OIG | OFFICE of the INSPECTOR GENERAL

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As part of the Office of the Inspector General's statutory authority, we monitor the California Department of Corrections and Rehabilitation's performance and compliance with the use of force at its 33 prisons, parole operations, and Office of Correctional Safety. This document presents four notable use-of-force incidents that the Field Investigations Monitoring Unit closed from February 6, 2024, through March 8, 2024.

Incident Number
24-00006-UOF

Reason for Monitoring
Potential misconduct

Incident Summary
On November 9, 2023, an officer completed an unclothed body search of an incarcerated person. As the incarcerated person was getting dressed, the officer searched the incarcerated person's lunch box and discovered a bindle with a substance that was later determined to be methamphetamine. Instead of securing the bindle of drugs out of the reach of the incarcerated person, the officer placed the bindle on a table within the reach of the incarcerated person and continued searching the incarcerated person's lunch box. While the officer continued the search, the incarcerated person grabbed the bindle of drugs, while striking the officer's hand, pushed the table into the officer's legs, and ran away. Two officers and a lieutenant pursued the incarcerated person. One officer physically forced the incarcerated person to the ground and placed him in hand restraints.

Incident Disposition
The hiring authority failed to identify any potential staff misconduct. The OIG identified that the officer failed to properly secure the drugs he had discovered while searching the incarcerated person's lunch box and also failed to place the incarcerated person in hand restraints. The OIG recommended training for the officer. The OIG also identified that a lieutenant had observed the use of force, but failed to submit a report until five days after the incident had occurred. The OIG recommended that the hiring authority refer the matter for investigation because the lieutenant failed to timely report the force he had observed. The hiring authority agreed to refer the matter for investigation regarding the lieutenant's failure to timely report the force he had observed.

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Incident Number
24-00007-UOF

Reason for Monitoring
Potential misconduct

Incident Summary
On November 28, 2023, an incarcerated person was being housed alone in a treatment center cell after having been placed on suicide watch. After the incarcerated person was removed from suicide watch and cleared to return to their assigned housing, two officers gave the incarcerated person verbal commands to vacate the cell. The incarcerated person stated to the officers he was still suicidal. Health care staff members were called, and it was determined that the incarcerated person was not a danger to himself, and the health care staff members verified that he could return to his assigned dormitory housing. The incarcerated person then became agitated and refused to leave the cell. An officer attempted to place hand restraints on the incarcerated person when he began to resist, which caused the officers to use physical force to overcome the resistance. The incarcerated person was then escorted to a therapeutic module to be evaluated by health care staff members for his suicidal thoughts.

Incident Disposition
The department determined that the actions prior to and during the use of force were compliant, but those that followed the use of force were out of compliance. During a review of videos from the audio video surveillance system and body-worn cameras, the department identified that a psychologist had observed officers use force during the incident. The psychologist failed to submit a report by the end of the shift as required by departmental policy and did not submit a report until 21 days thereafter. This late-reporting policy violation was referred to the health care chief executive officer (CEO) for administrative review. The review resulted in the department issuing a letter of instruction to the psychologist. The OIG disagreed with the issuance of the letter of instruction and recommended that the CEO instead refer this incident to the Office of Internal Affairs for investigation as required by departmental policy. The CEO did not accept the OIG's recommendation. In addition, the OIG noted that the incident commander failed to identify the psychologist who had observed the use of force. The hiring authority took no action against the incident commander.

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Incident Number
24-00008-UOF

Reason for Monitoring
Potential misconduct

Incident Summary
On December 17, 2023, in a prison treatment center cell, an incarcerated person committed an act of self-mutilation by repeatedly punching a concrete wall, which caused his hands to bleed. An officer ordered the incarcerated person to stop punching the wall, but the incarcerated person did not stop his actions. The officer then deployed a chemical agent into the cell, which stopped the incarcerated person's actions. Officers then removed the incarcerated person from the cell and offered him decontamination, a clean safety smock, and a blanket. The incarcerated person was medically evaluated and moved to a new cell.

Incident Disposition
The Institutional Executive Review Committee identified that two health care staff members had observed custody staff members using force, but failed to submit reports by the end of their shift as required by departmental policy. Health care staff members did not submit a report until 12 days later. The department determined that the actions prior to and during the use of force were compliant, but the actions following were out of compliance because of the late reports. The incident was referred to the health care chief executive officer (CEO) for an administrative review. The CEO determined that a letter of instruction should be issued to the two health care staff members who were involved in the incident. The OIG recommended referring the matter to the Office of Internal Affairs for an investigation for the medical staff members who failed to submit timely reports as required by departmental policy. The CEO disagreed with the OIG's recommendation. The OIG further noted the incident commander failed to identify that health care staff members had observed custody staff members using force, but failed to submit reports during their review. The hiring authority failed to take any action against the incident commander.

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Incident Number
24-00009-UOF

Reason for Monitoring
Potential Misconduct

Incident Summary

On October 25, 2023, several officers were alerted to a fight occurring between two incarcerated persons in a housing unit dayroom. Three officers gave orders to the incarcerated persons to stop fighting, which the incarcerated persons ignored. As a result, one officer deployed one 40mm wooden baton round,[1] and another officer deployed one burst of a chemical agent to stop the fight. Following the incident, medical staff met with both incarcerated persons, and the incarcerated persons were offered decontamination and fresh clothing.

Incident Disposition

Three health care staff members were identified as having observed the officers using force, but the health care staff members failed to submit reports by the end of their shift as required by departmental policy. The incident commander and the captain made numerous attempts to obtain the reports from the health care staff members; however, they were unable to obtain immediate responses. The reports were subsequently submitted 43, 102, and 106 days after the incident had occurred. The OIG recommended referring the matter to the Office of Internal Affairs for investigation as required by departmental policy. The hiring authority for the health care staff members disagreed with the OIG's recommendation and instead issued letters of instruction to the health care staff members.

1. A 40mm wooden baton round is a less-lethal projectile. A wooden baton round fired from a 40mm weapon should never be aimed directly at an incarcerated person, but instead, should be fired directly onto the ground in front of the incarcerated person. Moreover, this weapon should only be fired outside on an exercise yard or in a dayroom, never into a cell. Staff should use good judgment when deploying these weapons.

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