult Institutions (and the current Secretary of the department) issued a memorandum reiterating that wardens "shall follow established monitoring methods for progressive discipline for similar and/or same violations."[23]

In 2020, we published a report raising the same concern and urged the department to reevaluate the process. The director of the Division of Adult Institutions, issued a memorandum reiterating the expectation that "the review process at all levels be thorough and meaningful." The memorandum included direction to the wardens "to monitor the levels of review and impose training or corrective action on those failing to complete a satisfactory review."[24]

In our report published in 2022, we identified 444 incidents (46 percent of the incidents we monitored) in which one or more reviewers failed to identify a deficiency in a use-of-force incident. To address that concern, we recommended that the department develop a method to ensure that reviewers at all levels adequately review and identify policy and training violations. We also recommended that the department impose progressive discipline for supervisors and managers who repeatedly fail to complete satisfactory reviews. The department declined to take any action, responding that the current policy contained the language required to comply with the recommendation.

During this reporting period, we saw little improvement in the area. We identified 367 incidents (41 percent of the incidents we monitored) in which one or more reviewers failed to identify policy violations. However, hiring authorities provided corrective action to supervisors

23. Memorandum, Responsibilities for Tracking Employee Progressive Discipline Related to the Use of Force, Director of Adult Institutions (Acting), January 11, 2019.

24. Memorandum, Review of Use of Force Incidents, Director of Adult Institutions, September 1, 2020.

and managers who failed to address the deficiencies in only 62 cases (17 percent).

While the department's current policy may contain the language required to comply with our previous recommendations, we have found little evidence that hiring authorities follow the policy or the directives from departmental management to hold supervisors and managers accountable for not identifying policy violations. The multiple-level review process is important to ensure that deviations from policy, including possible misconduct, are identified and corrected.

Despite Our Recommendation in Last Year's Report, the Department Has Yet to Implement a Policy to Ensure Deferred Use-of-Force Incidents Are Reviewed Timely

Departmental policy requires prisons' executive review committees to conduct a review of every use-of-force incident. During this review, the committee may defer closing the incident for a variety of reasons, such as to request clarification from involved staff, refer potential misconduct to the department's Office of Internal Affairs, or refer the case for an internal administrative review.[25] Policy requires the committees to conduct an initial review within 30 days of the incident, but there is no policy requirement for the committees to re-review the incident within a specific period. The requirement to expeditiously review and close-out incidents is imperative to ensure policy and training violations are promptly addressed with corrective action to reduce the chance of repeat offenses. When the hiring authority identifies potential staff misconduct, he or she has a duty to promptly refer the matter to the Office of Internal Affairs to ensure the statutory deadlines for imposing disciplinary actions are met.

In our last report, we noted our concerns regarding the lack of policy to re-review incidents and identified several incidents with extensive delays between the initial and final review. To address unreasonable delays, we recommended that the department develop and implement a policy that would require deferred incidents be re-reviewed within a timely manner. The department responded, stating its staff have drafted a memorandum and new policy to address deferred cases. As of the date of this report, however, the department has still not implemented a policy setting time limits for deferred cases to be reviewed.

As of December 31, 2022, 89 incidents remained in deferred status; the oldest incident was still in deferred status 671 days after the initial review.

25. To our knowledge, *administrative review* is not a term or process defined in policy. Based on our observations, hiring authorities use this process to further consider what action, if any, to take following an incident.

We appreciate that the department acknowledged our previous recommendation and plans to implement a new policy to ensure incidents are re-reviewed in a timely manner after an initial deferral. However, we made the recommendation in August 2022 and the department has yet to act, causing further risk that policy violations or misconduct are not being addressed promptly.

Recommendations

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

Nº 1. Due to continued concerns regarding officers not adequately attempting to de-escalate situations prior to using force, the OIG recommends that the department reinstate its communication and de-escalation training as a mandated course to be completed by all custody staff at least one time each year.

Nº 2. The department continues to fail to address all levels of review, including sergeants, lieutenants, captains, associate wardens, use-of-force coordinators, and wardens when the reviewers fail to identify violations of departmental policies, procedures, and training. We have previously recommended in our use-of-force reports that the department track and monitor the levels of review and impose progressive discipline for reviewers who fail to complete satisfactory reviews. The department responded it had already addressed this matter with the September 1, 2020, memorandum from a director. Despite this memorandum being issued, wardens continue to fail to impose progressive discipline for deficiencies in the review of use-of-force incidents. We recommend that the department address this continued deficiency by imposing progressive discipline for supervisors and managers who fail to identify and address violations of policies, procedures, and training as it relates to the use of force.

Nº 3. In our 2021 monitoring the use-of-force report, we recommended that the department develop and implement a policy to require that deferred use-of-force incidents be re-reviewed by the prison's executive review committee in a timely manner and that the department track the department's compliance with the new policy. Despite an associate director verbally reporting that he would create a workgroup to develop a policy, the department has not implemented a new policy requiring that deferred use-of-force incidents be returned to the executive review committee within a specific time frame. We again recommend that the department implement a policy which requires that all deferred use-of-force incidents be reviewed by the institution executive review committee or department executive review committee within a specific time frame and impose progressive discipline for hiring authorities who fail to comply with the policy.

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

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STATE *of* CALIFORNIA
July 2023

OIG