Roy W. Wesley, *Inspector General*

Bryan B. Beyer, *Chief Deputy Inspector General*

OIG | OFFICE *of the* INSPECTOR GENERAL

Independent Prison Oversight

June 2019

Monitoring the Use of Force

The California Department of Corrections and Rehabilitation Continues to Perform Well in Self-Assessing Its Use-of-Force Incidents, but Has Shown Little Improvement in Its Overall Compliance with Policies and Procedures

Electronic copies of reports published by the Office of the Inspector General
are available free in portable document format (PDF)
on our website at **www.oig.ca.gov**.

We also offer an online subscription service.
For information on how to subscribe,
visit **www.oig.ca.gov/pages/mail-list.php**.

For questions concerning the contents of this report,
please contact Shaun Spillane, Public Information Officer,
at 916-255-1131.

STATE of CALIFORNIA
OIG | OFFICE of the INSPECTOR GENERAL

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

Independent Prison Oversight

Regional Offices
Sacramento
Bakersfield
Rancho Cucamonga

June 24, 2019

Dear Governor and Legislative Leaders:

Enclosed is the Office of the Inspector General's report titled *The California Department of Corrections and Rehabilitation Continues to Perform Well in Self-Assessing Its Use-of-Force Incidents, but Has Shown Little Improvement in Its Overall Compliance with Policies and Procedures*. It covers use-of-force incidents we monitored for which the California Department of Corrections and Rehabilitation (the department) completed a review between January 1, 2018, and December 31, 2018.

This report concludes that the department thoroughly reviewed incidents after its staff used force, which is similar to our observation during our prior reporting period from July 1, 2017, through December 31, 2017. However, the department's overall compliance rate remains low, with the department finding only 55 percent of incidents in full compliance with its policies and procedures. For most incidents, we concurred with the department's policy determinations and actions to address deviations. However, we did not agree with the review committee's decision for a small number of incidents.

We found the department demonstrated only minimal improvement concerning officers articulating the presence of an imminent threat to justify the force they used, compared with findings published in our previous report. Specifically, we found a disproportionate share of officers at contract facilities who did not articulate an imminent threat to justify force. In addition, while the department showed some improvement compared with the findings in our prior report—and the overall number is still relatively low—we found further instances in which its staff members' actions may have contributed to the need to use force.

We also found that, despite the department's repeated efforts to reinforce policy requirements, sergeants and lieutenants who conducted required video-recorded interviews of inmates who alleged unnecessary or excessive force continued violating policy at a high rate. Examples of such violations include sergeants and lieutenants completing untimely interviews, not recording inmate injuries, completing interviews in a nonconfidential setting, or conducting interviews even though they were involved in the incident. The failure to conduct proper interviews may hinder the department's ability to appropriately and thoroughly address an inmate's allegation of misconduct. Finally, we noted the persistence of a low compliance rate during controlled use-of-force incidents, a type of force staff used when the inmate did not pose an imminent threat and was isolated to a confined area.

Respectfully submitted,

Roy W. Wesley
Inspector General

Gavin Newsom, Governor

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

(This page left blank for reproduction purposes.)

Contents

Illustrations

Figures

Tables

Box

Summary

Within its statutory mandate, the Office of the Inspector General (OIG) monitors the California Department of Corrections and Rehabilitation's (the department) process for reviewing and evaluating uses of force by departmental staff, and reports its findings. This report contains our evaluation concerning the use-of-force incidents for which the department completed reviews during the period from January 1, 2018, through December 31, 2018.

Any departmental employee who uses force, or observes another employee use force, is required to prepare a written report of the incident before being relieved from duty at the end of the working shift. These reports are then subjected to a multitiered review process culminating with an executive review committee's evaluation. The OIG's monitoring process included having its inspectors visit every adult institution and juvenile facility, headquarters, and the northern and southern parole regions to attend 1,294 of the 1,764 executive review committee meetings (a 73 percent attendance rate), during which time, hiring authorities reviewed and evaluated every use-of-force incident to assess compliance with departmental policy and training.

As part of our oversight process for this 12-month period, our inspectors reviewed and analyzed 6,426 use-of-force incidents. OIG inspectors reviewed all written reports and documentation and, where applicable, viewed all related video recordings of incidents and interviews. We independently determined whether staff actions were reasonable under the circumstances and in compliance with the department's policy and training. During the committee meetings, our inspectors provided real-time feedback and recommendations to review committee chairs.

Use-of-Force Statistics for Incidents Monitored during the Period from January 1, 2018, through December 31, 2018

- The OIG monitored 6,426 use-of-force incidents by attending 1,294 of the department's 1,764 executive review committee meetings (73 percent).
- Approximately 93 percent of the use-of-force incidents (5,996 of 6,426) occurred at the state prisons and contract facilities housing adult inmates, with the remainder involving the juvenile facilities (359), parole regions (57), and the Office of Correctional Safety (14).
- Approximately one-third of the incidents we reviewed occurred at only five state prisons: Salinas Valley State Prison (500), California State Prison, Sacramento (495), Kern Valley State Prison (484), California State Prison, Los Angeles County (421), and California State Prison, Corcoran (420).
- We monitored 6,426 incidents involving 19,527 "applications" of force—for example, two baton strikes count as two "applications" during a single incident. Chemical agents accounted for 9,736 (50 percent) of total applications, while physical strength and holds accounted for 5,995 (31 percent). The remaining 19 percent of applications comprised force options such as less-lethal projectiles, baton strikes, tasers, and firearms.

Highlights

The department continued to perform well in reviewing incidents; however, staff were fully compliant with departmental policies in only 55 percent of the use-of-force incidents.

The department subjects its use-of-force incidents to several levels of review, which culminate with an executive review committee determining compliance with use-of-force policies and procedures. As noted in our last report,[1] this process has proven effective in self-identifying instances of noncompliance. For example, while the department found that 55 percent of the incidents during this period fully met policy standards, it identified policy violations by its staff in 45 percent (2,883 of 6,426) of the incidents that we monitored during this one-year period. We agreed with the vast majority of the department's compliance determinations, yet we also identified some

[1] In this report, when we refer to our "last report," this means our use-of-force monitoring report we published in July 2018.

instances of noncompliance that the department's review committees had not considered.

The department showed minimal improvement in articulating an imminent threat to justify the force used, and we identified additional incidents during which officers[2] contributed to the need to use force.

The department's policy for the use of immediate force requires that officers provide justification by articulating in reports their reasoning for using force, for example, in response to a threat against the life of another or to prevent great bodily injury or escape. Despite this requirement, we concluded that officers did not adequately articulate an imminent threat in 95 of the 6,426 incidents (1.5 percent) we monitored during this one-year period, leading us to question whether the use of force was justified. This percentage is similar to that noted in our last report covering our monitoring of use-of-force incidents, which was 1.8 percent. However, we reiterate that while the number of such instances is relatively small compared with the totality of all use-of-force incidents during the period, the negative impact of any such incident involving unnecessary force can be quite significant in its potential to create tension between the inmate population and staff members, and in exposing the department to legal liability.

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

Departmental policy requires that staff conduct video-recorded interviews with inmates who allege unnecessary or excessive force, or who sustain serious or great bodily injury, possibly from the use of force. The policy contains specific requirements, including that staff record these interviews within 48 hours of discovery of the injury or inmate allegation and that staff video-record any visible or alleged injuries. We noted that the department's compliance rate with its own standards was only 51 percent during this one-year period. Despite the department's repeated attempts to provide additional training and direction to its staff regarding the requirements, the compliance rate remained low throughout this reporting period.

[2] In this report, unless we specify an individual's classification, when we refer to "officers," the term refers to various departmental peace officer classifications, such as correctional officers, sergeants, lieutenants, youth correctional officers, parole agents, and special agents. This list is not all-inclusive of all departmental peace officer classifications.

In controlled use-of-force incidents, the department's compliance rate slightly improved over our 2017 reporting period, but noncompliance remained high, with at least one violation in 65 percent of incidents.

The department implements "controlled force" procedures when an inmate's presence or conduct poses a threat, yet the inmate is located in an area that can be controlled or isolated. These procedures require advance planning and organization by custody staff, and medical and mental health staff. In addition, institutional staff must video-record the incident.

Of the 100 controlled use-of-force incidents we monitored during our one-year review period, the department's executive review committees found that staff violated one or more departmental policies specific to controlled use-of-force policies in 65 incidents (65 out of 100). Most of these violations occurred, not with the force itself, but rather, with complying with the requirements that led up to the actual force. While this showed progress, compared with the compliance rate noted in our last report (a 75 percent noncompliance rate), there are opportunities for improvement.

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[3] (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.[4]

As a result of those findings, in 2007, the Office of the Inspector General (OIG) began monitoring the department's use-of-force internal review process. In 2011, after significant improvements to reform the department's use-of-force review and disciplinary processes, the federal court dismissed the case. The OIG, however, has continued monitoring these processes. This report includes use-of-force incidents that the department reviewed and we monitored from January 1, 2018, through December 31, 2018, and presents our analysis and conclusions of how well the department followed its own policies and training.

[3] In 2005, the Department of Corrections was subsequently renamed the Department of Corrections and Rehabilitation.

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

Use-of-Force Policy: Common Terms Defined

Throughout this report, we use a number of terms and concepts specific to the use of force and allegations of excessive force. For clarity, we present the department's policy definitions[5] for the following terms:

Definitions of Select Terms Used in This Report	
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	The use of 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 inmate's presence or conduct poses a threat to safety or security, and the inmate is located in an area that can be controlled or isolated. These situations do not normally involve the imminent threat to loss of life or imminent threat to institution security.
Serious bodily injury	A serious impairment of physical condition, including, but not limited to the following: (1) loss of consciousness; (2) concussion; (3) bone fracture; (4) protracted loss or impairment of function of any bodily member or organ; (5) a wound requiring extensive suturing; and (6) serious disfigurement.
Great bodily injury	Any bodily injury that creates a substantial risk of death.

Use-of-Force Options

Inmate behavior can be unpredictable, and at times, departmental staff must use force to gain an inmate's compliance to ensure the safety of other inmates or staff. When determining the best course of action to resolve a particular situation, staff must evaluate the totality of

[5] Article 2, Use of Force, 51020.4 "Definitions," *California Department of Corrections and Rehabilitation, Adult Institutions, Programs, and Parole Operations Manual*. On the web at **https://www.cdcr.ca.gov/Regulations/Adult_Operations/docs/DOM/DOM%202019/2019-DOM.pdf** (accessed 6-11-19). The publication is commonly referred to as the DOM.

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

- Chemical agents
- Hand-held baton
- Physical strength and holds[6]
- Less-lethal weapons[7]
- Lethal weapons[8]

Levels of Use-of-Force Review: Adult Institutions

Institution Executive Review Committee: This is the primary level of review for use-of-force incidents involving the Division of Adult Institutions, including in-state and out-of-state contract facilities. For each adult institution, an institution's executive review committee examines every use of force, except those involving deadly force. This committee is chaired by the warden (or his or her designee, such as a chief deputy warden). The committee also includes an institution's associate wardens, captains, and health care representatives. Committees at each institution meet regularly, depending on the volume of use-of-force incidents, to discuss the merits of the force used, and to determine whether staff followed policies and procedures when using force. Departmental policy generally requires the committees to review each incident within 30 days of occurrence.

[6] Refers to a staff member using any part of his or her body as force.

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

[8] Lethal weapons: A firearm is a lethal weapon because it is used to fire lethal projectiles. A lethal weapon is any weapon that is likely to result in death. DOM, 51020.5.

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

Levels of Use-of-Force Review: Juvenile Facilities

Force Review Committee: For each of the juvenile facilities,[9] a force review committee examines every use of force. The review committee is a multidisciplinary team at each facility tasked with evaluating use-of-force incidents to identify effective and noneffective intervention techniques with the goal of reducing the use of force. The committee is chaired by the superintendent (or his or her designee, such as an assistant superintendent or chief of security), and includes program administrators, treatment team supervisors, a training officer, and health care representatives. As with the adult committees, the juvenile committees meet regularly to ensure each incident is reviewed within 30 days of occurrence, as required by policy.

Division Force Review Committee: The Division Force Review Committee is a headquarters-based multidisciplinary team of representatives whose members are designated by the director of the Division of Juvenile Justice. This committee reviews a minimum of 10 percent of all use-of-force incidents that the Force Review Committee at each facility evaluates to provide another level of review and ensure employees act in accordance with the department's policies, procedures, and training.

Level of Use-of-Force Review: Adult Parole Operations

Field Executive Review Committee: For the two parole regions, a field executive review committee examines every use of force and is

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

chaired by the regional parole administrator (or his or her designee, such as a chief deputy). Normally, the committee consists of the chair, one other manager, a supervising training coordinator, and a use-of-force coordinator. The department's policy generally requires the committees to review each incident within 30 days of occurrence.

Level of Use-of-Force Review: Deadly Force (Statewide)

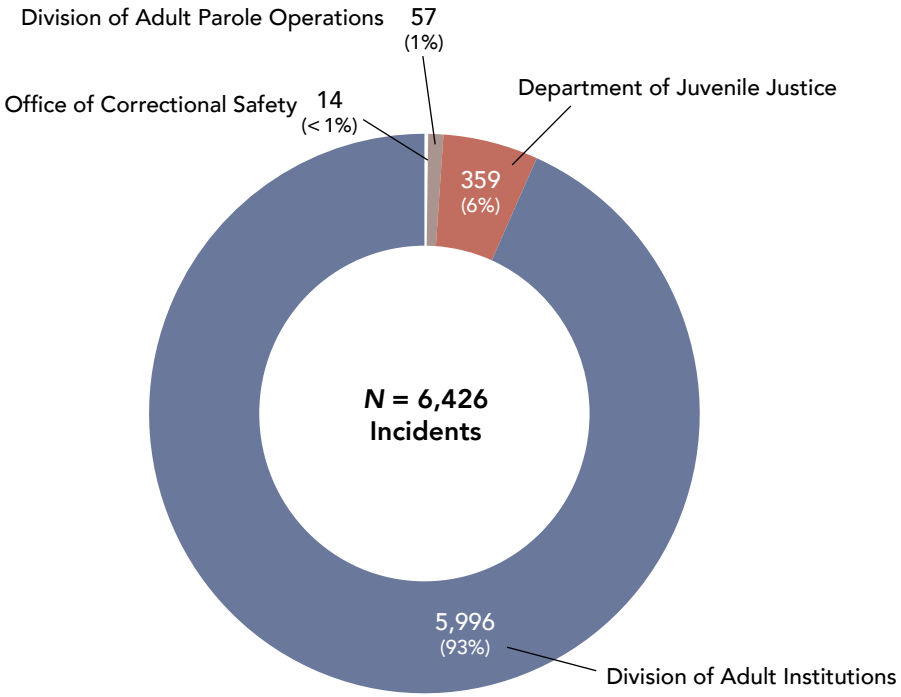
Deadly Force Review Board: The Office of Internal Affairs conducts criminal and administrative investigations into every use of deadly force (except for certain types of warning shots inside an institution) and every death or great bodily injury that could have been caused by a staff member's use of force, regardless of whether the incident occurred in an institutional or community setting. The department's Deadly Force Review Board subsequently examines these incidents. The board consists of at least four members, three of whom are law enforcement experts outside the department and another high-ranking official from the department. As part of its disciplinary monitoring function, the OIG monitors the Office of Internal Affairs' deadly force investigations, as defined above, and subsequently monitors the board's reviews of these investigations. The OIG reports on its monitoring of these deadly force incidents in a separate report semiannually.

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

We reviewed 6,426 use-of-force incidents for which the department conducted a review between January 1, 2018, and December 31, 2018. The majority of the incidents occurred at adult institutions, with a smaller share occurring in juvenile facilities and within the communities where offenders were on parole. We also reviewed a few incidents of force applied by the department's Office of Correctional Safety, which, among other things, acts as a liaison with other law enforcement entities and apprehends fugitives in the community (Figure 1, next page).

As part of the 6,426 use-of-force incidents that we monitored, staff members used 19,527 "applications" of force, defined as separate force actions. An application of force is a count of the number of times an officer used a force option. For example, if an officer used his baton to strike an inmate three times, this would count as three applications of force.

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



Source: Office of the Inspector General's Tracking and Reporting System for the period January 1, 2018, through December 31, 2018.

Table 1 on the following page identifies the number of force incidents, applications of force, and the number of staff and inmates involved. The Division of Adult Institutions experienced most of the incidents, accounting for nearly 93 percent of the incidents we monitored (5,996 of 6,426).[10]

[10] The total figure of 5,996 includes 5,830 incidents at all adult institutions, 46 incidents at in-state Contract Beds Unit facilities, and 120 incidents at out-of-state Contract Beds Unit facilities.

Table 1. Number of Use-of-Force Incidents by Departmental Entity

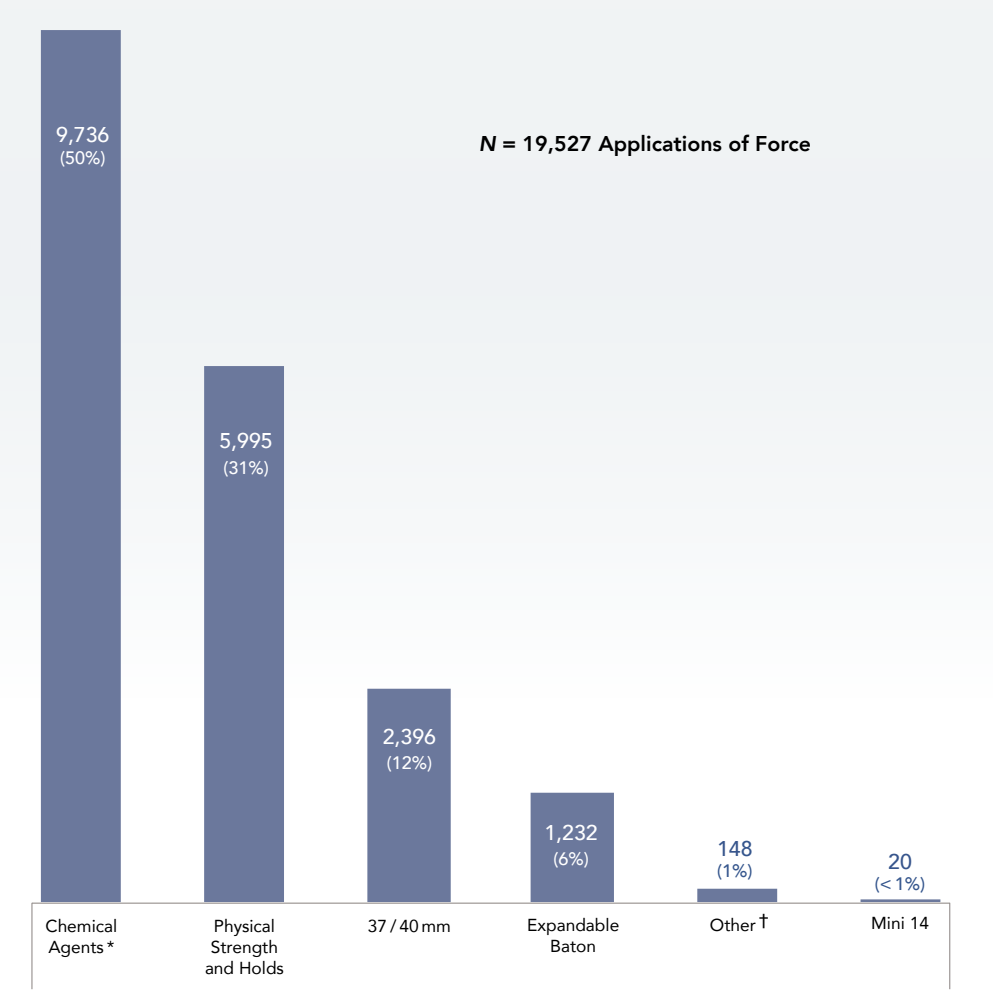
	Number of:			
Departmental Entity	Use-of-Force Incidents	Applications of Force	Staff Who Applied Force *	Inmates, Wards, or Parolees to Whom Force Was Applied *
Adult Institutions	5,830	17,539	13,656	10,721
Contract Beds Unit: In State	46	128	100	75
Contract Beds Unit: Out of State	120	468	220	322
Juvenile Facilities	359	1,214	733	1,150
Parole Regions	57	149	140	57
Office of Correctional Safety	14	29	25	14
Totals	**6,426**	**19,527**	**14,874**	**12,339**

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

Source: Office of the Inspector General's Tracking and Reporting System for the period January 1, 2018, through December 31, 2018.

When staff members encounter a situation in which an application of force is necessary, they must quickly assess the situation, and determine the most appropriate type of force for each situation to resolve the incident. The most common force option staff members used was chemical agents, which accounted for 50 percent of the total applications of force, followed by physical strength and holds, at 31 percent. Staff members used other force options less frequently, such as less-lethal projectiles, batons, a shield, nonconventional force, tasers, and the Mini 14 rifle (Figure 2, next page).

Figure 2. Distribution of the Applications of Force in 6,426 Uses of Force



* Chemical agents include oleoresin capsicum (OC) (8,951), CN gas (487), pepperball launcher (251), CS gas (32), and sting ball grenades (15).

† Other includes the use of a shield (77), nonconventional uses of force (50), and a taser (21).

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

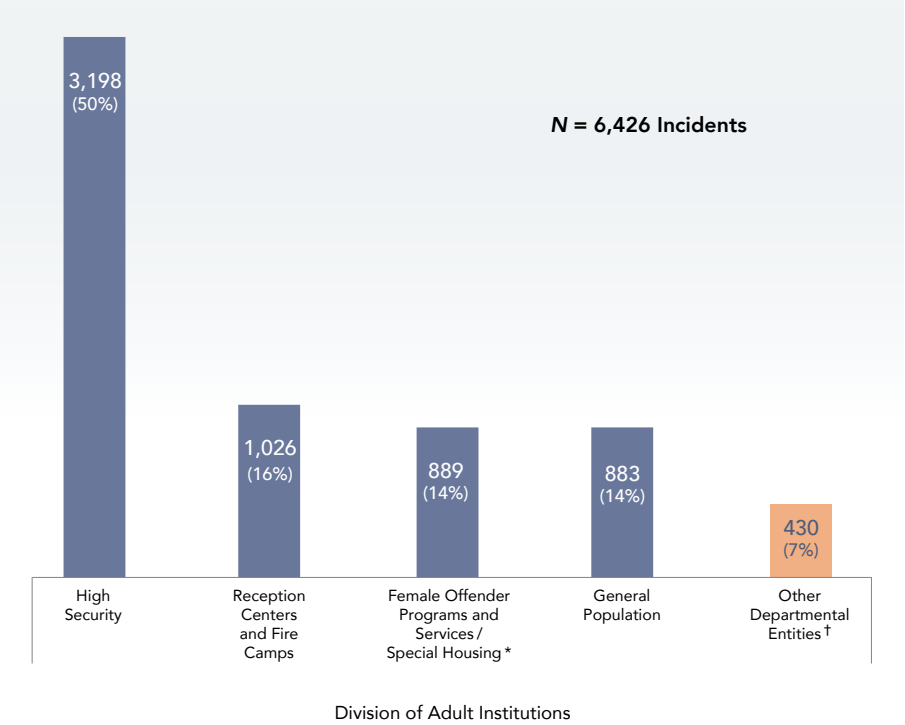
Source: Office of the Inspector General's Tracking and Reporting System for the period January 1, 2018, through December 31, 2018.

Frequency of Force Incidents

On the following page, Figure 3 shows the distribution of the 6,426 use-of-force incidents throughout the department's institutional missions and other departmental entities. Not surprisingly, the majority of incidents occurred at the department's adult institutions, which

accounted for 93 percent of all incidents we monitored. Institutions within the high security mission, which housed the most serious and dangerous offenders, accounted for the highest percentage (50 percent) of incidents. A closer look at the data revealed that within the high security mission, five adult prisons—Salinas Valley State Prison (500), California State Prison, Sacramento (495), Kern Valley State Prison (484), California State Prison, Los Angeles County (421), and California State Prison, Corcoran (420)—accounted for more than one-third of the incidents.

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



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

† Other Departmental Entities includes the Division of Adult Parole Operations (57), the Division of Juvenile Justice (359), and the Office of Correctional Safety (14).

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

Source: Office of the Inspector General's Tracking and Reporting System for the period January 1, 2018, through December 31, 2018.

(This page left blank for reproduction purposes.)

Scope and Methodology

In this report, the OIG presents its evaluation of the use-of-force incidents we monitored and for which the department completed a review between January 1, 2018, through December 31, 2018. To evaluate the effectiveness of the department's process of handling use-of-force incidents and its compliance with policies and procedures, our staff carefully reviewed various regulations and rules relevant to use-of-force practices. We also reviewed the department's use-of-force policy and related training modules, and other applicable operational policies. To further understand the department's procedures, we also observed use-of-force training at some institutions.

To determine whether institutions properly assessed use-of-force compliance, OIG inspectors visited every adult and juvenile institution as well as the northern and southern parole regions, and attended 1,246 of the 1,715 review committee meetings (73 percent) held during this period.[11] Our inspectors reviewed and analyzed 6,426 separate incidents concerning the use of force.[12] For each of these incidents, our inspectors reviewed all written reports and documentation and, when applicable, viewed all video recordings of both related incidents and interviews. We then independently determined whether staff actions before, during, and after the use of force were reasonable under the circumstances and within the bounds of departmental policy and training procedures. Finally, although OIG inspectors served as nonvoting attendees at review committee meetings, they provided real-time feedback and recommendations on compliance-related matters to committee chairs, when necessary.

Inmates alleged unreasonable force in 660 of the 6,426 incidents we monitored, approximately 10 percent. Departmental policy triggers specific procedures upon receipt of an allegation, including the requirement for staff to video-record an interview with the inmate. Our review process includes analyzing the department's compliance with its video-recording requirements.

[11] These numbers represent the number of meetings attended and held at the department's 35 adult institutions, two parole regions, and three juvenile facilities. A committee in the department's headquarters office reviews use-of-force incidents from all in-state and out-of-state contract facilities.

[12] If the department reviews the same incident at the institutional level and the headquarters level, we count that as one separate incident.

To determine whether the department executive review committees (for adult institutions) and the department force review committees (for juvenile facilities) properly assessed force incidents, inspectors attended 48 of the 49 meetings (98 percent) held at the department's headquarters level that the committees notified us were scheduled to take place during the 12-month period.[13]

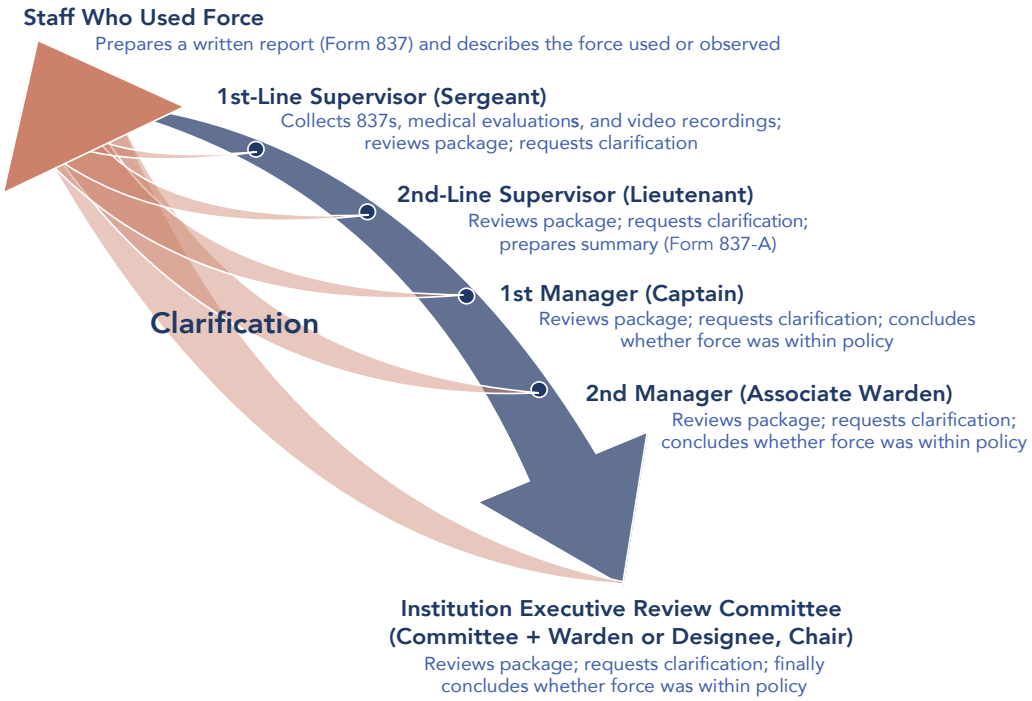
[13] The OIG attended 1,294 of the 1,764 total meetings held at the institutional level and the headquarters level combined.

Monitoring Results

Compared with Last Year, the Department Again Performed Well in Self-Assessing Compliance with Its Use-of-Force Policy, yet Its Compliance Rate Remained Low

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

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



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

The review process for the Division of Adult Institutions begins following any use of force. Departmental policy requires that staff who use or observe force submit a written report before being relieved from duty at the end of the working shift. In general, reports should include a description of the inmate's actions and the staff member's 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 inmate's level of resistance. The policy also requires that medical personnel evaluate and assess the extent of any injuries sustained during the event and thoroughly document their medical evaluation.

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

At the second level of review, the incident commander (typically, a second-level supervisor, such as a lieutenant) must review all the reports for quality, accuracy, and content. The incident commander may ask staff to submit additional information if he or she determines the initial staff reports were unclear or incomplete in their descriptions. The incident commander is also responsible for providing an overall summary of the incident based on all reports submitted by staff and then analyzing their actions taken during the use of force to determine whether such actions complied with policy and training. The incident commander then moves the incident package along to the next reviewer.

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

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

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

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

If the chair determines staff actions were out of policy, he or she may order corrective action, which could include training, a letter of instruction, or counseling. For more serious policy violations (or repeated violations), the chair may refer the matter to the department's Office of Internal Affairs for an investigation or authorization to impose disciplinary action[14] directly.

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

Between January 1, 2018, and December 31, 2018, the OIG reviewed and analyzed 6,426 staff-reported use-of-force incidents. These incidents predominantly occurred in a prison setting, but some occurred in the juvenile facilities or in a community setting.

Overall, the department determined that its staff completely followed policy in only 3,543 out of 6,426 incidents (55 percent) that we monitored during this period, as depicted in Table 2 on the next page. The OIG predominantly agreed with the review committees' decisions in these incidents. However, in our opinion, some type of policy violation was present for 276 of the incidents for which the department concluded its staff followed policy.

[14] Disciplinary action is also referred to as "adverse" action.

Table 2. Number of Incidents a Review Committee Determined Were In or Out of Policy Compliance

	Number of Incidents:		Percentage of Incidents:		Number of Incidents:
Category	Deemed In Policy by Committee	With at Least One Policy Violation	Deemed In Policy by Committee	With at Least One Policy Violation	In Which the OIG Did Not Concur with Committees' In-Policy Decision
Actual Force	6,247	179	97%	3%	41
Apart from Force	4,207	2,219	65%	35%	204
Nonuse of Force	5,331	1,095	83%	17%	58
Overall *	**3,543**	**2,883**	**55%**	**45%**	**276**

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

Source: Office of the Inspector General's Tracking and Reporting System for the period January 1, 2018, through December 31, 2018.

When evaluating force in relation to departmental policy, the OIG groups decisions into three primary categories: (1) *actual force*, referring to the force itself; (2) *apart from the actual force*, referring to requirements encompassed within the use-of-force policy, but not the force itself; and (3) *nonuse of force*, referring to actions covered under departmental policy, unrelated to the use-of-force policy or use-of-force training (see box, following page). These categories help provide some measure of context to overall compliance rates. Many of the incidents had more than one policy violation within a particular category, and some incidents had policy violations in more than one category. For additional detail, see Appendix B.

The department concluded that staff followed policy with the *actual force* requirements in 6,247 of the incidents, 97 percent. The OIG mostly agreed with the department's review committees' decisions, but determined 41 of the 6,247 incidents had at least one policy violation relevant to this category not addressed by the committee, fewer than 1 percent.

Regarding the *apart from the actual force* policy requirement, the department determined that it followed policy in only 4,207 of the incidents. This represents a 65 percent compliance rate, and, by far, it

was the lowest compliance rate of the OIG's three categories. Again, the OIG agreed with most of these determinations, but determined 204, or nearly 5 percent, of the 4,207 incidents reflected at least one policy violation relevant to this category that the committee failed to address. The number of disagreements was higher in this category than any other and represented a significant increase over the prior year when we disagreed with only about 2 percent of the department's conclusions.

Finally, the department determined that it followed policy with the *nonuse-of-force* requirements in 5,331 of the incidents, or 83 percent. The OIG mostly agreed, but concluded 58 of those incidents reflected at least one policy violation relevant to this category that the committee failed to address.

While the department's determination of compliance was essentially the same as the rate noted in our last report, during this period, we disagreed with the department's decisions more often. In our prior report, we disagreed with the department's decisions in about 2 percent of the incidents in which the department found no policy violations. In this report, that percentage of disagreements increased to about 8 percent of the incidents (276 of 3,543 incidents).

The OIG groups policy determinations into three primary categories:

Actual force	Refers to the force itself
Apart from the actual force	Refers to the department's policies and training encompassed within the use-of-force policy, excluding the force itself. Common examples of this include the completion of medical assessments and assessment forms, the timely completion of forms following an incident, requirements concerning video-recording interviews, and various protocols leading up to a controlled use of force
Nonuse of force	Refers to actions covered by departmental policy, unrelated to the use of force

Source: Office of the Inspector General.

Overwhelmingly, the Department Provided Training to Remedy Policy Violations; but in a Few Instances, It Took a Higher Level of Corrective or Adverse Action

The department identified policy violations in 2,883 of the 6,426 incidents, a rate of 45 percent. It required training for the staff involved for at least 2,747 of the 2,883 out-of-policy incidents, or 95 percent. Furthermore, the department took other corrective action by counseling staff in 163 of the 2,883 out-of-policy incidents (6 percent). Finally, the department imposed disciplinary action for staff misconduct in 35 of the 2,883 incidents (about 1 percent).[15] The OIG monitors and reports on the investigations the Office of Internal Affairs conducts, including any resulting disciplinary determinations, in a separate public report semiannually.

The Department Still Has Not Implemented a Reliable Statewide Use-of-Force Tracking System to Identify Trends and Monitor Corrective Action

In our last report, we noted that the department began tracking its use-of-force data in a statewide system called the Incident Report Tracking SharePoint (the tracking system).

The department designed the tracking system to include all reported use-of-force incidents at each institution and to display force incident-related information concerning individual staff members and inmates, the type of force used, the results of the use of force, and corrective action taken (if applicable). According to the department, the tracking system was supposed to provide staff with the ability to identify trends, create reports, and provide real-time data to its users.

Shortly after implementing the tracking system, however, the department determined the system was not reliable. The department notified our office that a replacement tracking system is scheduled to be implemented in August 2019. We will continue to monitor progress made toward it and report on its status in future reports.

[15] When allegations of serious misconduct arise, the institution executive review committee can defer a case and refer it to the Office of Internal Affairs for investigation. As of December 31, 2018, there were 31 cases that had been deferred by the committee for referral to the Office of Internal Affairs, which were pending a final outcome.

Departmental Staff Showed Minimal Improvement in Articulating an Imminent Threat to Justify the Force Used, and We Identified Additional Incidents in Which Officers Contributed to the Need to Use Force

The department allows officers to use immediate force when an imminent threat jeopardizes the safety of persons or compromises the security of the institution. Its policy further requires that officers clearly articulate in their use-of-force reports the threat that necessitated their actions. Despite this requirement, officers did not adequately articulate an imminent threat in 95 of the 6,426 incidents (1.5 percent), leading us to question whether the force was necessary. Although this is a very low percentage in relative terms, and represents a slight improvement since we issued our last report (1.8 percent), any instance of unnecessary force could represent a critical issue for staff, inmates, and the department. When officers engage in unnecessary force, doing so can increase tension between staff and inmates, and may also expose the department to legal liability.

Some Officers Did Not Articulate a Threat to Justify the Force Used

The department self-identified unnecessary force in 50 of these 95 incidents and took action to address the violations, ranging from training to formal discipline. The OIG identified an additional 44 incidents in which we believed the officer(s) did not adequately justify the need for force. In 7 of the 44 incidents, the review committee agreed with our position and concluded the force was out of policy. In the remaining 37 cases, the committee disagreed with our assertion and found no violation related to the force used.[16] The OIG recognizes the difficulty of making split-second decisions during these types of incidents; it is much easier to second-guess staff members' actions after the fact. Yet these events serve as a reminder of how dangerous it can be to work in a prison setting, how quickly situations can escalate, and how important it is for staff to remain vigilant and aware at all times.

In one case, an inmate refused to leave a medical clinic, but ultimately complied with an officer's orders. Once outside the clinic, the yard camera captured footage of the incident. The inmate continued

[16] In one additional incident, a sergeant's force was unintentional. Although not justified, the OIG agreed with the committee's decision to take no action against the sergeant.

to request medication and to see a doctor. The inmate refused the officer's orders to submit to handcuffs, but did not appear physically aggressive. Several officers responded to the scene and surrounded the inmate, while the initial officer continued to engage in a dialogue with the inmate. The footage showed an additional officer running to the scene, past the other officers, grabbing the inmate from behind, and physically forcing him to the ground. Other officers then joined in with physical force to place handcuffs on the inmate. We suggested, based on both the video recording and the officers' reports, there had been no imminent threat to the safety of persons or the security of the institution that would justify the officer grabbing the inmate and forcing him to the ground. The warden disagreed with our position that the force was unnecessary and determined the officers' actions were in policy.

In another case, an officer deployed pepper-spray against two fighting inmates. One inmate complied with orders to "get down," on the ground. The officer and a sergeant approached the other inmate, who was standing against a wall, rubbing his eyes from the pepper spray exposure. The officer and the sergeant physically forced the inmate face-down to the ground, "to gain compliance of [a] direct order." We believed the reports did not articulate an imminent threat necessitating the use of physical force. Furthermore, the officer articulated that he used immediate force solely to gain compliance with a lawful order—a violation of departmental policy. The warden referred the incident to the department's executive review committee. The department executives agreed with our position and determined the officers did not articulate an imminent threat to justify the immediate force. The committee ordered training for the officer, the sergeant, and the managers at the institution who reviewed the incident.

In a third case, an officer observed an inmate running from another officer on an exercise yard and refusing orders to get down. The officer stated that he drew his pepper spray and "in an attempt to keep [the inmate] from dumping the contraband he had into a dorm and to effect custody on him, I gave a 1-second burst of my [pepper spray] to his facial area." Departmental policy does not permit the use of force to prevent the destruction of contraband. The warden determined there was no imminent threat to the safety of persons or the security of the institution and imposed formal discipline on the officer.

The Department's Contract Facilities Experienced a High Percentage of Incidents in Which Officers Did Not Articulate a Threat to Justify the Force

We noted a disproportionately high number of incidents for the department's contract facilities during which officers did not articulate an imminent threat to justify the force. The use-of-force incidents at contract facilities accounted for fewer than 3 percent of the total number throughout the department. However, incidents at contract facilities accounted for 29 percent of incidents during which officers did not articulate a threat to necessitate such force. In all instances, the committee chair took appropriate action, ranging from training to formal discipline, but the number of incidents is clear cause for concern. To ensure officers at contract facilities understand the department's policy regarding immediate force, we recommend the department provide training to staff at the contract facilities concerning the department's use-of-force policies, and specifically regarding immediate-force requirements.

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

The actions of officers in 64 of the 6,426 incidents (1 percent) unnecessarily contributed to the need to use force. Although this is a very low percentage of occurrences, and is the same percentage noted in our last report, it is important to reiterate the seriousness of the conduct. While we recognize that results from these actions could not have been easily foreseen, the department should examine these types of events so that it can train staff to better recognize warning signs before dangerous situations materialize. Even though these officers may not have intended to use force at the time of their initial actions, their actions nevertheless contributed to the outcomes. The review committees identified most of these instances and took actions ranging from training to disciplinary action.

In one incident, for example, a control booth officer released an inmate from his cell to take a shower, without providing an escort, in violation of the institution's modified procedures for that day, which required an escort for any inmate released from his cell. As the inmate returned to his cell, investigative services unit officers entered the unit and ordered the inmate to stop. The inmate entered his open cell and reached for his waistband. The officers followed the inmate, and one of the officers grabbed the inmate's wrist and shoulder. The inmate pulled away from the officer and flushed an object in the toilet. The officer wrote in his report that he "was able to pull [the inmate] away from the toilet in

[an] attempt to stop him from flushing more contraband" and used further physical force to place the inmate in a prone position. The warden determined the control booth officer negligently allowed the inmate to exit his cell without an escort, and there was no imminent threat to the safety of persons or the security of the institution to justify the officer's use of physical force to prevent the inmate from flushing contraband. The warden imposed formal discipline on the control booth officer and the officer who used physical force.

In another case, a control booth officer released two inmates from their cells without the direction and presence of officers in the dayroom. One inmate stabbed the other inmate with a sharpened piece of metal. The control booth officer fired six less-lethal rounds to stop the attack. The victim sustained multiple stab wounds, including a punctured lung. The other inmate sustained minor injuries from the force used. The warden concluded that the control booth officer inappropriately released the inmates from their cells and imposed formal discipline.

In a third incident, a handcuffed inmate in a holding cell spat on a nearby officer who was monitoring the inmate. Two sergeants responded and instructed another officer to enter the cell and place a spit mask on the inmate. As the officer opened the holding cell door, the inmate kicked the officer, resulting in the officer and two sergeants using physical force to place the inmate on the ground. The inmate continued to resist the efforts of the sergeants and the officer and kicked at one of them. One of the sergeants struck the inmate four times on his leg to stop the kicking and control the inmate. One officer and the inmate sustained minor injuries during the incident. We suggested that the sergeants should have recognized that opening the cell door may have unnecessarily jeopardized the safety of the officer and sergeants. We further suggested—as did the associate warden who reviewed the incident—that the officer could have continued to monitor the inmate from a safe distance. The hiring authority disagreed with our position and determined that staff members' actions were appropriate.

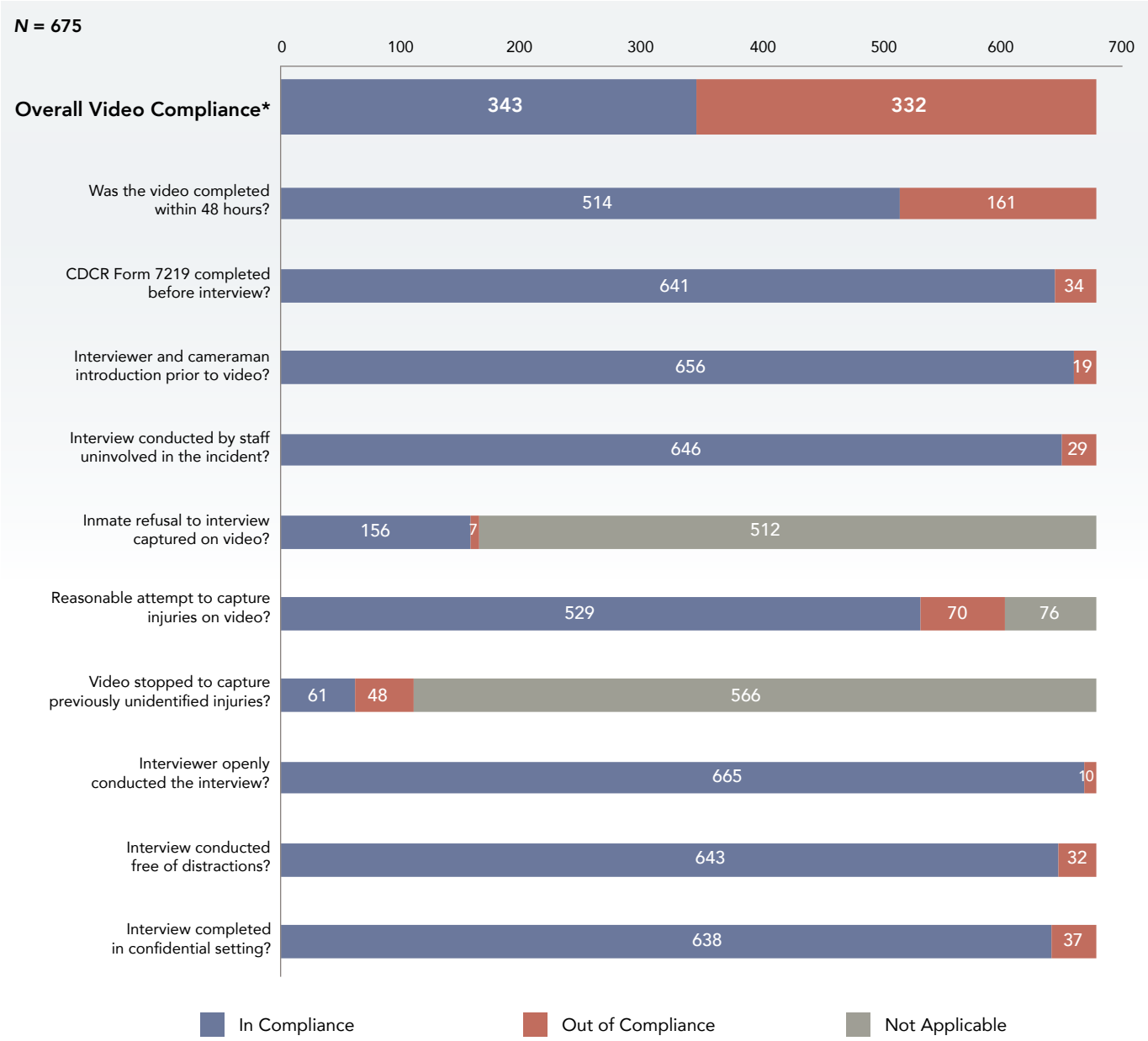
Sergeants and Lieutenants Continued to Routinely Violate Video-Recorded Interview Requirements

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

Figure 5, on the next page, displays the number of interviews the review committees found to be in compliance and out of compliance with video-recording policies, along with displaying the types of violations. The department's review committees found that staff actions in only 343 of the 675 video-recorded interviews we monitored fully complied with policy. This represents a compliance rate of only 51 percent. The review committees found at least one instance of noncompliance in each of the remaining 332 interviews.

Similar to our last report, the most common violation resulted from interviews that staff did not perform promptly. Staff failed to timely interview inmates in 161 of the 675 video-recorded interviews assessed by the OIG. The number of days beyond the required 48 hours ranged from one day to 252 days. There are several reasons for the 48-hour requirement, perhaps most importantly, to capture potential visual evidence of the inmate's alleged injuries. In all the interviews reviewed, we identified 70 instances during which the interviewer failed to capture the inmate's alleged injuries on camera, even when conducting a timely interview. Timely and properly documenting evidence may obviously support an inmate's claim, but a lack of visible injuries may refute an inmate's allegation. For instance, an inmate's allegation that officers punched and kicked him in the face could be seen as less credible if no visible injuries were promptly and properly documented. In addition, without gathering prompt and proper documentation, the department is left susceptible to allegations of a cover-up and ultimately impairs the department's ability to take prompt action.

Figure 5. Departmental Compliance with Video-Recorded Interviews



* **Overall Video Compliance** encompasses total compliance for all questions. We found at least one deficiency in 332 of the 675 videos we reviewed, a compliance rate of 51 percent.

Source: Office of the Inspector General's Tracking and Reporting System for the period January 1, 2018, through December 31, 2018.

The OIG has presented this concern in past reports, but the low compliance rate persists, with an additional 6 percent drop in the compliance rate, compared with the figure of 57 percent from our last report. In March 2017, after we published the low video-recording compliance rate of 61 percent for the July-through-December-2016 period, the department directed that additional training be given to all custodial supervisors and managers concerning its video-recording requirements. However, the timing of this training did not help the department achieve an improved compliance rate for the next six-month period. Specifically, during the period covering January through June 2017, the compliance rate continued to drop, falling another three percentage points, to 58 percent. In our last report, we concluded that the department complied with policy in 57 percent of the required interviews. To improve the compliance rate, the OIG recommended that the department reevaluate the training it provides regarding the correct procedures to follow when conducting video-recorded interviews. In January 2019, in response to our recommendation, the department reiterated its video-recording requirements to all wardens and required that certified use-of-force instructors train all supervisors and managers regarding these requirements. We will continue to monitor the department's compliance in this area and report the results in future reports.

The Department's Noncompliance Rate Involving Controlled Use-of-Force Incidents Remained a Concern

The department defines the controlled use of force as "the force used in an institutional or facility setting when an inmate's presence or conduct poses a threat to safety or security, and the inmate is located in an area that can be controlled or isolated. These situations do not normally involve the imminent threat to loss of life or imminent threat to institution security."[17] A controlled use of force involves advance planning, staffing, and organization; it also requires both the authorization and the presence of a first- or second-level manager (or an administrator-of-the-day during nonbusiness hours), and a video-recording of the incident.

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

During this reporting period, the OIG monitored 100 controlled use-of-force incidents.[18] Figure 6 (page 32) displays the incidents of controlled uses of force, by institution. More than 87 percent of these incidents involved an inmate who, at the time of the incident, was participating in the department's mental health services delivery system. The department's review committees found staff violated policy in 65 of the 100 incidents, a 35 percent compliance rate. The review committees found 64 of the 65 incidents out of compliance with elements "apart from the actual force" and also found seven incidents among the 65 out of compliance during the actual application of force. The OIG agreed with the committee findings in all but three incidents. In those three incidents, the review committees determined actions in compliance "apart from the actual force," but we identified at least one area of noncompliance with which the committee did not agree. The OIG independently identified "apart from the actual force" policy violations in 20 incidents and "actual force" policy violations in two incidents.

---

[17] Article 2, Use of Force, 51020.4 "Definitions," DOM.

[18] Some incidents involved more than one inmate. In the 100 controlled use-of-force incidents, 111 inmates were involved.

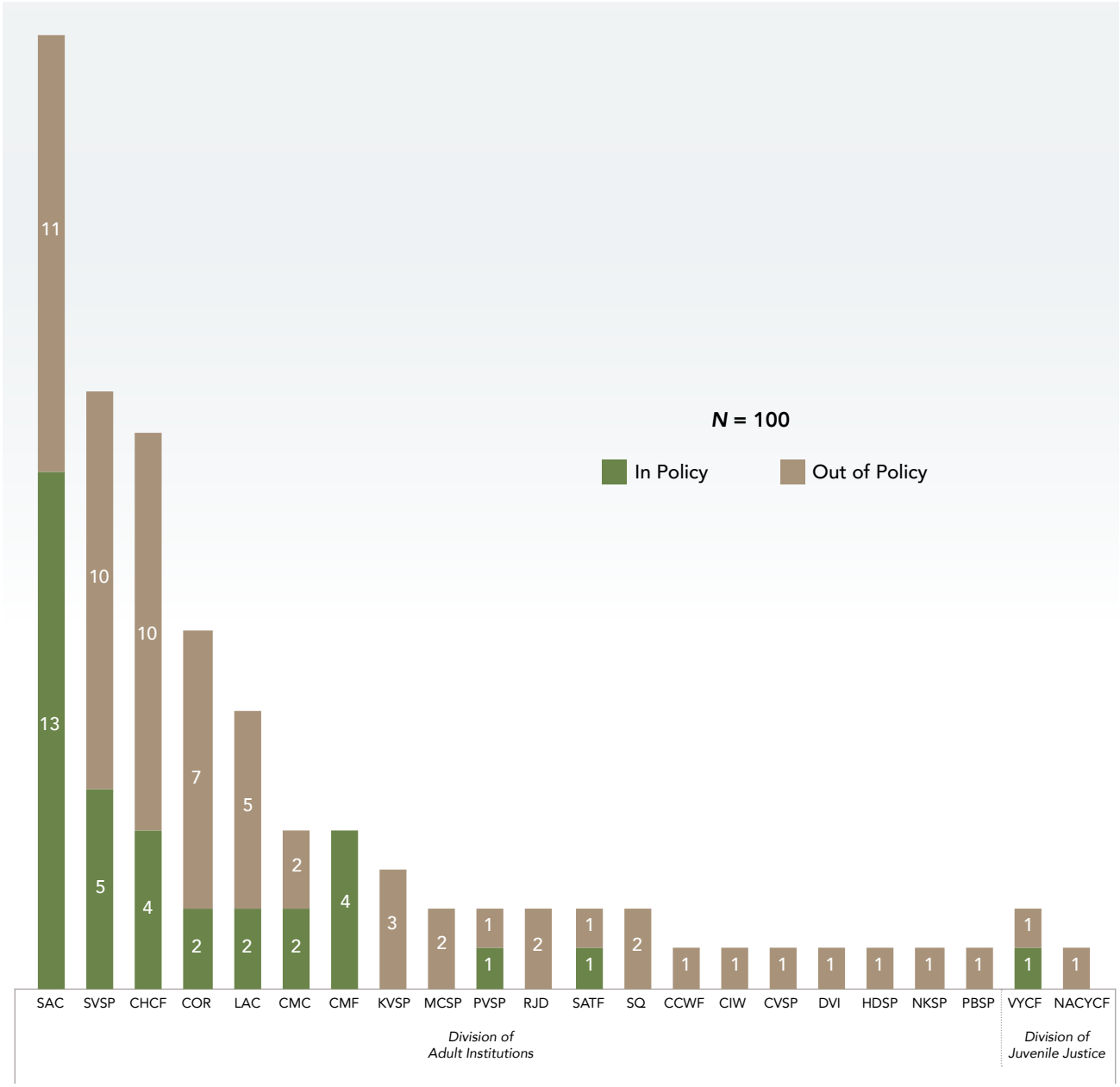
We persuaded the review committees that the department should provide training to its staff for both types of violations.

During the reporting period of July 1, 2017, to December 31, 2017, the department's noncompliance rate concerning its controlled use-of-force incidents was 75 percent. In response, we recommended that the department "reevaluate its training curriculum, provide additional training to staff, and select for participation in controlled use-of-force incidents only those who have completed additional training." The department rejected our recommendation, stating:

> The current lesson plan was reviewed and deemed adequate. The infrequent amount of controlled UOF [use-of-force] incidents can be attributed to the outstanding job staff are doing using communication and de-escalation techniques. Select group training will not be implemented.

While the department has shown slight improvement in its compliance rate—35 percent compliance versus the previous 25 percent—in the OIG's opinion, there is room for more improvement (Figure 6, next page).

Figure 6. Incidents of Controlled Uses of Force, by Institution or Facility



Source: Office of the Inspector General's Tracking and Reporting System for the period January 1, 2018, through December 31, 2018.

Recommendations

We recommend that the department pursue the following actions:

Ensure that the department validates the data collected in the new tracking system for accuracy and evaluates the data for monitoring use-of-force trends.

For the 2017 reporting period, we made several recommendations to the department based on its implementation of a statewide tracking system. Our recommendations included identifying beneficial use-of-force management reports, analyzing the data the system would produce for trends, monitoring staff who frequently use force or violate policy, and tracking the corrective or adverse actions hiring authorities imposed. While the department was generally responsive to our recommendations, the tracking system will not be implemented until August 2019. We look forward to the new tracking system's deployment and recommend that the department continuously analyze the information to ensure it meets management's needs.

Ensure that managers hold supervisors accountable for deficiencies in the video-recorded interview process.

The OIG previously recommended that the department reevaluate the training it provides regarding the correct procedures to follow when conducting video-recorded interviews. In January 2019, in response to our recommendation, the department reiterated its video-recording requirements to all wardens and required that certified use-of-force instructors train all supervisors and managers regarding the requirements. The department's compliance has not improved since we reported the deficiencies in 2017, yet the department determined its training curriculum to be adequate. Therefore, we recommend the department's managers hold supervisors accountable by imposing progressive discipline on those who violate the requirements.

Ensure that managers hold staff accountable for violations of policy related to controlled use-of-force incidents.

Due to the low compliance rate with controlled use-of-force requirements, we recommended in our prior report that the department evaluate its training curriculum, provide additional training to staff, and consider utilizing only a select group of trained staff to participate in these incidents. The department rejected our recommendation and determined that its current training was adequate. We recommend that the department impose progressive discipline on staff who violate policy while supervising and/or participating in controlled use-of-force incidents.

Require all staff at contract facilities to attend use-of-force training to ensure compliance with the department's use-of-force policy.

The staff at the department's contract facilities used force without articulating an imminent threat to necessitate that force at a disproportionate rate when compared with officers at the department's institutions. To increase compliance with the use of immediate force at the contract facilities, we recommend the department provide training to staff at the contract facilities concerning the department's use-of-force policies, and specifically regarding immediate-force requirements.

Appendices

Appendix A: Detail of Use-of-Force Incidents

	Number of:			
Prison or Departmental Entity	Use-of-Force Incidents	Applications of Force	Staff Who Applied Force *	Inmates, Wards, or Parolees to Whom Force Was Applied *
Adult Institutions	5,830	17,539	13,656	10,721
Avenal State Prison	48	119	91	126
California City Correctional Facility	26	79	55	54
Calipatria State Prison	146	426	305	351
California Correctional Center	75	173	142	160
California Correctional Institution	323	885	737	703
Central California Women's Facility	262	760	631	395
Centinela State Prison	86	200	146	196
California Health Care Facility	203	721	619	224
California Institution for Men	39	73	54	61
California Institution for Women	105	230	203	146
California Men's Colony	107	297	242	148
California Medical Facility	90	305	271	111
California State Prison, Corcoran	420	1053	869	690
California Rehabilitation Center	47	153	95	99
Correctional Training Facility	26	82	60	61
Chuckawalla Valley State Prison	20	45	38	49
Deuel Vocational Institution	109	283	231	217
Folsom State Prison	63	251	167	118
High Desert State Prison	267	1017	724	587
Ironwood State Prison	38	119	92	80
Kern Valley State Prison	484	1360	1064	930
California State Prison, Los Angeles County	421	1371	1108	728
Mule Creek State Prison	300	996	726	489
North Kern State Prison	130	284	216	230
Pelican Bay State Prison	72	430	288	221
Pleasant Valley State Prison	128	435	335	345
Richard J. Donovan Correctional Facility	156	313	275	222
California State Prison, Sacramento	495	1613	1279	791
California Substance Abuse Treatment Facility	190	541	383	327
Sierra Conservation Center	50	136	93	111

Continued on next page.

Appendix A: Detail of Use-of-Force Incidents (continued)

	Number of:			
Prison or Departmental Entity	Use-of-Force Incidents	Applications of Force	Staff Who Applied Force *	Inmates, Wards, or Parolees to Whom Force Was Applied *
California State Prison, Solano	67	184	138	127
San Quentin State Prison	134	381	267	220
Salinas Valley State Prison	500	1649	1314	992
Valley State Prison	24	61	52	30
Wasco State Prison	179	514	346	382
Contract Beds: Community Correctional Facilities (In State)	46	128	100	75
Central Valley Modified Community Correctional Facility	3	3	3	4
Delano Modified Community Correctional Facility	18	44	38	24
Desert View Modified Community Correctional Facility	1	7	1	1
Golden State Modified Community Correctional Facility	1	2	2	2
McFarland Female Community Reentry Facility	3	6	5	5
Shafter Modified Community Correctional Facility	17	58	45	34
Taft Modified Community Correctional Facility	3	8	6	5
Contract Beds: Out of State	120	468	220	322
Tallahatchie County Correctional Facility	42	127	64	100
La Palma Correctional Center	78	341	156	222
Juvenile Facilities	359	1214	733	1150
N.A. Chaderjian Youth Correctional Facility	165	651	365	477
O.H. Close Youth Correctional Facility	118	283	179	389
Pine Grove Youth Conservation Camp	1	1	1	1
Ventura Youth Correctional Facility	75	279	188	283
Parole Regions	57	149	140	57
Parole Region North	19	42	40	19
Parole Region South	38	107	100	38
Office of Correctional Safety	14	29	25	14
Grand Totals	**6,426**	**19,527**	**14,874**	**12,339**

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

Source: Office of the Inspector General's Tracking and Reporting System for the period January 1, 2018, through December 31, 2018.

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

		Out of Policy:					
Prison or Departmental Entity	Number of Incidents	Number of Incidents: Apart from Use of Force	Apart from Use of Force (%)	Number of Incidents: Actual Use of Force	Actual Use of Force (%)	Number of Incidents: Nonuse of Force	Nonuse of Force (%)
Adult Institutions	5,830	1,878	32%	109	2%	1,012	17%
Avenal State Prison	48	10	21%	0	0%	7	15%
California City Correctional Facility	26	21	81%	2	8%	12	46%
Calipatria State Prison	146	24	16%	10	7%	23	16%
California Correctional Center	75	20	27%	1	1%	15	20%
California Correctional Institution	323	69	21%	1	0%	53	16%
Central California Women's Facility	262	132	50%	15	6%	90	34%
Centinela State Prison	86	13	15%	1	1%	5	6%
California Health Care Facility	203	114	56%	6	3%	23	11%
California Institution for Men	39	15	38%	0	0%	11	28%
California Institution for Women	105	38	36%	4	4%	31	30%
California Men's Colony	107	75	70%	2	2%	23	21%
California Medical Facility	90	45	50%	1	1%	9	10%
California State Prison, Corcoran	420	159	38%	0	0%	103	25%
California Rehabilitation Center	47	11	23%	0	0%	5	11%
Correctional Training Facility	26	14	54%	3	12%	4	15%
Chuckawalla Valley State Prison	20	2	10%	0	0%	2	10%
Deuel Vocational Institution	109	28	26%	0	0%	24	22%
Folsom State Prison	63	16	25%	0	0%	8	13%
High Desert State Prison	267	32	12%	4	1%	34	13%
Ironwood State Prison	38	4	11%	3	8%	4	11%
Kern Valley State Prison	484	148	31%	4	1%	51	11%
California State Prison, Los Angeles County	421	70	17%	4	1%	50	12%
Mule Creek State Prison	300	121	40%	11	4%	34	11%
North Kern State Prison	130	39	30%	2	2%	25	19%
Pelican Bay State Prison	72	23	32%	1	1%	15	21%
Pleasant Valley State Prison	128	20	16%	2	2%	24	19%
Richard J. Donovan Correctional Facility	156	28	18%	2	1%	27	17%
California State Prison, Sacramento	495	143	29%	15	3%	95	19%
California Substance Abuse Treatment Facility	190	86	45%	2	1%	60	32%
Sierra Conservation Center	50	22	44%	1	2%	17	34%

Continued on next page.

Appendix B: Detail of Policy Violations (continued)

		Out of Policy:					
Prison or Departmental Entity	Number of Incidents	Number of Incidents: Apart from Use of Force	Apart from Use of Force (%)	Number of Incidents: Actual Use of Force	Actual Use of Force (%)	Number of Incidents: Nonuse of Force	Nonuse of Force (%)
California State Prison, Solano	67	32	48%	0	0%	2	3%
San Quentin State Prison	134	60	45%	2	1%	23	17%
Salinas Valley State Prison	500	193	39%	9	2%	74	15%
Valley State Prison	24	6	25%	1	4%	5	21%
Wasco State Prison	179	45	25%	0	0%	24	13%
Contract Beds: Community Correctional Facilities (In State)	46	31	67%	15	33%	8	17%
Central Valley Modified Community Correctional Facility	3	2	67%	1	33%	1	33%
Delano Modified Community Correctional Facility	18	11	61%	8	44%	1	6%
Desert View Modified Community Correctional Facility	1	1	100%	0	0%	0	0%
Golden State Modified Community Correctional Facility	1	1	100%	0	0%	0	0%
McFarland Female Community Reentry Facility	3	2	67%	0	0%	2	67%
Shafter Modified Community Correctional Facility	17	12	71%	4	24%	1	6%
Taft Modified Community Correctional Facility	3	2	67%	2	67%	3	100%
Contract Beds: Out of State	120	87	73%	45	38%	42	35%
Tallahatchie County Correctional Facility	42	33	79%	18	43%	14	33%
La Palma Correctional Center	78	54	69%	27	35%	28	36%
Juvenile Facilities	359	213	59%	9	3%	22	6%
N.A. Chaderjian Youth Correctional Facility	165	101	61%	6	4%	8	5%
O.H. Close Youth Correctional Facility	118	75	64%	1	1%	5	4%
Pine Grove Youth Conservation Camp	1	1	100%	0	0%	0	0%
Ventura Youth Correctional Facility	75	36	48%	2	3%	9	12%
Parole Regions	57	10	18%	1	2%	11	19%
Parole Region North	19	5	26%	0	0%	3	16%
Parole Region South	38	5	13%	1	3%	8	21%
Office of Correctional Safety	14	0	0%	0	0%	0	0%
Grand Totals	**6,426**	**2,219**	**35%**	**179**	**3%**	**1,095**	**17%**

Source: Office of the Inspector General's Tracking and Reporting System for the period January 1, 2018, through December 31, 2018.

(This page left blank for reproduction purposes.)

Monitoring the Use of Force

OFFICE *of the* INSPECTOR GENERAL

Roy W. Wesley
Inspector General

Bryan B. Beyer
Chief Deputy Inspector General

STATE *of* CALIFORNIA
June 2019

OIG