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 three notable use-of-force incidents that the Field Investigations Monitoring Unit closed from January 1, 2024, through February 5, 2024.

Incident Number
24-00001-UOF

Reason for Monitoring
Potential Misconduct

Incident Summary
On October 28, 2023, an incarcerated person approached two officers who were standing at their workstation in the dayroom. There was a verbal altercation between the incarcerated person and the officers. The officers used physical force in which they punched, strangled, and threw the incarcerated person to the ground. Following the incident, staff documented that the incarcerated person was suicidal. Video footage showed staff failed to monitor the suicidal incarcerated person as required by policy.

Incident Disposition
The hiring authority identified that the officers used force without the presence of an imminent threat from the incarcerated person and referred the officers' actions for investigation. The OIG recommend the hiring authority refer the first officer for investigation of unnecessary and excessive force because the officer punched, strangled, and threw the incarcerated person to the ground. The OIG also found that officers contributed to the need to use force because they failed to de-escalate the interaction with the incarcerated person. The OIG also determined officers failed to properly supervise and observe the incarcerated person when placed on suicide watch. The hiring authority disagreed with the OIG's recommendation and concluded that the first officer did not use excessive force, officers did not contribute to the need to use force, and officers appropriately supervised the incarcerated person while on suicide watch.

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Incident Number
24-00002-UOF

Reason for Monitoring
DERC Eligible

Incident Summary

On September 21, 2023, officers were alerted to a fight between two incarcerated persons in their assigned cell. Two officers gave orders to stop fighting which went ignored. As a result, officers ordered the cell door open and chemical agents were used at the cell entrance in attempt to quell the fight. One incarcerated person complied with the orders; however, the other incarcerated person charged the officers at the cell door and wrapped his arms around one officer which caused both officers to fall to the ground onto the tier walkway. The incarcerated person then placed one officer in a strangle hold restricting his airway and kicked responding officers. Officers used physical force to gain compliance from the incarcerated person; however, as responding officers escorted the incarcerated person from the housing unit he continued to resist, resulting in officers using physical force as a restraint. Medical staff determined the incarcerated person suffered a serious bodily injury of a fractured upper jaw, during the incident and was transported to an outside hospital for treatment.

Incident Disposition

The hiring authority determined several officers failed to initiate an alarm response by activating their personal alarms. Additionally, the response supervisor and incident commander failed to properly review officer's incident reports. Several officer reports failed to articulate the force used or observed during the incident. As a result, the associate warden requested clarifying interviews to determine how the serious bodily injury occurred. The hiring authority issued various trainings to the officers and supervisors for the above issues. The OIG also identified that the incarcerated person was not placed in a recovery position following the use of chemical agents.

Lastly, the OIG determined that the hiring authority failed to notify the OIG about the incarcerated person's serious bodily injury and failed to immediately conduct interviews related to the injury. The hiring authority declined to take action on the concerns that the OIG identified.

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Incident Number
24-00003-UOF

Reason for Monitoring
Potential misconduct

Incident Summary

On December 1, 2023, an officer observed an incarcerated person approach another incarcerated person from behind and strike them in the head multiple times. Officers initiated an alarm and one officer utilized pepper spray to quell the incident. The use of chemical agents was successful and both incarcerated persons separated.

Incident Disposition

The institution's executive review committee determined the officer who used force failed to activate his body-worn camera prior to the incident, which is the policy at this prison permitting officers to only activate their body-worn cameras when interacting with incarcerated persons. As a result, the hiring authority issued corrective action by placing the officer on a body-worn-camera restriction, which required the officer to keep his body-worn camera activated at all times while on duty. In addition, the OIG identified that the incident commander failed to identify that the officer violated policy by not activating his body-worn camera prior to interaction with incarcerated persons. The hiring authority failed to take action against the incident commander.

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