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OIG | OFFICE *of the* INSPECTOR GENERAL

Independent Prison Oversight

August 2022

# 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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Independent Prison Oversight

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August 16, 2022

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 fifth annual report, as mandated by California Penal Code sections 6126 (j) and 6133 (b) (1); the present report addresses the California Department of Corrections and Rehabilitation's (the department) use-of-force incidents that occurred between January 1, 2021, and December 31, 2021.

Our monitoring methodology assesses the department's process for reviewing uses of force prior to, during, and following each incident that we monitored. For this reporting period, we monitored 958 of the department's 6,596 use-of-force incidents that occurred in 2021, and we concluded that the department's performance was satisfactory overall. We assessed the department's performance as superior in seven incidents, satisfactory in 771 incidents, and poor in 180 incidents.

Based on concerns we identified in our monitoring, we provided five recommendations to the department: (1) to reevaluate its current policies and training related to communication and de-escalation to increase opportunities to resolve situations without using force; (2) to develop a process to ensure that video-recorded interviews are recorded within 48 hours as required by departmental policy, modify the interview forms to remove ambiguity regarding video recording alleged injuries, and provide direction regarding video recording actual or alleged injuries on parts of the body that may compromise an incarcerated person's privacy; (3) to track and monitor the levels of review and impose progressive discipline for supervisors and managers who fail to adequately review use-of-force incidents; (4) to revise its policy to include a specific time frame for deferred use-of-force cases to return to the institution's executive review committee for final closure; and (5) to seek a legal opinion from its attorneys, and to develop and implement a clear policy and training for its staff when *Miranda* warnings are required.

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 | |
|---|---|
| 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. |
| Unnecessary force | The use of force when none is required or appropriate. |
| Excessive force | More force than is objectively reasonable to accomplish a lawful purpose. |
| 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. |
| 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. |
| 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 | Any bodily injury that creates a substantial risk of death. |

Source: Article 2, Use of Force, 51020.4 "Definitions," *California Department of Corrections and Rehabilitation, Adult Institutions, Programs, and Parole Operations Manual* (hereafter: DOM), accessible on the **world wide web**.

| Other Terms Used in This Report | |
|---|---|
| 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. |
| Custody staff | Sworn peace officers at all levels within an institution or facility. |
| Noncustody staff | All nonsworn employees, including administrative, medical, and educational staff within an institution or facility. |

Source: The department's DOM.

# California Department of Corrections and Rehabilitation
# Institutions and Parole Regions


Map provided courtesy of the California Department of Corrections and Rehabilitation.

# Summary

This is the Office of the Inspector General's fifth 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 that occurred between January 1, 2021, and December 31, 2021.

Through our monitoring methodology, we assess staff members' actions prior to, during, and following each use-of-force incident we monitored. Our methodology consists of 11 units of measurement that we call performance indicators (*indicators*). These indicators assess the following: (1) staff's actions prior to the use-of-force, including whether staff contributed to the need for force and used de-escalation techniques; (2) whether staff used reasonable force and complied with training requirements regarding methods of deployment; (3) how well staff complied with decontamination requirements after using chemical agents; (4) how well staff followed requirements to medically evaluate each incarcerated person involved in a use-of-force incident; (5) how well staff complied with requirements to supervise an incarcerated person in restraints or a spit hood following a use-of-force incident; (6) how well staff who used force documented their actions in the required report following an incident; (7) how well staff who did not use force documented their actions and observations in the required report following an incident; (8) how well staff conducted video-recorded interviews of incarcerated persons alleging unnecessary or excessive force; [1](9) how well staff conducted inquiries following an incident in which an incarcerated person sustained serious or great bodily injury that may have been caused by staff's use-of-force; (10) how well institutions reviewed and evaluated each incident; and (11) how well the department's executive level committee reviewed required incidents.

Our monitoring of the department's compliance with its use-of-force policies and procedures is limited to documentation and other evidence the department maintains and makes available to us. Because not all use-of-force incidents are captured on video and because we are not authorized to conduct our own investigations into these incidents, our assessments rely on departmental staff's written accounts of the use-of-force incidents and other evidence we can obtain from the department. During this reporting period, the department implemented body-worn camera technology at six of 35 adult institutions. Staff at one of those six prisons were required to wear cameras beginning in January, and staff at the other five were required to wear cameras beginning in the second half of the year. For the incidents that the OIG monitored, we reviewed video surveillance from the body-worn cameras during our attendance at the institutions' executive review committee meetings. The department

1. Our review of the allegations in these incidents focused on the video-recorded interview requirements following the allegation. We did not assess the adequacy of the allegation inquiries.

plans to implement body-worn cameras at four additional prisons in fiscal year 2022–2023, for a total of 10 adult institutions. We anticipate the department's further implementation of the body-worn cameras will enhance our ability to monitor and assess each incident.

For this reporting period, we monitored 958 of the department's 6,596 use-of-force incidents and concluded that the department's performance was overall *satisfactory*. We assessed the department's performance as *superior* in seven incidents, *satisfactory* in 771 incidents, and *poor* in 180 incidents. In the seven incidents in which we assessed the department's performance as *superior*, staff performed exceptionally well in multiple areas, such as attempting to de-escalate the situation prior to using force, decontaminating involved incarcerated persons and the exposed area following the use of chemical agents and describing in the required reports the force used and observed. In the 180 incidents in which we assessed the department's overall performance as *poor*, we identified multiple failures within a single incident, such as not following decontamination protocols after using chemical agents, medical staff not evaluating incarcerated persons as soon as practical following an incident, and the levels of review failing to identify and address policy violations. The incidents in which we assessed the department's performance as *poor* also included incidents in which we identified a single violation that was particularly egregious, such as officers using unnecessary force or staff failing to recognize and address an incarcerated person's allegation of unreasonable force.

During this reporting period, we identified 40 instances in which we believed officers had the opportunity but did not make any attempt to de-escalate or did not adequately attempt to de-escalate a potentially dangerous situation prior to using force. We also identified 69 incidents (7 percent) in which staff's actions (or failure to act) unnecessarily contributed to the need to use force. This is a significant increase from last year, when we identified this issue in only 4 percent of the incidents we monitored. We recommended the department evaluate its current policies and training pertaining to de-escalation.

As in our prior reports, we found that supervisors and managers performed poorly when conducting video-recorded interviews following an incarcerated person's allegation of unreasonable force, or when an incarcerated person sustained serious bodily injury that may have been caused by staff's use-of-force. Specifically, we found deficiencies in the timeliness of both the interviews and the video recording of all actual and alleged injuries. Consequently, we recommend the department develop a process to ensure that video-recorded interviews are conducted within the time frame required by policy. In addition, we recommend the department modify the "Inmate Interview" forms to remove ambiguity regarding video recording injuries and specify that alleged injuries, even those not visible or documented on the medical evaluation form, shall

be video recorded. Finally, we recommend the department develop and implement policy, procedures, and training regarding video recording actual or alleged injuries to an area of the body that would require the incarcerated person to remove clothing that may compromise the incarcerated person's privacy.

Another area of concern we identified is the persistent inadequacy of supervisors' and managers' reviews following a use-of-force incident. Policy requires multiple levels of review, including by the institution's executive review committee, to ensure that deviations from policy, procedures, and training, including potential misconduct, are identified and corrected. Of the 958 incidents we monitored during this reporting period, we identified 444 incidents in which one or more reviewers failed to identify a deviation from policy, procedures, and training. We recommend the department track and monitor the levels of review and impose training or discipline when supervisors and managers fail to adequately review use-of-force incidents.

We also identified the department lacks a policy requirement for the institutions' executive review committees to re-review an incident after deferring it during an initial review. During our reporting period, the department deferred 247 incidents after an initial review, with an average of 56 days between the initial review and subsequent action. To ensure that policy deviations or potential misconduct are promptly addressed, we recommend the department revise its policy to include a requirement that the executive review committees conduct a final review within a specified time frame following an initial deferral and track compliance with the new requirement.

Furthermore, we identified that the department's executive review committees did not review all incidents that met the criteria for review and failed to address all deficiencies in the incidents they reviewed. While we monitored all 29 incidents reviewed by the Division of Adult Institution's executive review committees, we identified another 11 incidents that met the criteria for review, but were not reviewed.

Finally, during one of the department's executive review committee meetings, an associate director asserted that the legal criteria stemming from *Miranda* is not applicable to the department. Since this assertion conflicts with the department's policy and training, we recommend the department seek a legal opinion from its attorneys, and develop and implement a clear policy and training for its staff when *Miranda* warnings are required.

## Use-of-Force Statistics, 2021

The OIG monitored 958 of the 6,596 use-of-force incidents that occurred (15 percent).

The OIG attended 754 of the 1,550 review committee meetings (49 percent).

Approximately 88 percent of the use-of-force incidents we monitored (840 of 958) occurred at adult institutions, with the remainder involving juvenile facilities (75), parole regions (30), and the Office of Correctional Safety (13).

The 958 incidents we monitored involved 3,163 applications of force. Physical strength and holds accounted for 1,297 of the total applications (41 percent), while chemical agents accounted for 1,249 of the total applications (39 percent). The remaining 20 percent of force applications consisted of options such as less-lethal projectiles, baton strikes, tasers, and the Mini-14 rifle.

# 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[2] (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.[3]

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), the OIG continues to monitor the department's process for reviewing uses of force. This report includes use-of-force incidents that occurred in 2021 and presents our analysis of the adequacy of the department's use-of-force review process and how well the department followed its own policies and training.

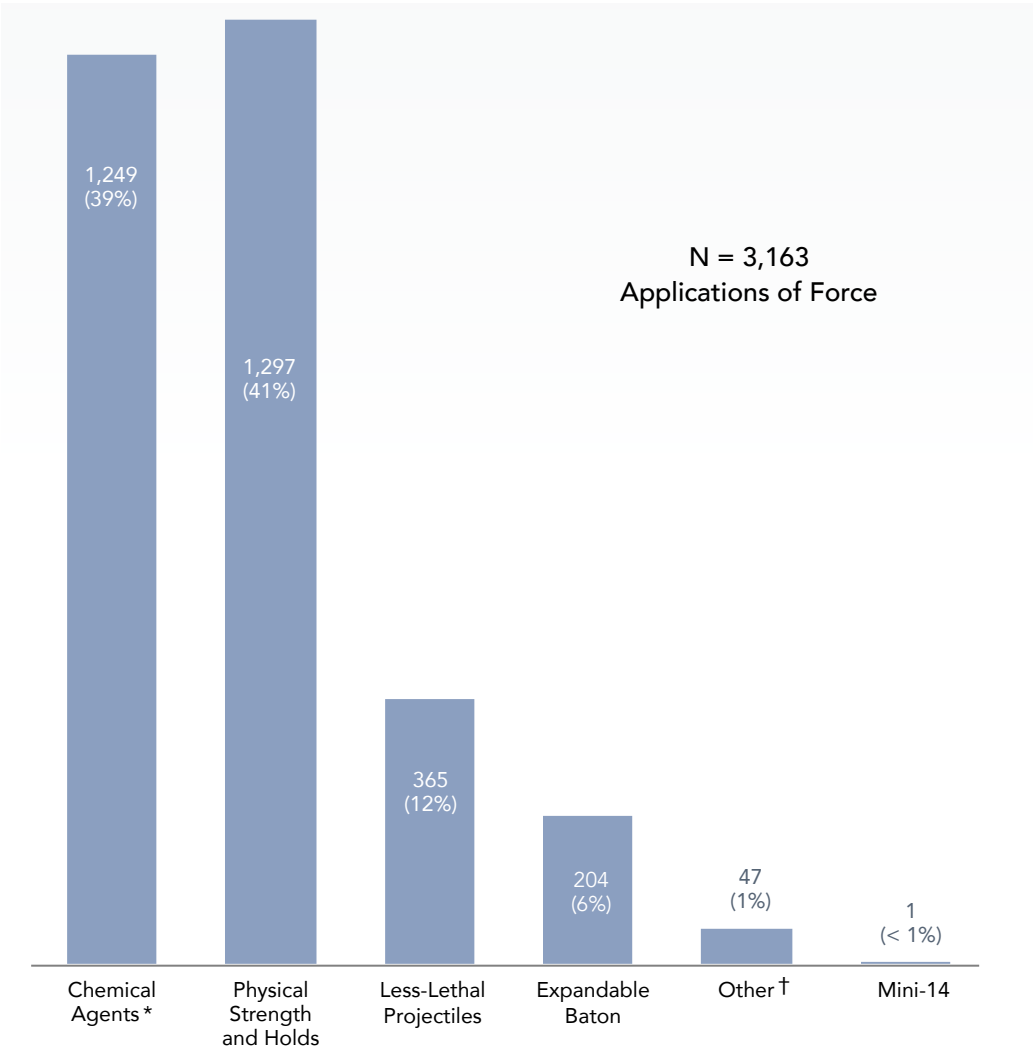
## Use-of-Force Options

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 includes several force options, which are described in detail on the following pages. See Figure 1, next page, for the distribution of these applications for this reporting period.

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

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

**Figure 1. Distribution of the Application of Force in the 958 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.

## Chemical Agents

The department uses three approved types of chemical agents: chloroacetophenone (CN), orthochlorobenzalmalononitrile (CS), and oleoresin capsicum (OC or pepper spray). Each type of chemical agent has different training requirements. While each chemical agent causes different physiological reactions, they all generally cause eye and respiratory irritation. Deployed through an aerosol cannister or a grenade-type device, chemical agents provide staff with the ability to use force while maintaining a safe distance from the threat, such as a group of fighting incarcerated persons (see Figure 2 for examples). Chemical agents accounted for 1,249 of the 3,163 total applications of force used in the incidents we monitored.

**Figure 2. Delivery Methods for Deploying Chemical Agents**


*Aerosols* *Pyrotechnics* *Blasts*

Source: Chemical Agents: Instructor Guide—Version 2.0, Basic Correctional Officer Academy, Office of Training and Professional Development (Sacramento: California Department of Corrections and Rehabilitation, June 2014).

## Hand-Held Baton

A hand-held expandable baton is a force option normally issued to officers assigned to positions who have direct contact with incarcerated persons (Figure 3, shown below).

**Figure 3. Hand-Held Baton**

Expandable Baton: Instructor Guide—Version 1.1, Basic Correctional Officer Academy, Office of Training and Professional Development (Sacramento: California Department of Corrections and Rehabilitation, October 2013).

The hand-held baton is an impact weapon designed to strike or jab an incarcerated person in close proximity when the baton is in either an opened or closed position. Departmental training includes specific target areas with varying levels of potential trauma. Due to the risk of serious injury or death, officers may not target areas such as the head, neck, spine, or solar plexus, unless the department's criteria for deadly force is present. Hand-held batons accounted for 204 of the 3,163 total applications of force used.

## Physical Strength and Holds

The department defines the use of physical strength and holds (or physical force) as "any deliberate physical contact, using any part of the body to overcome conscious resistance. A choke hold or any other physical restraint which prevents the person from swallowing or breathing shall not be used unless the use of deadly force would be authorized."[4]

Physical strength and holds encompass a wide variety of techniques the department uses, including:

- Control holds, which staff may use to maintain control of a resistive incarcerated person during an escort;
- Takedown techniques, which may be used to force an incarcerated person to the ground; and
- Punches and kicks, which staff may use in self-defense when attacked by an incarcerated person.

Physical force accounted for 1,297 of the 3,163 total applications of force we monitored during this reporting period.

## Less-Lethal Weapons

Departmental policy defines less-lethal weapons as any weapon that is not likely to cause death. A 37mm or 40mm launcher has the appearance of a firearm, but is designed to fire less-lethal projectiles composed of foam, rubber, or wood. Due to the risk of serious injury, or death, the legs and buttocks are the only authorized target areas. Less-lethal weapons accounted for 365 of the 3,163 applications of force in the incidents we monitored during this reporting period (see Figure 4, next page, for examples of less-lethal weapons).

4. *California Department of Corrections and Rehabilitation, Adult Institutions, Programs, and Parole Operations Manual.* This publication is commonly referred to as the DOM. All DOM references in this report are specific to Section 51020.

The less-lethal launcher may be fired from the ground, but it is more commonly used by officers assigned to an elevated post, such as a housing unit control booth or an observation tower on an exercise yard.

**Figure 4. Less-Lethal Launchers**

*Penn Arms 40mm Single-Shot Launcher*

*Penn Arms 40mm Multi-Shot Launcher*

Source: Chemical Agents: Instructor Guide—Version 2.0, Basic Correctional Officer Academy, Office of Training and Professional Development (Sacramento: California Department of Corrections and Rehabilitation, June 2014).

## Lethal Weapons

A lethal weapon is any weapon whose use is likely to result in death.[5] A firearm is a lethal weapon because it is used to fire lethal projectiles. When presented with a situation in which deadly force is authorized, an officer may aim and fire a lethal weapon directly at the incarcerated person, or the officer may fire a *warning shot*, which is a lethal round fired in a safe area of the institution, such as the side of a building or an unoccupied area of an exercise yard. During this reporting period, we monitored only one incident that involved a lethal weapon.

5. DOM, Section 51020.5.

## 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. A separate director oversees each division. Although each division is distinct, the divisions have a similar process for reviewing and evaluating use-of-force incidents and allegations of unreasonable force.

The Division of Adult Institutions policy requires that the 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 from duty at the end of their shift. In general, reports should include a description of the incarcerated person's (or incarcerated persons') actions and the staff member's (or members') perception of the threat that led to the use-of-force, a description of the specific force used or observed, and a description of the incarcerated persons' level of resistance.[6]

After staff complete their reports, the complete incident package is reviewed by a lieutenant, a captain, and an associate warden for content and sufficiency, and each reviewer may request that staff clarify their respective reports. Each of these reviewers independently determines compliance with both policy and training. The final level of review at the institution occurs at the institution's executive review committee meeting, which is chaired by the warden or chief deputy warden and attended by other institutional managers, including medical and mental health care representatives. Departmental policy requires that the committee review every incident within 30 days. Ultimately, the committee chair determines whether the force used, and staff's actions were within policy, procedures, and training. If the chair determines staff's actions violated policy, procedures, or training, he or she may order corrective action. For more serious violations, the chair may refer the matter to the department's Office of Internal Affairs to request an investigation.[7]

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 sustained 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,[8] and the committee is required to review the incidents within 60 days of the institution's completed review.

6. DOM, Section 51020.17.

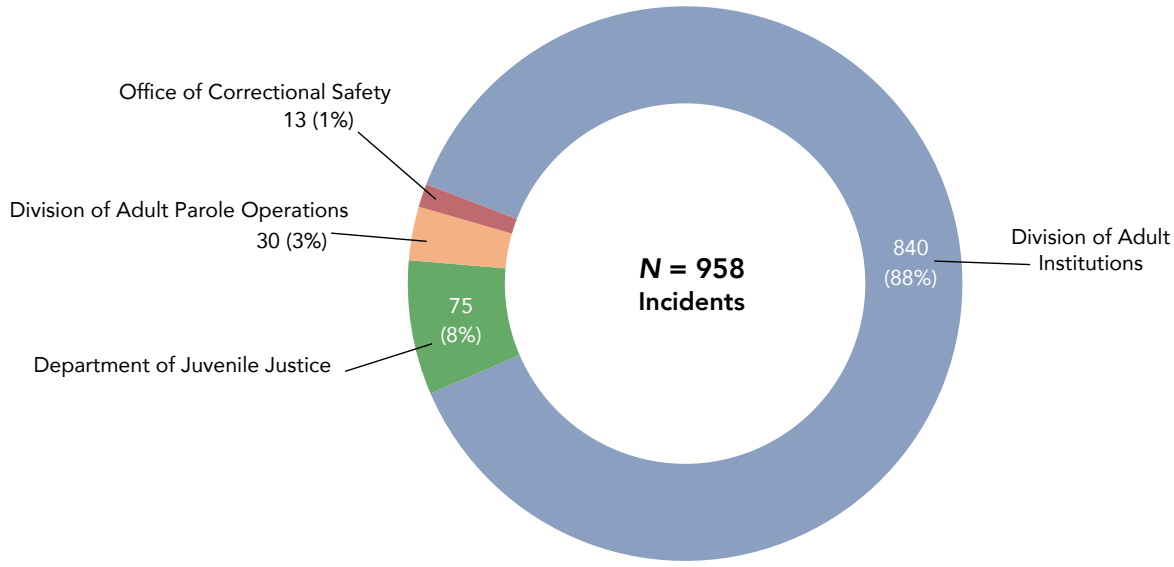
7. DOM, Section 51020.19.

8. The principal missions within the Division of Adult Institutions are F*emale Offender Programs and Services/Special Housing, General Population, Reception Center, and Camps (Male),* and *High Security*.

## Number of Use-of-Force Incidents

We reviewed 958 of the 6,596 use-of-force incidents that occurred within the department between January 1, 2021, and December 31, 2021. Most of the incidents occurred at adult institutions (840), with a smaller share occurring in juvenile facilities (75) and within the communities where offenders were on parole (30) (Figure 5, below). We also reviewed a few incidents of force applied by the department's Office of Correctional Safety (13), which acts as a liaison with other law enforcement entities and apprehends fugitives in the community.

**Figure 5. Distribution of the 958 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*

In this report, the OIG presents its evaluation of the use-of-force incidents that occurred between January 1, 2021, and December 31, 2021. To evaluate the effectiveness of the department's process of handling use-of-force incidents and its compliance with policies and procedures, our staff reviewed various rules and regulations relevant to the department's use-of-force practices. We also reviewed the department's use-of-force policy, related training modules, and other applicable operational policies. To further understand the department's procedures, we also observed use-of-force training at some institutions.

The OIG reviewed and analyzed 958 of the 6,596 use-of-force incidents (15 percent) that occurred within the department between January 1, 2021, and December 31, 2021. To reach this number, we randomly selected 663 incidents. In addition, we also selected another 295 incidents based on their characteristics (e.g., serious bodily injury to an incarcerated person caused by force, a riot, a reported force incident involving an allegation of unnecessary or excessive force) and the workload of our inspectors. Incarcerated persons alleged unnecessary or excessive force in 115 of the 958 incidents (12 percent) we monitored. In our review of the allegations in these cases, we assessed the department's compliance with its policies related to video-recorded interviews. We did not assess the overall adequacy of the department's inquiry into the allegations at the local level or, if applicable, through its Allegation Inquiry Management System (AIMS).[9]

Our inspectors visited every adult prison and juvenile facility,[10] as well as the northern and southern parole regions, and attended 754 of the department's 1,550 review committee meetings (49 percent) to monitor incidents that occurred in 2021.[11] Although OIG inspectors served as nonvoting attendees at these committee meetings, they provided real-time feedback and, when necessary, also provided recommendations on compliance-related matters to the committee chairs.

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9. The OIG issued a special report in February 2021 regarding inquiries into incarcerated persons' allegations of staff misconduct through its new unit, the Allegation Inquiry Management Section (AIMS). The report is titled ***The California Department of Corrections and Rehabilitation: Its Recent Steps Meant to Improve the Handling of Incarcerated Persons' Allegations of Staff Misconduct Failed to Achieve Two Fundamental Objectives: Independence and Fairness; Despite Revising Its Regulatory Framework and Being Awarded Approximately $10 Million of Annual Funding, Its Process Remains Broken***.

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

11. Since departmental policy requires that the institutional review committees review each incident within 30 days from the date of the incident, some of the meetings we attended occurred in January 2022. Additionally, we attended departmental executive committee meetings through March 2022 since policy requires a review to occur at the departmental level within 60 days after the institution's review committee completes its review.

## *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. We present our assessment of use-of-force incidents and the department's subsequent review process using data and information garnered from an assessment tool. The tool divides the department's processes into 11 units of measurement that we refer to as *performance indicators*, as described below:

- **Indicator 1** addresses how well staff followed policies and procedures prior to the use of force, including whether staff contributed to the need to use force and used proper de-escalation techniques.
- **Indicator 2** addresses how well staff followed policies and procedures during the use of force, including whether force was reasonable and whether staff followed training regarding methods of deploying force options.
- **Indicator 3** addresses how well staff complied with decontamination policies following the use of force, including whether the affected incarcerated person and area were properly decontaminated.
- **Indicator 4** addresses how well medical staff evaluated incarcerated persons following the use of force, including the timeliness of the medical evaluation and the adequacy of the documentation.
- **Indicator 5** addresses how well staff followed policies and procedures when supervising incarcerated persons following uses of force, including incarcerated persons who required constant or direct supervision while in restraints or in a spit hood.
- **Indicator 6** addresses how well staff who used force documented their actions following the use of force, including circumstances leading up to the force, articulation of the perceived threat, and the force used.
- **Indicator 7** addresses how well staff who did not use force documented their actions following the use of force, including circumstances leading to the force, articulation of their involvement, and any force observed.
- **Indicator 8** addresses how well staff followed policies and procedures when conducting video-recorded interviews of incarcerated persons alleging unnecessary or excessive force but does not address the adequacy of the allegation inquiry.
- **Indicator 9** addresses how well staff followed policies and procedures when conducting inquiries into serious or great bodily injury that could have been caused by staff's use of force,

including timeliness of the notification to the OIG and video-recording requirements.

- **Indicator 10** addresses how well the institution reviewed and evaluated the use of force, including the adequacy of each level of review and the decision of the institution's executive review committee.
- **Indicator 11** addresses how well the department reviewed and evaluated the use of force, including the timeliness and adequacy of review by the department's executive review committee.

Our monitoring of the department's compliance with its use-of-force policies and procedures is limited to the documentation and other evidence the department maintains and makes available to us. Although the department began increasing its camera coverage by installing fixed cameras and requiring staff to wear cameras at six prisons beginning in 2021 and plans to do so at four additional prisons in 2022, most use-of-force incidents in our review period were not captured on video. In addition, we are not authorized to conduct our own investigations into these incidents. Therefore, our assessments rely on departmental staff's written accounts of the use-of-force incidents and other evidence we can obtain from the department.

Concerning each indicator, we developed a series of compliance- or performance-related questions. Our inspectors who monitored the use-of-force incidents collected data to answer the questions. Based on the collective answers, we rated each of the 11 indicators for each incident as *superior*, *satisfactory*, or *poor*.[12] Then, using the same rating descriptors, our inspectors determined an overall rating for each incident they monitored.

The rating for each indicator, and ultimately the rating for the entire incident, is based on the department's compliance with its own policies, procedures, and training concerning the use-of-force, combined with our opinion regarding the department's handling of an incident, from the circumstances leading up to the incident, through the various levels of review, until the review committee makes a decision. We understand that policy or training violations do not necessarily render the department's performance as *poor*. However, we may assign a *poor* rating when major or multiple deviations from the process occur, because such deviations could lead to an increased risk of harm to and tension among staff and incarcerated persons. On the other hand, we may assign a *superior* rating when, in our opinion, the department performed exceptionally well in multiple or critical areas.

12. Certain indicators are not applicable for all incidents. For instance, if chemical agents were not one of the force options used, Indicator 3, which assesses decontamination, would not apply. Similarly, if none of the involved incarcerated persons alleges unnecessary or excessive force, Indicator 8 would not apply.

To arrive at meaningful data to monitor during this reporting period and to track the compliance and ratings of the department over time, we assigned a numerical point value to each of the individual indicator ratings and to the overall rating for each incident.

The point system is as follows:

***Superior*** ..... 4 points

***Satisfactory*** ..... 3 points

***Poor*** ..... 2 points

We then added the collective value of the assigned points and divided the result by the total number of points possible to arrive at a weighted average score. To illustrate how this scoring method works, consider a hypothetical example consisting of 10 incidents. The maximum point value—the denominator—would be 40 points (10 incidents multiplied by 4 points). If the department scored one *superior* result, seven *satisfactory* results, and two *poor* results, its raw score—the numerator— would be 29 points. To arrive at the weighted average score, we would then divide 29 by 40, yielding a score of 72.5 percent. The formula for the hypothetical situation is given in the equation below.

**Equation. Scoring Methodology**

$$\frac{[\,(1\ \textit{superior} \times 4\ \text{points}) + (7\ \textit{satisfactory} \times 3\ \text{points}) + (2\ \textit{poor} \times 2\ \text{points})\,]}{(10\ \text{incidents} \times 4\ \text{points})}$$

Finally, we assigned a rating of *superior* to weighted averages that fell between 100 percent and 80 percent, *satisfactory* to weighted averages that fell between 79 percent and 70 percent, and *poor* to weighted averages that fell between 69 percent and 50 percent. Thus, using the example above, the summary-level rating would be *satisfactory* because the weighted average score of 72.5 percent was between 79 percent and 70 percent. As we assign a minimum of two points to each rating, the minimum weighted average percentage value is 50 percent.

| *Results & Percentages* | | |
|---|---|---|
| ***Superior*** | ***Satisfactory*** | ***Poor*** |
| 100%–80% | 79%–70% | 69%–50% |

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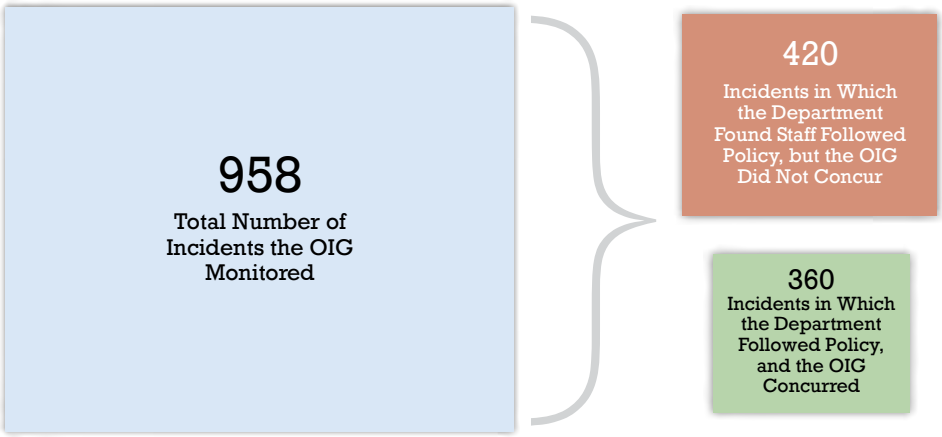
# Monitoring Results

## The Department Continued to Struggle With a Consistent Application of Its Use-of-Force Policy

The OIG reviewed and evaluated 958 staff-reported use-of-force incidents that occurred between January 1, 2021, and December 31, 2021. At the time of this report, an additional 77 use-of-force incidents remained in deferred status pending final review by the department.

Overall, the department determined its staff completely followed policy in 780 of the 958 incidents (81 percent) that we monitored during this reporting period, as depicted in Figure 6 below. In 360 incidents, we agreed with the department's determination. In our opinion, staff violated policy, procedures, or training in 420 of the 780 incidents in which the department found no violation. When evaluating force in relation to departmental policy, we considered the department's performance prior to, during, and immediately following the incident, including the department's review process. We considered the totality of the circumstances for each incident to generate a complete assessment of the department's actual compliance with its policies, procedures, and training.

**Figure 6. Total Number of Incidents Found In and Out of Compliance With the Department's Use-of-Force Policy**

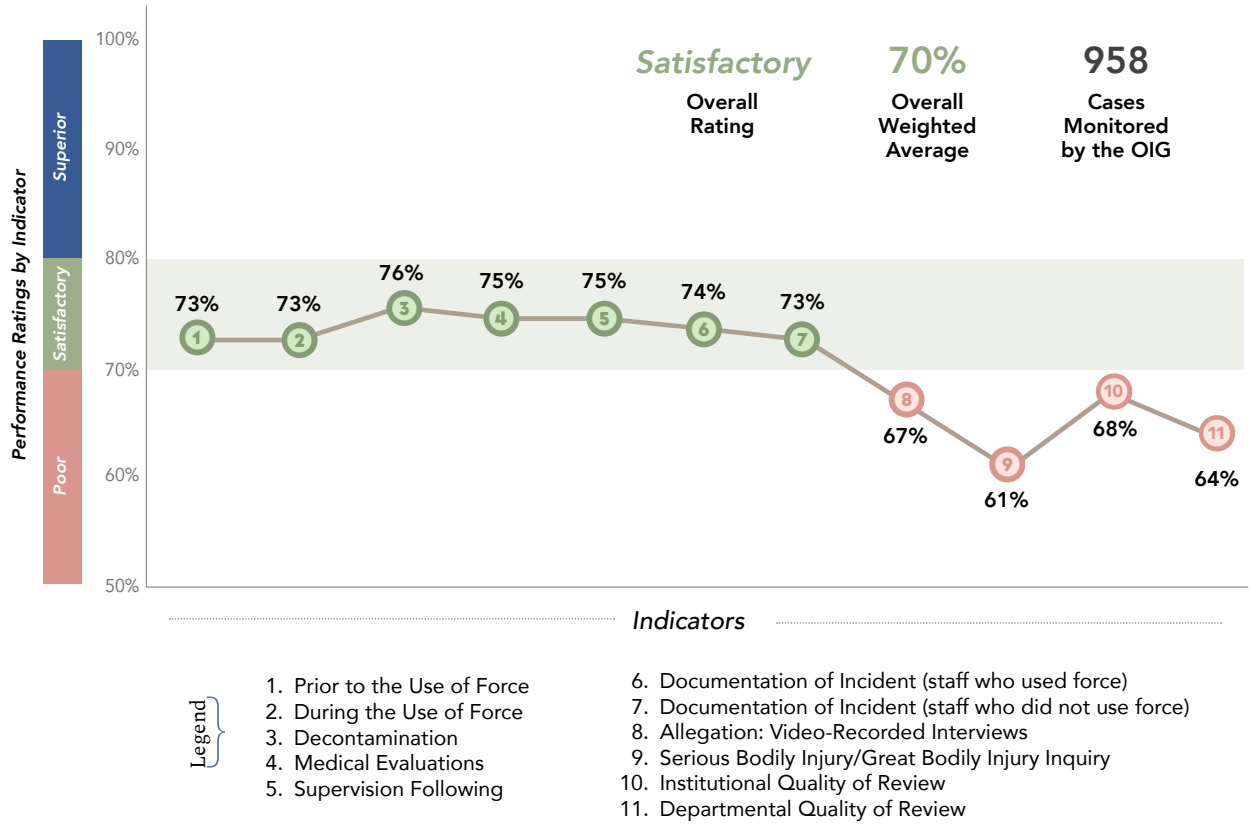



Source: The Office of the Inspector General Tracking and Reporting System.

## Although the Department's Overall Performance in Handling Its Use-of-Force Incidents Was Satisfactory, We Identified Several Areas of Concern

The OIG determined the department's overall performance in handling its use-of-force incidents was *satisfactory.* We rated the department's overall performance as *superior* in seven incidents, *satisfactory* in 771 incidents, and *poor* in 180 incidents. Although we rated most of the incidents *satisfactory* and also rated seven of the 11 individual indicators *satisfactory*, we found opportunities for improvement in the areas of conducting video-recorded interviews following an allegation of excessive or unnecessary force (Indicator 8), conducting inquiries into serious bodily injury that may have been caused by staff's use-of-force (Indicator 9), and conducting use-of-force reviews at the institutions' executive review level (Indicator 10) and department's executive levels (Indicator 11).

**Figure 7. The OIG's Overall Rating of the Department's Reviewing of Its Use-of-Force Incidents**




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

The OIG's overall assessment of how well the department performed prior to, during, and following a use-of-force incident was based on a cumulative assessment of the 11 indicators.[13] Our rating for each of the indicators was based on the answers to specific compliance- and performance-related questions. To answer the questions, we used the requirements outlined in the department's operations manual and in other established procedures,[14] such as the department's training manuals regarding the different force options, and memorandums.

During this reporting period, we assigned an overall rating of *superior* to seven incidents. The following case is an example of staff performing exceptionally well during a use-of-force incident:

- An officer escorted a newly arrived incarcerated person to a housing unit. The incarcerated person ran toward and physically attacked another incarcerated person. Officers quickly responded, utilizing chemical agents to quell the overall incident and prevent further attack. Immediately following the attack and the use of chemical agents, the officers who used and observed force documented their observations and actions in an exceptionally clear and concise manner, including detailed steps regarding the decontamination process.

In contrast, we assigned an overall rating of *poor* to 180 incidents in which staff performed inadequately in multiple areas or in a single critical area. This may include the use of excessive or unnecessary force. The following are examples of cases in which staff performed poorly:

- In one incident, we rated the department's overall performance *poor* because an officer contributed to the need to use force, a failure that led to a serious assault on the officer, and ultimately to a use-of-force incident. In this incident, an officer arrived at a cell door to collect waste items from the incarcerated person. Instead of following the institution's local procedure to direct the incarcerated person to pass the waste items through a port in the cell door, the officer elected to open the cell door. Once the cell door was opened, the incarcerated person, who was unrestrained at the time, immediately attacked the officer, punching the officer in the face and head. The incarcerated person then pulled the officer into the cell. Once inside the cell, the incarcerated person continued to attack the officer, ultimately causing the officer to lose consciousness on two occasions. While a captain ordered training for the officer for opening the cell door in lieu of using the port, the department erroneously determined the officer did not violate policy or procedure. The OIG disagreed, as it is the institution's local policy to use the port for transactions

13 Not all 11 indicators are applicable to every incident.

14. DOM, Section 51020.1.

with incarcerated persons. The port was specifically designed to enhance safe passage of items to and from an incarcerated person who is inside a cell. We identified the officer's failure to use the port as a serious staff-safety issue. Furthermore, the officer who used force during the incident did not clearly describe the incident in the report he prepared, and the department failed to request clarification or otherwise address the deficiency. We also found the incident commander had initially reported that the officer sustained serious bodily injury during the incident (loss of consciousness on two occasions), but then reported the incident did not involve serious bodily injury. The department was unable to explain this discrepancy and why the loss of consciousness was no longer considered serious bodily injury.

- In another incident, an officer elected to escort a maximum-custody incarcerated person, who was assigned to a secured housing unit, without a second officer for assistance and protection as required by departmental policy. The same officer failed to properly secure the incarcerated person in hand restraints. The officer further failed to follow some basic principles of officer safety and correctional awareness when he identified the incarcerated person had been manipulating the hand restraints: the officer only elected to *ask* the incarcerated person whether he had been tampering with the hand restraints instead of ensuring that the hand restraints were properly placed and secured. The incarcerated person then attacked the officer; other officers used physical force to stop the attack. The officers' use-of-force caused serious bodily injury (10 sutures) to the incarcerated person's head. We found that two officers failed to report the physical force they observed. The department failed to timely notify the OIG of the incarcerated person's serious bodily injury; and the department failed to conduct a thorough inquiry into the incident. Both the institution's and the department's executive review committees failed to identify these deficiencies. During the department's executive review committee, the assigned associate director ordered training for the officers based on the OIG's recommendations; however, when the department drafted the final memorandum regarding the incident, the associate director did not include these deficiencies.

For detailed information and data regarding each indicator please visit the **Data Explorer page on our website**. In this report, we highlight the following areas of concern with recommendations if appropriate.

## In Several Incidents, Staff Failed to Attempt De-escalation Techniques That May Have Prevented the Use of Force

In Indicator 1, we evaluate how well staff followed policies, procedures, and training prior to the use-of-force. Our assessment includes examining whether staff's actions contributed to the need to use force and whether they used de-escalation techniques when appropriate. Despite the overall rating of satisfactory for this indicator, in 40 of the 156 incidents (26 percent) in which staff had the opportunity to de-escalate the situation, staff made an inadequate attempt to de-escalate the situation or made no attempt at all.

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, 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."[15] Staff are 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."[16]

Here are some examples of the department's failure to de-escalate an incident:

- In one incident, an officer working inside a housing unit stood behind a podium while supervising the incarcerated population. The officer reported observing an incarcerated person walking quickly in the direction of the officer, "muttering profanities" and not wearing an N95 face covering. The officer failed to even attempt de-escalation before using chemical agents striking the incarcerated person. When asked to clarify the imminent threat that caused the officer to use chemical agents, the officer again reported the only justification for using force was that the incarcerated person had approached the officer without a face covering and did not have a reason for being in the dayroom. At the institution's executive review committee, we expressed our concern that the officer deployed force without an imminent threat. The hiring authority agreed and referred the incident to the department's Office of Internal Affairs to request an

15. DOM, Section 51020.5.

16. From the department's communication and de-escalation techniques training.

investigation; however, the Office of Internal Affairs rejected the case. After the Office of Internal Affairs failed to accept the incident for investigation, the hiring authority chose to provide the lowest level of action, which was on-the-job training for the officer.

- While officers entered a housing unit to conduct a count of the incarcerated population, one incarcerated person refused more than one staff member's orders to enter his cell. This incarcerated person was a participant in the department's mental health program and was also issued a medical mobility device (a walker). A sergeant reported the incarcerated person remained seated on his walker in the dayroom and refused to return to his cell. At the time of the incident, the incarcerated person was the only member of the incarcerated population in the dayroom. A sergeant approached the incarcerated person and ordered him to return to his cell or force would be used. After the incarcerated person again refused to return to his cell and remained seated on his walker, the sergeant and another officer physically forced the incarcerated person to the ground. Six other officers then responded to the incident and used physical force to restrain the incarcerated person. We determined the sergeant failed to utilize any de-escalation techniques and had violated departmental policy by failing to initiate a controlled use-of-force when no imminent threat was present. We also identified the sergeant had failed to adequately report his observations and actions. We voiced these concerns at the institution's executive review committee meeting, and the chief deputy warden agreed with our concerns. However, he only elected to provide the lowest level of action, which was on-the-job training for the sergeant.

Due to the high percentage of incidents in which we believed officers did not adequately attempt to de-escalate a situation, we recommend the department evaluate its current policies and training as they relate to communication and de-escalation techniques to reduce the overall instances in which staff need to use force. In addition, we recommend continued de-escalation training for supervisors and managers to ensure instances in which staff do not adequately attempt to de-escalate a situation are captured during the review process.

## In Several Incidents, Staff Actions Contributed to the Need to Use Force

In monitoring the department's compliance with its policy, procedures, and training prior to the use-of-force, we identified 69 incidents in which staff's actions contributed to the need to use force. For example:

- In one incident, an officer escorted an incarcerated person housed in an administrative segregation unit (ASU). This incarcerated person had previously attacked an officer and

sergeant and, as a result had been housed in the ASU. As the officer escorted the incarcerated person, walking on a roadway, the officer elected to remove the hand restraints from the incarcerated person. The incarcerated person then attacked the officer, and six officers used physical force and a baton to stop the attack. We determined by prematurely releasing the incarcerated person from the hand restraints during the escort, the officer had contributed to the need to use force and the entire incident could have been avoided had the restraints not been removed during the escort. The warden disagreed and failed to address our concerns.

- In another incident, an officer assigned to work in a control booth was opening cell doors to release specific incarcerated persons from their cells. The officer opened an incorrect cell door, which permitted an incarcerated person to exit a cell without authorization. This incarcerated person then attacked an officer, causing injuries to the officer which required medical treatment at an outside hospital. At the institution's executive review committee meeting, we raised concerns regarding the incarcerated person's release. The assigned chief deputy warden reported, "training was probably provided" to the officer; however, the department was unable to verify the training occurred.

The OIG identified six incidents in which staff contributed to the need to use force by conducting inadequate searches, specifically, of incarcerated persons who had expressed suicidal ideations and required direct staff observation to prevent self-harm. In these instances, staff's failure to properly conduct searches caused incarcerated persons to gain access to objects they could use for self-harm, thus prompting officers to use force. The following example illustrates this concern:

- A medical doctor placed an incarcerated person under direct staff observation status because the incarcerated person expressed and exhibited suicidal ideations. When an incarcerated person is at risk of self-harm, staff are required to replace the incarcerated person's standard clothing with clothing items with which the person cannot use to injure him- or herself. However, staff failed to replace the incarcerated person's clothing and failed to properly search the incarcerated person and the cell before placing the incarcerated person in the cell. The incarcerated person was then able to gain access to a sharp, metal object and used it to cut his forearm. An officer then deployed chemical agents to stop the incarcerated person from inflicting self-harm.

## Staff Often Failed to Comply With Video-Recorded Interview Requirements

Some of the incidents we monitored included allegations of unnecessary or excessive force made by incarcerated persons against staff. The department's policy requires staff to conduct an inquiry into these allegations. During the committee meetings, our inspectors may provide real-time feedback regarding the adequacy of an allegation inquiry. However, in this report, our monitoring results are primarily based on the department's compliance with video-recorded interview requirements, not the overall outcome of the inquiry.[17]

Departmental policy requires staff to video record an interview with an incarcerated person in two circumstances: (1) following an incarcerated person's allegation of unnecessary or excessive force, and (2) following a use-of-force incident during which an incarcerated person sustains serious or great bodily injury that may have been caused by staff's use-of-force.

In both situations, policy requires that an uninvolved supervisor video record an interview with the incarcerated person within 48 hours of the triggering event. In the case of an allegation of unnecessary or excessive force, staff must conduct the interview no later than 48 hours from the discovery of the allegation. Following an incident in which an incarcerated person sustains serious or great bodily injury that may have been caused by staff's use-of-force, a supervisor must conduct the video-recorded interview no later than 48 hours from the discovery of the injury. During this reporting period, we identified that staff failed to conduct a timely video-recorded interview in 28 of the 123 incidents that required an interview.

Departmental policy further requires the supervisor conducting the interview to video record "any visible or alleged injuries" (emphasis added). During this reporting period, we identified that staff failed to video record visible or alleged injuries in 33 of the 105 applicable incidents in which injuries were visible or alleged. Notably, the instructions on the department's "Inmate Interview" form the supervisors complete during the interviews do not specify that any alleged injuries must also be video recorded. Rather, the instructions on the form state, "The Custody Supervisor shall ensure all injury(s) are captured on the video recording. The view should be close enough to accurately account for the injuries noted on the CDCR 7219." Because of this ambiguity on the interview form, alleged injuries may not be video recorded. For instance, if an incarcerated person alleged during the video-recorded interview that an officer kicked him in the ribs and that he was in pain, the policy requires the interviewer to video

17. A separate unit within the OIG monitors a percentage of the department's allegation inquires and publishes those results in a separate report.

record the area of the alleged injury. However, the interview form may be interpreted as only visible injuries, or those indicated on the CDCR 7219, be recorded. We also identified that the interview forms lack clear direction for instances in which an incarcerated person has an actual or alleged injury to a part of the body covered by clothing that, if removed, may present a privacy concern for the incarcerated person. For instance, if an incarcerated person alleges that he sustained an injury to his buttocks area, video recording that alleged injury may require the incarcerated person to pull down or remove his undergarments. Without clear direction, an interviewer may not take the appropriate steps to capture the necessary evidence. Consequently, interviewers may be inconsistent in their approaches to this scenario.

There are several reasons that staff are to conduct video-recorded interviews. Perhaps the most critical reason is to immediately document possible visual evidence of an incarcerated person's alleged injuries or serious injuries that could have been caused by staff's use-of-force. Failure to conduct timely interviews and video record all visible and alleged injuries not only diminishes evidentiary value, but leaves the department susceptible to allegations of a cover-up or the impression that the department did not take the allegations seriously. While an injury may support an incarcerated person's allegation of unreasonable force, a lack of visible injuries may refute an incarcerated person's allegation.

To address these concerns, we recommend the department develop a process to ensure that video-recorded interviews are conducted within the time frame required by policy. In addition, we recommend the department modify the "Inmate Interview" forms to remove ambiguity regarding the process of video recording injuries and specify that alleged injuries, even those not visible or not documented on the medical report of injury form (CDCR 7219), be video recorded. Finally, we recommend the department develop and implement policies, procedures, and training on video recording actual or alleged injuries to an area of the body that would require the incarcerated person to remove clothing that may compromise the incarcerated person's privacy.

## Supervisors, Managers, and Wardens Who Reviewed Uses of Force Frequently Failed to Identify Staff's Noncompliance With Departmental Policy, Procedures, or Training

In Indicator 10, we evaluate how well an institution reviewed and evaluated the use-of-force. This assessment includes the evaluation of each level of review and the institution's executive review committee's final decision. Departmental policy states: "Each incident or allegation shall be evaluated at both supervisory and management levels to determine if the force used was reasonable under policy, procedure, and training. For reported incidents, a good faith effort must be made at all levels of review to reach a judgment whether the force used followed policy, procedures and training and follow-up action if necessary."[18] At the culmination of the five levels of review, the executive review committee makes a final determination regarding each incident.

This multiple-level process is designed to ensure that deviations from policy, procedure, and training, including potential misconduct, are identified and corrected. Failures at any level of review to identify violations of the use-of-force policy, procedures, and training permit staff to repeatedly commit the same violations without being held accountable. Such failures to identify deficiencies may also give staff the impression that departmental and institutional executives do not support the department's policies, procedures, and training.

Among incidents we monitored during this review period, we found the department's compliance with its policies and procedures at the institutional levels of review continues to be poor, and we rated this indicator poor for 267 incidents. We did not assign a superior rating for any incident within this indicator.

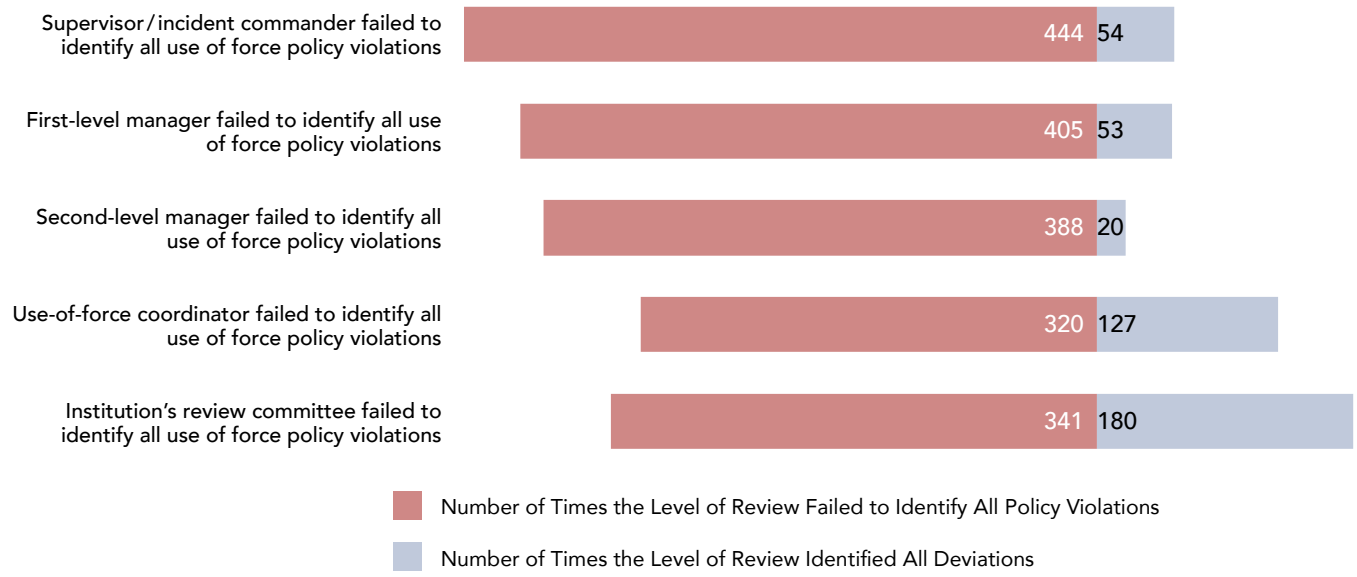
In Figure 8 on the next page, we identify the number of deficiencies that reviewers at each level did not identify. Of the 958 incidents we monitored, we identified 444 incidents in which one or more reviewers failed to identify a deficiency in a use-of-force incident.

The following examples illustrate the failures at various institutional levels to address use-of-force policy deficiencies:

- An incarcerated person arrived at a classification committee meeting, sat in a chair, and pulled down his N95 face covering. After an officer instructed him to properly wear the face covering, the incarcerated person completely removed the face covering, stating he could not breathe. Another officer provided the incarcerated person with a surgical style face covering,

18. DOM, Section 51020.19.

**Figure 8. Identification of Policy Violations by Levels of Review**




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

which the incarcerated person agreed to wear. As the meeting proceeded, officers reported the incarcerated person appeared agitated, clenched his fists, and shook his leg while seated in a chair. The incarcerated person then removed his face covering again, and the meeting chair ended the meeting. The meeting chair instructed the incarcerated person to leave the office. The incarcerated person continued to appear agitated and threatened to harm staff if they touched him. Officers failed to even attempt to de-escalate the situation and instead yelled at the incarcerated person, escalating the situation further. Without reporting an imminent threat, the officers physically forced the incarcerated person to the ground, causing serious bodily injury to the incarcerated person's head (bone fractures). During the 25 minutes following the use-of-force incident, the department failed to timely provide medical assistance to the incarcerated person, despite his sustained serious injuries. At the executive review committee meeting, we presented our concerns regarding the officers' failure to attempt to de-escalate the incident and that the officers used force without an imminent threat. The warden disagreed and failed to address our concerns.

- At another prison, one officer deployed chemical agents to stop seven inmates fighting inside a dormitory. A captain identified a potential unreasonable use of force while reviewing footage from an officer's body-worn camera. The footage showed that one of the responding officers appeared to place the tip of his

baton on the rib area of an incarcerated person who was sitting on the floor and used pressure to force the incarcerated person to a prone position. This officer did not report using force during the incident. Rather than submitting a formal request for investigation to the Office of Internal Affairs, the institution conducted an inquiry regarding the officer's potential use of unnecessary force and the officer's failure to report the force used. During the inquiry, a sergeant provided a copy of the video to the Office of Internal Affairs, but only requested an informal opinion as to whether the officer used unnecessary force.

The Office of Internal Affairs reviewed the video and determined that the officer did not appear to have used any unnecessary force. Specifically, the Office of Internal Affairs identified the officer was in close proximity to the incarcerated person with his baton expanded and the officer "appeared to be either nudging the inmate to get his attention with the side of his leg or using the [baton] in the extended position to lightly touch the inmate for attention purposes." Furthermore, the Office of Internal Affairs advised that even if the hiring authority had instead sent a formal request for investigation to the Office of Internal Affairs, that request still would likely have been returned to the hiring authority with recommendations for corrective action in lieu of investigation.

Following our review of the video, we recommended the hiring authority formally refer the matter to the Office of Internal Affairs and request an investigation regarding the possible misconduct, which includes the officer's failure to report his force used. Based on the informal opinion provided by the Office of Internal Affairs, however, the hiring authority declined our recommendation and elected to only provide officer safety training to the officer.

We discussed this matter with the Office of Internal Affairs, but its staff disagreed with our opinion that the possible misconduct was apparent in the video and defended its practice of providing informal opinions to the institutions.

The Office of Internal Affairs told us that at no time did its staff advise the sergeant not to formally submit the matter for review. It only advised that the institution would need to conduct additional inquiry to reach a reasonable belief of misconduct.

We also found the department's levels of review struggled to identify potential misconduct, such as staff collaborating on incident reports and, in some instances, plagiarizing entire reports.

- In one case, while an officer observed incarcerated persons arriving at an educational class, an officer reported one incarcerated person yelled obscenities at another incarcerated

person. The officer intervened and used physical force to place the first incarcerated person into hand restraints. Reportedly, two officers then physically forced the incarcerated person to the ground. After the incident, the two officers appear to have collaborated, submitting nearly identical reports of the incident. None of the levels of review, including the executive review committee, identified the officers collaborated on their reports. During the initial committee meeting we expressed our concerns that the officers may have collaborated with their reports and the committee deferred the incident. At the final committee meeting, based on our concerns, the chief deputy warden who chaired the committee meeting agreed the officers appeared to have collaborated with their reports, but only ordered training. The chief deputy warden excused the potential misconduct, stating, "It was more than likely lazy behavior by cutting and pasting narratives."

We recommend the department develop a method to ensure that reviewers at all levels adequately review and identify deviations from use-of-force policy, procedures, and training. In many instances, reviewers at all levels, from the incident commander to the institution's review committee, failed to identify violations of use-of-force policy, procedures, and training. Furthermore, in some instances, reviewers concurred with the reviewers at the prior level all the way through the multiple-level review process, leaving the violations to be identified by the use-of-force coordinator, a noncustodial staff member, or the institution's review committee. We recommend the department track and monitor the levels of review and impose progressive discipline for all reviewers who fail to complete satisfactory reviews.

## The Department Lacks a Policy to Ensure That Institutions' Executive Review Committees Conduct a Final Review of Deferred Use-of-Force Incidents in a Timely Manner

Departmental policy requires the institutions' executive review committees to review every use-of-force incident and every allegation of unreasonable force. During this review, the committee may "defer" the incident for a variety of reasons, such as to request clarification from staff involved in the incident, review an incarcerated person's allegation of unreasonable force, refer the case to the Office of Internal Affairs, or refer the case for an internal administrative review[19] (see Table 1, below). Policy requires the committees conduct the 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 following a deferral.

During this reporting period, the executive review committees deferred 247 incidents after an initial review, with an average of 56 days between the initial review and a subsequent action.[20] The department re-reviewed and closed most of the deferred incidents during our reporting period, but as of January 31, 2022, there were 77 incidents (31 percent) that the department had not finalized.

**Table 1. Summary of Deferrals Monitored by the OIG**

| Prison's Stated Reason for Deferral | Sum of Days Deferred | Number of Deferrals | Average Number of Days Deferred |
|---|---|---|---|
| Administrative Review | 1,360 | 20 | 68 |
| Clarification | 4,496 | 110 | 41 |
| Local Inquiry | 6,355 | 82 | 78 |
| Referred to the Office of Internal Affairs | 1,161 | 31 | 37 |
| Serious Bodily Injury Inquiry | 542 | 4 | 136 |
| Grand Total | 13,914 | 247 | 56 |

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

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

20. For the subsequent action, we used the date the committee re-reviewed and closed the incident, or in cases of a referral to the Office of Internal Affairs, we used the date of the referral.

## Obtaining Clarification During the Deferral Process

The most common reason for deferral was to obtain clarification from staff when the initial reports were unclear, missing information, or inconsistent with other staff reports. During this reporting period, the department deferred 110 incidents (45 percent) to obtain clarification from involved staff. On average, it took the executive review committees 41 days to complete a final review of an incident. While institutions often re-review the incidents quickly, the following example illustrates that without a policy requirement, the final review may be significantly delayed:

- In one incident, the institution's executive review committee conducted a preliminary review on July 1, 2021, and deferred the incident pending a simple clarification. One of the levels of review asked an officer to clarify the reason he gained control of the incarcerated person's arm before using force. The clarification was completed on December 13, 2021, nearly five months after the initial review was completed. The institution's executive review committee returned to the incident for a final review on December 20, 2021, and the incident was closed with no further action needed. Had the institution's executive review committee determined that the officer violated departmental policy and that further investigation was necessary, the delay could have adversely impacted the Office of Internal Affairs' ability to complete the investigation within the time frame required by statute.

## Administrative Deferrals Process

During this period, the committees deferred 20 incidents (8 percent) for an "administrative review." We find this process concerning because it is undefined by policy and is most often used after the hiring authority has identified potential misconduct. On average, it took hiring authorities 68 days to make an appropriate determination after deferring an incident for administrative review. The oldest incident had been deferred for 368 days and was still outstanding as of January 31, 2022, the cut-off date for this reporting period. The following is an example that illustrates this type of egregious delay:

- The institution's executive review committee reviewed an incident on March 9, 2021. The committee deferred the incident because a chief deputy warden acting as chair identified that an officer failed to articulate in his report that he used force. According to the department's policy and disciplinary matrix, failing to report the use-of-force is cause for an investigation and, possibly, an adverse action. The chief deputy warden deferred the incident for an administrative review and for possible referral to the Office of Internal Affairs to request an investigation. As of May 26, 2022, this incident had not been

referred to the Office of Internal Affairs and had not been returned to the institution's executive review committee.

The requirement to expeditiously review and close use-of-force incidents is imperative to ensure that policy violations are promptly addressed with corrective action to reduce the chance of repeat offenses. When a 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 that statutory deadlines for imposing adverse actions are met.

The OIG recommends the department develop and implement a policy that would require deferred incidents be re-reviewed within a timely manner. Furthermore, we recommend the department track compliance with the new policy.

## The Department's Executive Review Committees Failed to Review All Incidents Required by Policy and Failed to Address All Concerns With the Use of Force

The department's executive review committees are required to review significant incidents that could have been caused by staff's use-of-force, such as those involving warning shots, serious bodily injury, great bodily injury, or death.[21]

In addition to this requirement, the department's executive review committees may review other use-of-force incidents the review committees at institutions or facilities refer, or they may directly request to review incidents. Policy requires that a review occur at the departmental level no more than 60 days after the institution's review committee completes its review, unless the incident took place at a facility within the Division of Juvenile Justice, in which case there is no policy-mandated time frame.[22]

During this reporting period, we monitored all 29 incidents the Division of Adult Institutions' department's executive review committees had reviewed. However, of the incidents we reviewed, we identified another 11 incidents we believed met the criteria for review, but which were not reviewed by the department.

The following are examples of incidents involving serious bodily injury that could have been caused by staff's use-of-force, but which were not reviewed by the department's executive review committee:

- In one incident, several incarcerated persons were observed fighting on a prison recreational yard. Officers used chemical agents and fired multiple less-lethal rounds to stop the fight. One of the incarcerated persons sustained serious bodily injury (fractures) to the head and alleged the injuries were caused by a less-lethal round. A lieutenant reported several less-lethal rounds were unaccounted for, and a medical staff member reported the incarcerated person's head injuries could have been caused by a less-lethal round. Despite this evidence, all levels of review at the institution failed to acknowledge the incarcerated person's head injuries could have been caused by staff's use-of-force. At our request, the incident was forwarded to the department's executive review committee; however, the assigned associate director refused to review the incident unless he was certain the

21. DOM, Section 51020.19.6.

22. Ibid.

incarcerated person's injury was actually caused by staff's use-of-force saying, "I don't feel this is a DERC case. I want to know it [the incarcerated person's injury] was caused by staff."

- In another incident, two incarcerated persons were observed fighting inside a housing unit. Officers used chemical agents, baton strikes, and less-lethal rounds to stop the fight. The incident commander reported an incarcerated person sustained serious bodily injuries, including a brain bleed and a fractured femur. Based on one officer's statement that she could not see where she had struck the incarcerated person with her baton on three occasions, we concluded it was certainly possible that at least one of the three baton strikes could have caused the incarcerated person's serious bodily injuries. However, the department failed to notify our administrative officer of the day of the injuries and failed to conduct an inquiry into the cause of the injuries. Moreover, all levels of review failed to acknowledge the officer should not have used the baton if she could not see where her strikes landed. The department's executive review committee refused our request and failed to review the incident.

The following is an example describing a warden's failure to refer a use-of-force incident to the department's executive review committee until we contacted an associate director.

- An incarcerated person suffered a medical emergency and temporarily lost consciousness while in a shared housing cell with other incarcerated persons. In preparing to transport the incarcerated person for medical treatment, staff placed the incarcerated person in a Stokes litter.[23] The incarcerated person resisted the officers, and the officers used physical force to restrain the incarcerated person's upper body, legs, and feet. The incarcerated person sustained a serious bodily injury (fractured ankle) and alleged that staff caused the injury. At the institution's executive review committee, we identified the incarcerated person's serious bodily injury could have been caused by an officer's restraint of the incarcerated person's leg as reported in the incident. While the warden agreed the injury could have been caused by staff's use-of-force, he did not refer the incident to the department's executive review committee for review. The warden failed to refer the incident for 356 days; it was not until we contacted an associate director, did the department's executive review committee review the case. The department's executive review committee then ordered training for the warden, associate warden, captain, and use-of-force coordinator.

23. A Stokes litter, stretcher, or basket is a metal wire or plastic litter that is can be used to carry a person where there are obstacles to movement, such as in confined spaces.

## Department Executives Concluded That *Miranda* Warnings Do Not Apply To Incarcerated Persons During Video-Recorded Interviews

Another area of concern we identified with the department's executive review committees was the department's failure to consistently determine when its staff (peace officers) are required to provide the *Miranda* warnings to an incarcerated person. During one of the meetings, while discussing a use-of-force incident the department had referred to a local district attorney's office for prosecution of an incarcerated person, a lieutenant requested training for a sergeant for failure to provide the incarcerated person (who was the criminal suspect) the *Miranda* warnings before an interview. The assigned associate director disagreed and said, "I see what you are saying. I get where the OIG is coming from, but I just do not think that *Miranda* applies to us." This statement is in direct conflict with the department's Inmate Interview or Allegation Worksheet, which states in part, "If the incident is a DA referral, you should provide/remind the inmate of a *Miranda* Admonishment prior to the interview."

> "I just do not think that *Miranda* applies to us."
>
> *– Stated by a departmental executive to an OIG inspector*

After the department's initial executive review committee meeting, four supervising inspectors met with the associate directors assigned to each mission and again expressed our concern regarding the department's failure to provide the *Miranda* warnings for future incidents the department refers for criminal prosecution. Collectively, the department's associate directors said they were not required to provide the *Miranda* warnings to this incarcerated person and criminal suspect when it questioned the incarcerated person regarding an incident referred for criminal prosecution. It is unclear from the department's policy and training when the department requires its staff to provide the *Miranda* warnings to an incarcerated person, and we observed institution and department executives review and follow *Miranda* inconsistently. We recommend the department seek a legal opinion from its attorneys, develop and implement a clear policy and training for its staff regarding when the *Miranda* warnings are required.[24]

24. Sources: *Miranda* v. *Arizona*, 384 US 436, 1966; DOM, Section 52050.7; the department's training courses regarding laws of arrest, *Miranda,* and courtroom preparation; and Inmate Interview for Allegation and great bodily injury and serious bodily injury worksheets.

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# Recommendations

For the January through December 2021 reporting period, we offer five recommendations to the department:

Nº 1. Due to the high percentage of incidents in which we believed officers did not adequately attempt to de-escalate a situation, we recommend the department evaluate its current policies and training as they relate to communication and de-escalation techniques to reduce the overall instances in which staff need to use force. In addition, we recommend continued de-escalation training for supervisors and managers to ensure instances in which staff do not adequately attempt to de-escalate a situation are captured during the review process.

Nº 2. The department should develop a process to ensure that video-recorded interviews are conducted within the time frame required by policy. In addition, we recommend the department modify the "Inmate Interview" forms to remove ambiguity regarding the video recording of injuries and specify that alleged injuries, even those not visible or documented on the form CDCR 7219, shall be video recorded. Finally, we recommend the department create and implement policy, procedures, and training regarding video recording of actual or alleged injuries to an area of the body that would require the incarcerated person to remove clothing that may compromise the incarcerated person's privacy.

Nº 3. The department should develop a method to ensure that reviewers at all levels adequately review and identify deviations from use-of-force policy, procedures, and training. In many instances, reviewers at all levels, from the incident commander to the institution's review committee, failed to identify violations of use-of-force policy, procedures, and training. Furthermore, in some instances, reviewers concurred with the reviewers at the prior level all the way through the multiple-level review process, leaving the violations to be identified by the use-of-force coordinator, a noncustodial staff member, or the institution's review committee. We recommend the department track and monitor the levels of review and impose progressive discipline for reviewers who fail to complete satisfactory reviews.

Nº 4. The department should revise its current policy to include a specific time frame for deferred cases to be returned to the committee. Furthermore, the OIG urges the department to develop a comprehensive tracking system to monitor compliance with such a time frame.

Nº 5. We recommend the department seek a legal opinion from its attorneys, and develop and implement a clear policy and training for its staff when Miranda warnings are required.

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# Response to the Report

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STATE OF CALIFORNIA — DEPARTMENT OF CORRECTIONS AND REHABILITATION GAVIN NEWSOM, GOVERNOR

**OFFICE OF THE SECRETARY**
**P.O. Box 942883**
**Sacramento, CA 94283-0001**

August 11, 2022

Ms. Amarik Singh
Office of the Inspector General
10111 Old Placerville Road, Suite 110
Sacramento, CA 95827

Dear Ms. Singh:

The California Department of Corrections and Rehabilitation (Department) submits this letter in response to the Office of the Inspector General's (OIG) draft titled *Monitoring the Use-of-Force Review Process of the California Department of Corrections and Rehabilitation* for the period of January 1, 2021, through December 31, 2021.

The Department has reviewed and is currently evaluating OIG's assessment and statements regarding the mirandizing requirements, specifically in regard to the information found on page 37 - *Department Executives Concluded That Miranda Warnings Do Not Apply To Incarcerated Persons During Video-Recorded Interviews*.

The Department's position at this time is that we neither agree nor disagree with the statements made in that section. We are consulting with our Office of Legal Affairs, as we need more time to make a final determination.

If you have further questions, please contact me at (916) 323-6001.

Sincerely,

DocuSigned by:
Kathleen Allison
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KATHLEEN ALLISON
Secretary

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

OFFICE *of the* INSPECTOR GENERAL

*Amarik K. Singh*
Inspector General

*Neil Robertson*
Chief Deputy Inspector General

STATE *of* CALIFORNIA
August 2022

OIG