



*Roy W. Wesley, Inspector General*

*Bryan B. Beyer, Chief Deputy Inspector General*

---

# OIG | OFFICE *of the* INSPECTOR GENERAL

---

Independent Prison Oversight

July 2020

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

---

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

We also offer an online subscription service.

For information on how to subscribe,  
visit [www.oig.ca.gov](http://www.oig.ca.gov).

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

Regional Offices

Sacramento

Bakersfield

Rancho Cucamonga

July 13, 2020

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

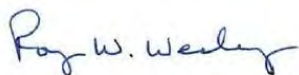
Dear Governor and Legislative Leaders:

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 third 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, 2019, and December 31, 2019.

Beginning with this reporting period, we have implemented a new monitoring methodology to assess the department's compliance with its use-of-force policies and procedures prior to, during, and following each incident that we monitored. For this reporting period, the OIG monitored 2,296 of the department's 9,692 use-of-force incidents which occurred in 2019 and concluded that the department's performance was overall *satisfactory*. We assessed the department's performance as *superior* in 24 incidents, *satisfactory* in 2,063 incidents, and *poor* in 209 incidents.

Based on concerns we identified in our monitoring, we provided four recommendations to the department: (1) implement a policy which clearly requires decontamination of all indoor areas following the use of chemical agents; (2) implement an unambiguous policy to clearly state the required elements for each use-of-force report; (3) track individual supervisors and impose progressive discipline on those supervisors who do not fulfill their duty to thoroughly review each use-of-force incident; and (4) implement a policy with a specified time frame to ensure the higher-level committee within the Division of Juvenile Justice reviews the more significant incidents without undue delay.

Sincerely,



Roy W. Wesley  
Inspector General



*(This page left blank for reproduction purposes.)*

# Contents

<b>Illustrations</b>	<b>iv</b>
<b>Summary</b>	<b>1</b>
<b>Introduction</b>	<b>5</b>
<b>Background</b>	<b>5</b>
Use-of-Force Options	5
Reporting and Review Requirements	13
Scope and Methodology	21
<b>Monitoring Results</b>	<b>25</b>
Overall, Even Though the Department Performed Satisfactorily in Its Handling of Its Use-of-Force Incidents, Staff Continue to Comply With the Department’s Use-of-Force Policy at a Low Rate	25
The Department’s Overall Performance in Handling Its Use-of-Force Incidents Was <b>Satisfactory</b>	27
Indicator 1. The Department’s Compliance With Policies and Procedures Before the Use of Force Was <i>Satisfactory</i>	31
Indicator 2. The Department’s Compliance With Policies and Procedures During the Application of Force Was <i>Satisfactory</i>	36
Indicator 3. The Department’s Compliance With Decontamination Policies and Procedures Following the Use of Chemical Agents Was <i>Satisfactory</i>	41
Indicator 4. The Department’s Compliance With Policies and Procedures in Medically Evaluating Inmates Who Were Involved in a Use-of-Force Incident Was <i>Satisfactory</i>	45
Indicator 5. The Department’s Compliance With Policies and Procedures When Supervising Inmates Following a Use of Force Was <i>Satisfactory</i>	52
Indicator 6. The Department’s Compliance With Policies and Procedures Specific to Users-of-Force Reporting Requirements Was <i>Satisfactory</i>	54
Indicator 7. The Department’s Compliance With Policies and Procedures Specific to Nonusers-of-Force Reporting Requirements Was <i>Satisfactory</i>	64
Indicator 8. The Performance of Staff When Conducting Video-Recorded Interviews Following Allegations of Unnecessary or Excessive Force Was <i>Poor</i>	69
Indicator 9. The Department’s Compliance With Policies and Procedures When Staff Conducted Inquiries Into Serious or Great Bodily Injury That Could Have Been Caused by Staff’s Use of Force Was <i>Poor</i>	73
Indicator 10. The Department’s Compliance With Policies and Procedures at the Institutional Levels of Review Was <i>Satisfactory</i>	78
Indicator 11. The Department’s Compliance With Its Policies and Procedures Regarding Department-Level Executive Review of Use-of-Force Incidents Was <i>Poor</i>	81
<b>Recommendations</b>	<b>83</b>

## Illustrations

### Figures

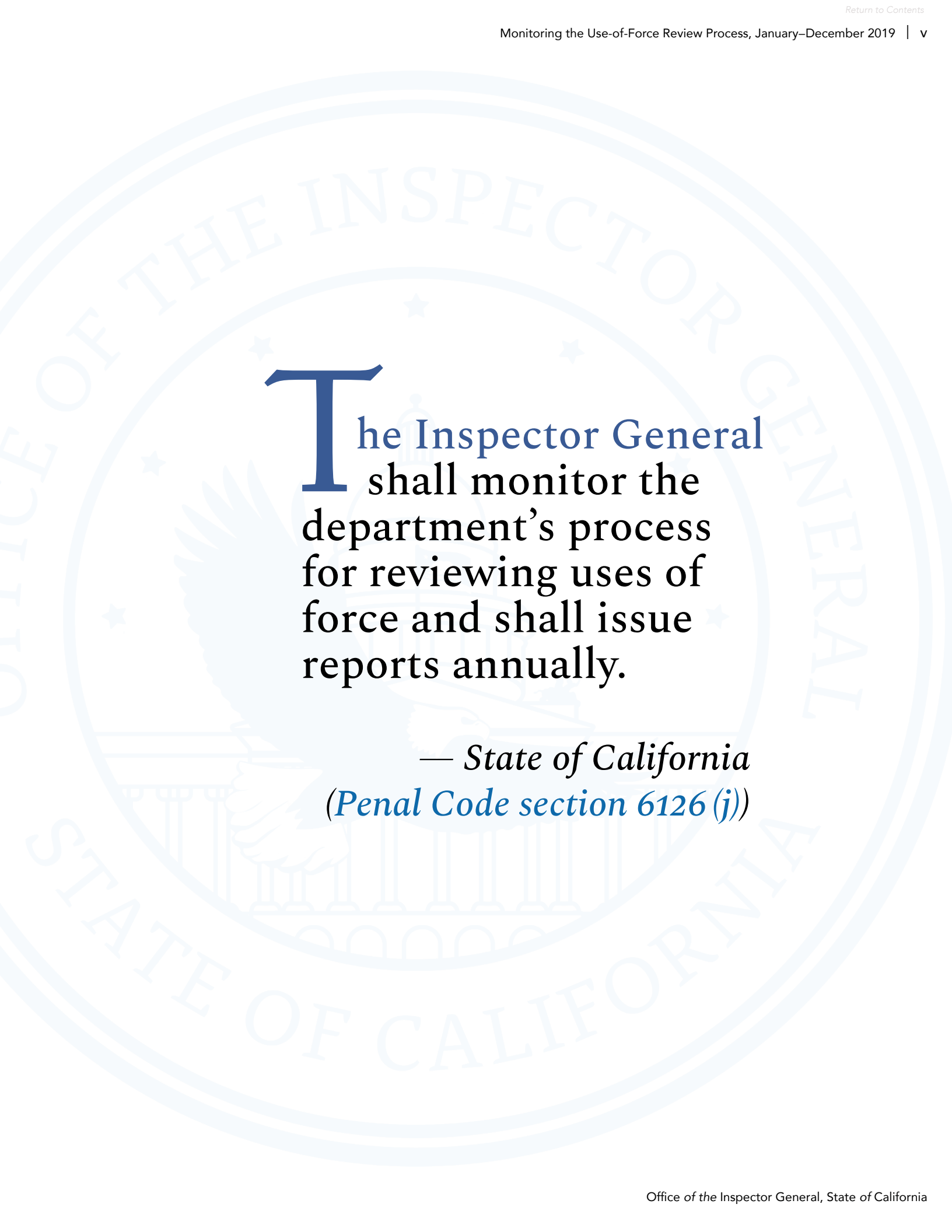
1. Delivery Methods for Deploying Chemical Agents	6
2. Impact Munition Projectiles Designated for Use in a Less-Lethal Launcher	10
3. Flowchart Depicting the Division of Adult Institutions' Use-of-Force Review Process	13
4. Distribution of the 2,296 Use-of-Force Incidents the OIG Monitored by Division and Other Entities	18
5. Use-of-Force Incidents the OIG Monitored by Mission and Other Entities	19
6. Distribution of the Applications of Force in 2,296 Use-of-Force Incidents	20
7. Total Number of Incidents Found In and Out of Compliance With the Department's Use-of-Force Policy	26
8. The OIG's Overall Rating of the Department's Handling of Its Use-of-Force Incidents	27
9. Medical Report of Injury or Unusual Occurrence (CDCR Form 7219)	45
10. Medical Evaluation Forms for Victim and Aggressor	50
11. Medical Evaluation Forms for Recipient of Force and Victim	51
12. CDCR 837 Crime/Incident Report Form	55
13. Inmate Interview for Allegation Worksheet (CDCR Form 3013-2)	70
14. Inmate Interview (CDCR Form 3013)	74
15. Report of Findings – Inmate Interview (CDCR Form 3014)	75

### Tables

Use-of-Force Policy: Definitions of Common Terms	vi
Other Terms Used in This Report	vii
1. Chemical Agents	7
2. Authorized Munition Projectiles for Less-Lethal Force	11
3. Number of Incidents the OIG Monitored by Departmental Entity	19
4. Inmate Allegation Video-Recorded Interview Compliance Rates	71
5. Serious Bodily Injury Video-Recorded Interview Compliance Rates	76
6. Policy Violations Not Identified at a Level of Review	79

### Graphics

The Office of the Inspector General's Mandate Concerning the Use of Force	v
The California Department of Corrections and Rehabilitation: Institutions and Parole Regions	viii

The background of the page features a large, light blue watermark of the official seal of the Office of the Inspector General, State of California. The seal is circular and contains the text "OFFICE OF THE INSPECTOR GENERAL" at the top and "STATE OF CALIFORNIA" at the bottom. In the center of the seal is an eagle with its wings spread, perched on a shield. The eagle is facing left. The shield has a banner across it with the word "EUREKA". There are five stars arranged in an arc above the eagle's head.

**T**he 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 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 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*. On the web at <https://www.cdcr.ca.gov/regulations/wp-content/uploads/sites/171/2020/03/2020-DOM-02.27.20.pdf?label=View%20the%20CDCR%202020%20Department%20Operations%20Manual&from=https://www.cdcr.ca.gov/regulations/cdcr-regulations/dom-toc/> (accessed 6-30-20). The publication is commonly referred to as the DOM.

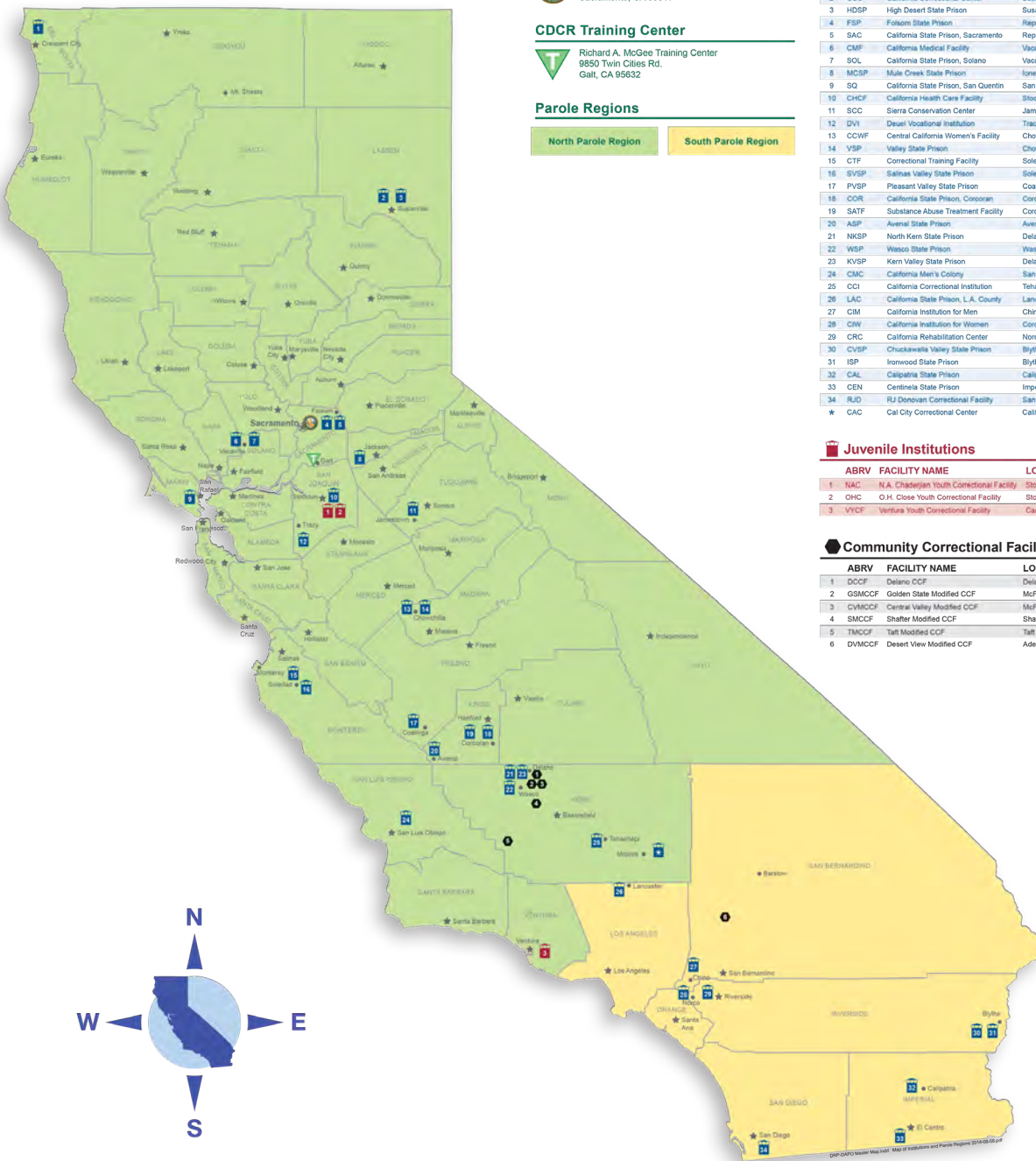


Other Terms Used in This Report	
<b>Hiring authority</b>	The secretary of the department, the general counsel, an undersecretary, or any chief deputy secretary, executive officer, chief information officer, assistant secretary, director, deputy director, associate deputy director, associate director, warden, superintendent, health care manager, regional health care administrator, or regional parole administrator.
<b>Custody staff</b>	Sworn peace officers at all levels within an institution or facility.
<b>Noncustody staff</b>	All nonsworn employees, including administrative, medical, and educational staff within an institution or facility.
<b>Contract facilities</b>	Facilities outside the 35 adult prisons under the Division of Adult Institutions that house state inmates for the purpose of reducing overcrowding.

Source: The department's DOM.



# California Department of Corrections and Rehabilitation Institutions and Parole Regions



### CDCR Headquarters

 Department of Corrections and Rehabilitation  
1515 'S' St.  
Sacramento, CA 95811

### CDCR Training Center

 Richard A. McGee Training Center  
9850 Twin Cities Rd.  
Galt, CA 95632

### Parole Regions

- North Parole Region
- South Parole Region

### Adult Institutions

ABRV	FACILITY NAME	LOCATION
1	PBSP Pelican Bay State Prison	Crescent City
2	CCC California Correctional Center	Susansville
3	HDSP High Desert State Prison	Susansville
4	FSP Folsom State Prison	Represas
5	SAC California State Prison, Sacramento	Represas
6	CMF California Medical Facility	Vacaville
7	SOL California State Prison, Solano	Vacaville
8	MCSP Mule Creek State Prison	Ione
9	SO California State Prison, San Quentin	San Quentin
10	CHCF California Health Care Facility	Stockton
11	SCC Sierra Conservation Center	Jamestown
12	DVI Deuel Vocational Institution	Tracy
13	CCWF Central California Women's Facility	Chowchilla
14	VSP Valley State Prison	Chowchilla
15	CTF Correctional Training Facility	Soledad
16	SVSP Salinas Valley State Prison	Soledad
17	PVSP Pleasant Valley State Prison	Coalinga
18	CCR California State Prison, Corcoran	Corcoran
19	SATF Substance Abuse Treatment Facility	Corcoran
20	ASP Arsenault State Prison	Avenal
21	NKSP North Kern State Prison	Delano
22	WSP Wasco State Prison	Wasco
23	KVSP Kern Valley State Prison	Delano
24	CMC California Men's Colony	San Luis Obispo
25	CCI California Correctional Institution	Tehachapi
26	LAC California State Prison, L.A. County	Lancaster
27	CIM California Institution for Men	Chino
28	CIV California Institution for Women	Corona
29	CRC California Rehabilitation Center	Norco
30	CVSP Chuckawalla Valley State Prison	Blythe
31	ISP Ironwood State Prison	Blythe
32	CAL Calipatria State Prison	Calipatria
33	CEN Centinela State Prison	Imperial
34	RJD RJ Donovan Correctional Facility	San Diego
★	CAC Cal City Correctional Center	California City

### Juvenile Institutions

ABRV	FACILITY NAME	LOCATION
1	NAC N.A. Chadejian Youth Correctional Facility	Stockton
2	OHC O.H. Close Youth Correctional Facility	Stockton
3	VYCF Ventura Youth Correctional Facility	Camarillo

### Community Correctional Facilities

ABRV	FACILITY NAME	LOCATION
1	DCCF Delano CCF	Delano
2	GSMCCF Golden State Modified CCF	McFarland
3	CVMCCF Central Valley Modified CCF	McFarland
4	SMCCF Shafter Modified CCF	Shafter
5	TMCCF Tull Modified CCF	Tull
6	DVMCCF Desert View Modified CCF	Adelanto

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

## Summary

This is the Office of the Inspector General’s third 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, 2019, and December 31, 2019.

Beginning with this reporting period, we have implemented a new monitoring methodology to assess the department’s compliance with its use-of-force policies and procedures prior to, during, and following each incident that we monitored. Our new methodology consists of 11 units of measure which we call *performance indicators* (indicators). We apply the indicators to assess the following: (1) staff actions prior to the use of force, including whether officers contributed to the need for force and used de-escalation techniques; (2) whether staff used reasonable force and complied with training requirements for 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 inmate involved in a use-of-force incident; (5) how well staff complied with requirements to supervise an inmate 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 inmates alleging unnecessary or excessive force; (9) how well staff conducted inquiries following an incident in which an inmate sustained serious or great bodily injury that may have been caused by staff’s use of force; (10) how well the institutions reviewed and evaluated each incident; and (11) how well the department’s executive level committee reviewed required incidents.

For this reporting period, we monitored 2,296 of the department’s 9,692 use-of-force incidents and concluded that the department’s performance was overall *satisfactory*. We assessed the department’s performance as *superior* in 24 incidents, *satisfactory* in 2,063 incidents, and *poor* in 209 incidents. In the 24 incidents in which we assessed the department’s performance as *superior*, the staff performed exceptionally well in multiple areas, such as, attempting to de-escalate the situation prior to using force, decontaminating involved inmates and the exposed area following the use of chemical agents, and describing in the required reports the force used and observed. In the 209 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 inmates 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 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 inmate's allegation of unreasonable force.

The department performed satisfactorily prior to the use of force, but we identified some instances in which officers had the opportunity, but did not attempt to de-escalate a potentially dangerous situation prior to using force. Also, similar to our prior reports, we identified several incidents in which an officer's actions unnecessarily contributed to the need to use force. During this period, we identified that staff's actions (or failure to act) contributed to the need to use force in approximately 3 percent of the incidents we monitored, representing an increase from the approximately one percent of the incidents in our prior report.

We found that, overall, the department performed satisfactorily during the actual use of force, but, similar to our prior reports, we identified some instances in which officers failed to describe an imminent threat to justify the force used, leading us to conclude that the force was unnecessary. The number of instances rose from approximately 1.5 percent of the incidents in our prior report, to approximately 2.2 percent of the incidents in this reporting period.

We assessed the department's performance in several areas following the use of force, including staff's compliance with the requirements to decontaminate inmates and affected areas after using chemical agents. We found that staff performed well in decontaminating involved inmates, but noted several instances in which staff did not adequately decontaminate a housing unit or offer decontamination to uninvolved inmates in the area. We also found that institutions inconsistently interpreted the requirement to decontaminate a housing unit, with some believing that the requirement does not extend to other indoor areas, such as classrooms and gymnasiums. Consequently, we provide a recommendation to the department to implement a policy which clearly requires decontamination of all indoor areas.

The department performed satisfactorily overall when writing reports following an incident and describing, among other things, the inmate's actions which led to the force and the force used and observed. We found that institutions inconsistently interpreted the report writing requirements when considering which elements are required in a report. Accordingly, we recommend that the department implement an unambiguous policy to clearly state the required elements for each use-of-force report.

One area of concern we identified is the quality of the reviews conducted by supervisors and managers at the institutions. The review process for each incident involves a minimum of five levels of review, during which each reviewer is required to review and evaluate staffs' actions and identify policy deviations. We found that supervisors and managers often failed to identify and address policy violations, creating an

inefficient process and leading us to question whether the supervisors and managers require additional training or whether they merely neglect their duty to make a good faith effort to review each incident thoroughly. Consequently, we provide a recommendation to the department to track the individual reviewers and impose progressive discipline on those who do not fulfill their duty.

Finally, the department's policy requires that incidents within certain categories, such as an officer's use of force causing serious bodily injury to the inmate, be reviewed at a higher level after the institution's review. We found that the department's Division of Adult Institutions reviewed only 75 percent of the incidents that we believed met these criteria. In addition, the department reviewed only 62 percent of the incidents within the required 60-day time frame. The department's Division of Juvenile Justice reviewed all of the incidents that met these criteria, but unlike the Division of Adult Institutions, there is no requirement for its higher-level committee to review the incidents within a certain time frame. Therefore, we recommend that the department implement a policy requiring this review be completed within a specified time frame to ensure the higher-level committee reviews these more significant incidents without undue delay.

## Use-of-Force Statistics, 2019

The OIG monitored 2,296 of the 9,692 use-of-force incidents that occurred (24 percent).

The OIG attended 973 of the 1,861 review committee meetings (53 percent).

Approximately 92 percent of the use-of-force incidents we monitored (2,125 of 2,296) occurred at the adult institutions and contract facilities housing adult inmates, with the remainder involving juvenile facilities (136), parole regions (19), and the Office of Correctional Safety (16).

Approximately 35 percent of the incidents we reviewed occurred at one of only five state prisons: Salinas Valley State Prison (215); California State Prison, Sacramento (206); Kern Valley State Prison (190); High Desert State Prison (104); and California State Prison, Corcoran (89).

The 2,296 incidents we monitored involved 7,717 applications<sup>1</sup> of force. Chemical agents<sup>2</sup> accounted for 3,511 of total applications (45 percent), while physical strength and holds accounted for 2,713 (35 percent). The remaining 19 percent of force applications consisted of options such as less-lethal projectiles, baton strikes, tasers, and firearms.<sup>3</sup>

---

1. The number of times a staff member used a force option in an incident; e.g., two baton strikes in one incident counts as two applications.

2. Chemical agents are described in detail in the force options section, beginning on page 6.

3. Percentages may not sum to 100 due to rounding.

# 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<sup>4</sup> (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.<sup>5</sup>

As a result of those findings, in 2007, the Office of the Inspector General (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. The OIG, however, has continued monitoring these processes. This report includes use-of-force incidents that occurred in 2019, and presents our analysis of how well the department followed its own policies and training.

## Use-of-Force Options

Inmate behavior can be unpredictable, and at times, departmental staff must use force to gain inmates’ compliance to ensure the safety of other inmates or staff. 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 inmate’s demeanor, mental health status and medical concerns (if known), and the inmate’s ability to understand and comply with orders. Policy further 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 of each force option when choosing among 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 inmate, the number of staff and inmates involved, and the inmate’s ability to understand.<sup>6</sup> Departmental policy includes a number of force options, which are described in further detail on the following pages.

---

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

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

6. California Department of Corrections and Rehabilitation, Department Operations Manual (hereafter referred to as DOM), Section 51020.

## Chemical Agents

The department has three approved types of chemical agents: chloroacetophenone (CN), orthochlorobenzalmalononitrile (CS), and oleoresin capsicum (OC or pepper spray). Each type has specific training requirements, and each type causes different physiological reactions. Of the three types, pepper spray is the most common type of chemical agent used by officers during use-of-force incidents, while CS is only authorized in limited circumstances. The chemical agents provide officers the ability to use force while maintaining distance from the threat, such as a group of fighting inmates.

Figure 1.  
Delivery Methods  
for Deploying Chemical Agents

### *Aerosol*

Chemical agent aerosols operate similarly to a can of spray paint. A pressurized gas disperses the chemical agent in a liquid stream or mist. This is the most common method of pepper spray deployment by officers.



### *Pyrotechnics*

Chemical agents in a solid state are always dispersed using a pyrotechnic device and are generally for use only in large outdoor areas due to potential fires.



### *Blasts*

CS and OC may be dispersed by a blast grenade that spreads the chemical agent over an area.



Source: The California Department of Corrections and Rehabilitation. See Table 1, next page, for additional source information.



In Table 1 below, we identify the more common types of chemical agents used by departmental staff, with training requirements regarding distance, target areas, and area usage. Deploying chemical agents at a shorter distance than the recommended minimum creates the potential for injury to inmates' eyes, and also increases the likelihood of the chemical agent splashing back and exposing staff. Recommended target areas ensure maximum effectiveness.

**Table 1. Chemical Agents**

Type	Minimum Distance Requirements	Deployment / Target Areas	Indoor / Outdoor	Common Uses
MK9 pepper spray stream	6 feet	Facial area: specifically the eyes, forehead and brow	Both	Inmate fights, attacks on staff
MK9 pepper spray vapor	No distance	Disperse in the area of the inmate	Indoor	Cell extractions
MK46 pepper spray	12 feet	Facial area	Both	Larger scale incidents, such as riots
Blast grenades	No distance	Deployed underhand (similar to bowling)	Both	Inmate fights or riots

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).

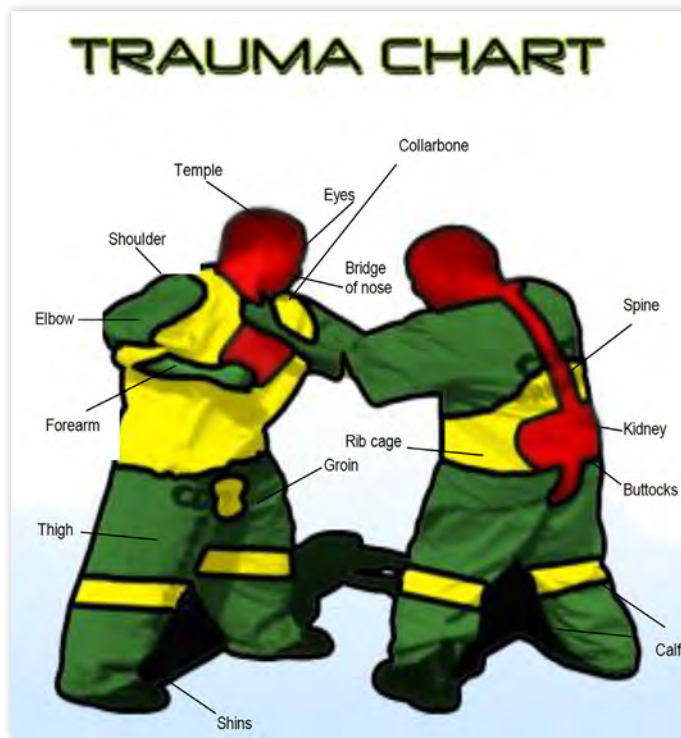
### Hand-Held Baton

Shown below, a hand-held expandable baton is a tool normally issued as a use-of-force option to officers assigned to positions with direct inmate contact. The hand-held baton is an impact weapon designed to strike or jab an inmate in close proximity while the baton is in an opened or closed position.



Source: 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).

Departmental training includes eight different types of strikes and four jab techniques. The training also includes specific target areas with varying levels of potential trauma. The color-coded trauma chart (illustration, right) shows the different target areas, with blows to the green area resulting in the minimal level of trauma, those to the yellow area resulting in a moderate to serious level of trauma, and those to the red area resulting in the highest level of trauma. The red areas are not authorized for blows unless the criteria for deadly force is met.



Source: The California Department of Corrections and Rehabilitation.

### Physical Strength and Holds

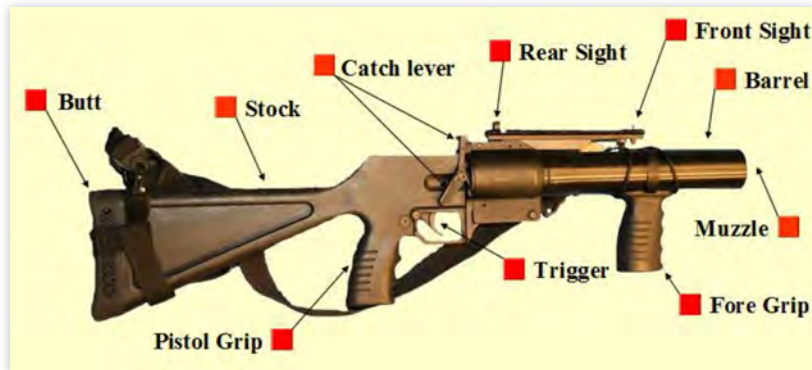
The department defines the use of physical strength and holds (or physical force) as “any deliberate physical contact, using any part of the body to overcome conscious resistance. A choke hold or any other physical restraint which prevents the person from swallowing or breathing shall not be used unless the use of deadly force would be authorized.”<sup>7</sup> Physical strength and holds encompass a wide variety of techniques trained by the department, including:

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

7. DOM. Section 51020.5

## Less-Lethal Weapons

Departmental policy defines less-lethal weapons as “any weapon that is not likely to cause death. Shown below, a 37mm or 40mm launcher, and any other weapon used to fire less-lethal projectiles, is a less lethal weapon.” The launcher has the appearance of a firearm, but is designed to fire “less-lethal projectiles.” These weapons are not designed to be deadly, but departmental training notes that “it must be understood that they can cause serious injury or even death.”<sup>8</sup>



Source: The California Department of Corrections and Rehabilitation.

The training guidelines for the launcher identify “zones,” or target areas. The only authorized target area during less-lethal situations is Zone 1. Zones 2 and 3 are not authorized unless deadly force is authorized.<sup>9</sup>

- Zone 1, which includes the legs and buttocks;
- Zone 2, consisting of skeletal and medium muscle groups, including shoulders and arms, and
- Zone 3, which consists of the head and neck, chest, solar plexus, groin, spine, and lower back.

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

Figure 2 on the next page depicts three authorized impact munition projectiles designated for use in a less-lethal launcher.

8. Impact Munitions training manual, prepared by the department’s Office of Training and Professional Development, Basic Correctional Officer Academy, which cites: “Zone 2 is not an approved target zone in less-lethal situations because it was found that while targeting Zone 2, the dynamics of the situation resulted in frequent Zone 3 strikes.” (Sacramento: California Department of Corrections and Rehabilitation, April 2013.)

9. Ibid.

Figure 2.

### Impact Munition Projectiles Designated for Use in a Less-Lethal Launcher

#### *Stinger Rounds*

Stinger rounds have multiple rounds of either .32 or .60 caliber rubber balls, which are authorized as a direct impact munition, i.e., fired directly at the inmate, with an effective range of 10 to 40 feet.



#### *Baton Rounds*

Baton rounds have multiple payloads of three projectiles made from foam, rubber, or wood. Foam baton rounds are designed as a direct impact round, while rubber and wood rounds are indirect rounds, i.e., fired in front of the inmate, designed to skip off the ground prior to impacting the target inmate.



#### *Sponge Rounds*

Sponge rounds are single rounds designed as direct impact munitions with an authorized range of 10 to 105 feet.



Source: The California Department of Corrections and Rehabilitation.

**Table 2. Authorized Munition Projectiles for Less-Lethal Force**

Round Type	Direct / Indirect	Minimum / Maximum Distance	Authorized Target
Stinger round	Direct	10–40 feet	Zone 1
Baton round (foam)	Direct	10–40 feet	Zone 1
Baton round (wood/rubber)	Indirect	Maximum 60 feet	3 feet in front of target from an elevated post
Sponge round	Direct	10–105 feet	Zone 1

Source: The California Department of Corrections and Rehabilitation.

### Lethal Weapons

A firearm is a lethal weapon because it is used to fire lethal projectiles. A lethal weapon is any weapon whose use is likely to result in death.<sup>10</sup> When presented with a situation in which deadly force is authorized, an officer may aim and fire a lethal weapon directly at the inmate, 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 on an exercise yard.

<sup>10</sup>. DOM, Section 51020.5.

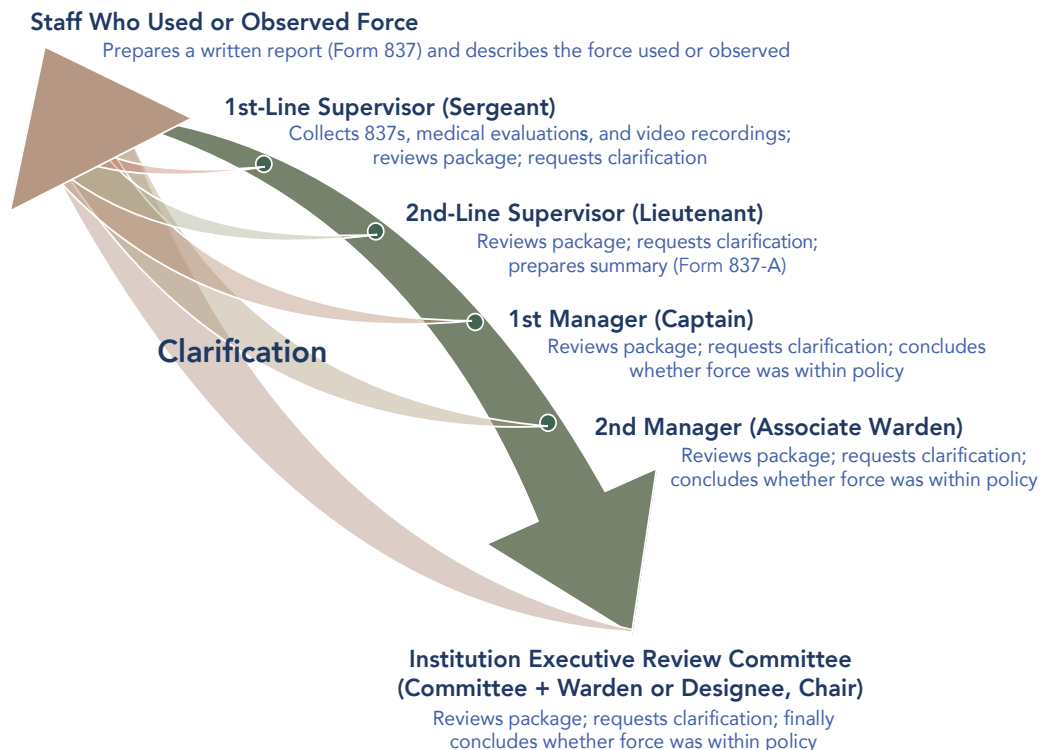
*(This page left blank for reproduction purposes.)*

## 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.

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 3: 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<sup>11</sup> begins after any use of force: departmental policy requires that staff who use or observe force submit a written report prior to being relieved from duty at the end of the working shift. In general, reports should include a description of the inmate's (or inmates') 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 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 actions taken during the use of force to determine whether such actions complied with policy and training. The incident commander then submits the incident package 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. Each of these reviewers, in turn, independently determines compliance with both policy and training and submits the reports to the next level of review.

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

---

11. The review process is similar for the Division of Juvenile Justice and the Division of Adult Parole Operations.



also reviews every allegation of excessive or unnecessary force, which may arise either directly in connection with use-of-force incidents or via inmates reporting through a separate process.

During these meetings, if the institution's 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 (the warden or chief deputy warden) determines whether the force used and the staff's actions were within policy.

If the chair determines that 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 approval to address the allegations without an investigation.

#### **Levels of Review: Adult Institutions**

*Institution Executive Review Committee:* This is an institution's review committee, which is the primary committee level of review for use-of-force incidents occurring within the Division of Adult Institutions. For each adult institution, an institution's executive review committee reviews 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.

*Department Executive Review Committee:* The department groups adult prisons into different collectives of institutions, called *missions*, with a separate associate director assigned to oversee each mission. The principal missions in the Division of Adult Institutions are *Female Offender Programs and Services/Special Housing*, *General Population*, *Reception Centers*, and *High Security*.

Each mission has a committee of staff selected by, and that includes, the associate director of the respective mission in which the force occurred. This committee reviews incidents in which serious bodily injury could have been caused by the use of force and incidents involving a warning shot from a lethal weapon. In addition, this committee may

review any incidents referred by a warden or otherwise requested by the associate director of the mission. To reduce the duplication of work, this committee will not review incidents for which the Office of Internal Affairs has completed an investigation.<sup>12</sup> The department's policy allows this committee up to 60 days to complete its review.<sup>13</sup>

### Levels of Review: Juvenile Facilities

*Force Review Committee:* For each of the juvenile facilities,<sup>14</sup> a force review committee reviews 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 ineffective 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 whom the director of the Division of Juvenile Justice designates to ensure employees act in accordance with the crisis prevention and management policy. 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 assess compliance with the department's policies, procedures, and training.

### Levels of Review: Adult Parole Operations

*Field Executive Review Committee:* There are two parole regions, a northern region and a southern region. For the two parole regions, a field executive review committee reviews every use of force and is 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.

---

12. Memorandum, "Revised Department Executive Review Committee Expectations" from the department's director, Kathleen Allison, September 20, 2017.

13. DOM, Section 51020.19.6.

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

## Deadly Force (Statewide)

*Deadly Force Review Board:* The Office of Internal Affairs conducts criminal<sup>15</sup> and administrative investigations into every use of deadly force (except for certain types of warning shots inside of an institution) and every death or great bodily injury that could have been caused by a staff use of force, regardless of whether the incident occurred in an institutional or community setting. The department's Deadly Force Review Board subsequently reviews these incidents. The board consists of at least four members, three of whom are law enforcement experts outside of the department and one of whom is a 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 participates in the board's review in a nonvoting capacity. The OIG reports on its monitoring of these incidents in a separate report, the OIG's Discipline Monitoring Report, issued semiannually.

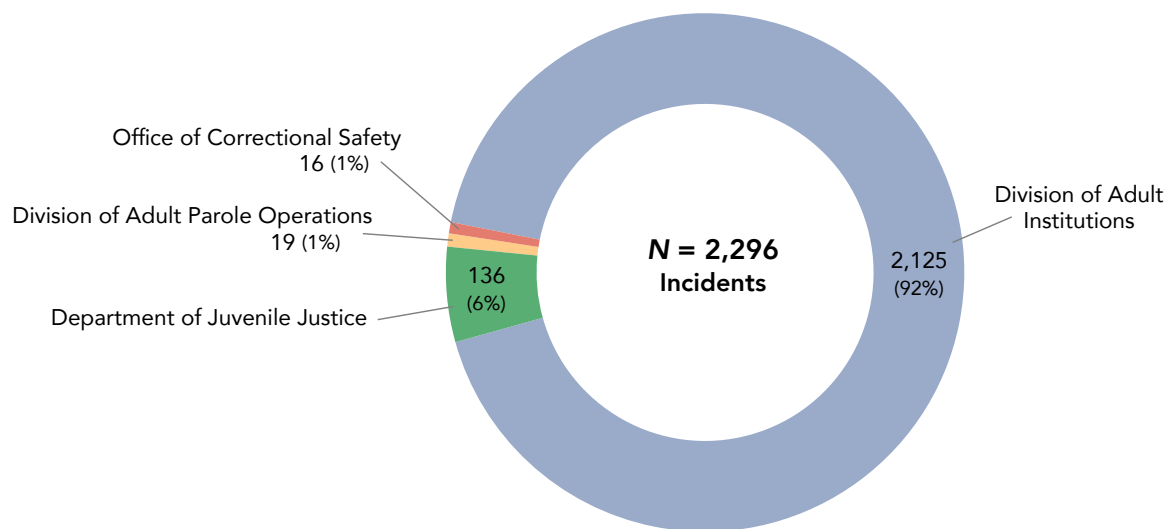
## Number of Use-of-Force Incidents and Type of Force Applied

We reviewed 2,296 of the 9,692 use-of-force incidents that occurred within the department between January 1, 2019, and December 31, 2019. The majority of the incidents occurred at adult institutions (2,125), with a smaller share occurring in juvenile facilities (136) and within the communities where offenders were on parole (19) (Figure 4 on the next page). We also reviewed a few incidents of force applied by the department's Office of Correctional Safety (16), which acts as a liaison with other law enforcement entities and apprehends fugitives in the community.

---

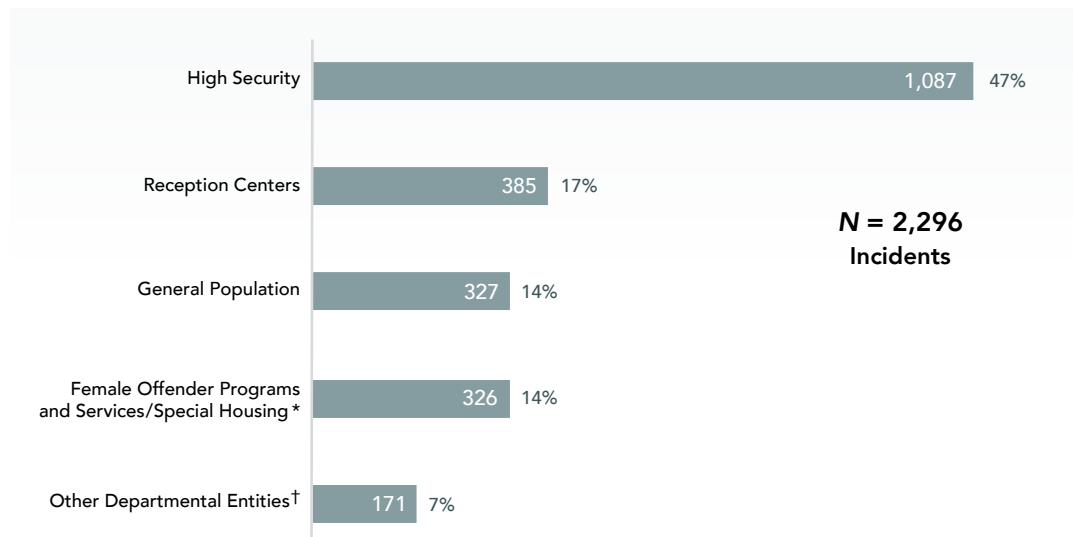
15. In some instances of deadly force, an outside law enforcement agency may conduct a criminal investigation. In those cases, the Office of Internal Affairs will not conduct a criminal investigation.

**Figure 4. Distribution of the 2,296 Use-of-Force Incidents the OIG Monitored by Division and Other Entities**



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

Among the 2,125 incidents we monitored that occurred within the Division of Adult Institutions, the vast majority of incidents took place at the institutions within the categories *High Security mission* (1,087), followed by *Reception Centers and Fire Camps* (385), *General Population* (327), and *Female Offender Programs and Special Services* (326). The category *Other Departmental Entities* (171) includes the Division of Juvenile Justice, Division of Adult Parole Operations, and the Office of Correctional Safety (Figure 5).

**Figure 5. Use-of-Force Incidents the OIG Monitored by Mission and Other 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, the Division of Juvenile Justice, and the Office of Correctional Safety.

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

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

**Table 3. Number of Incidents the OIG Monitored by Departmental Entity**

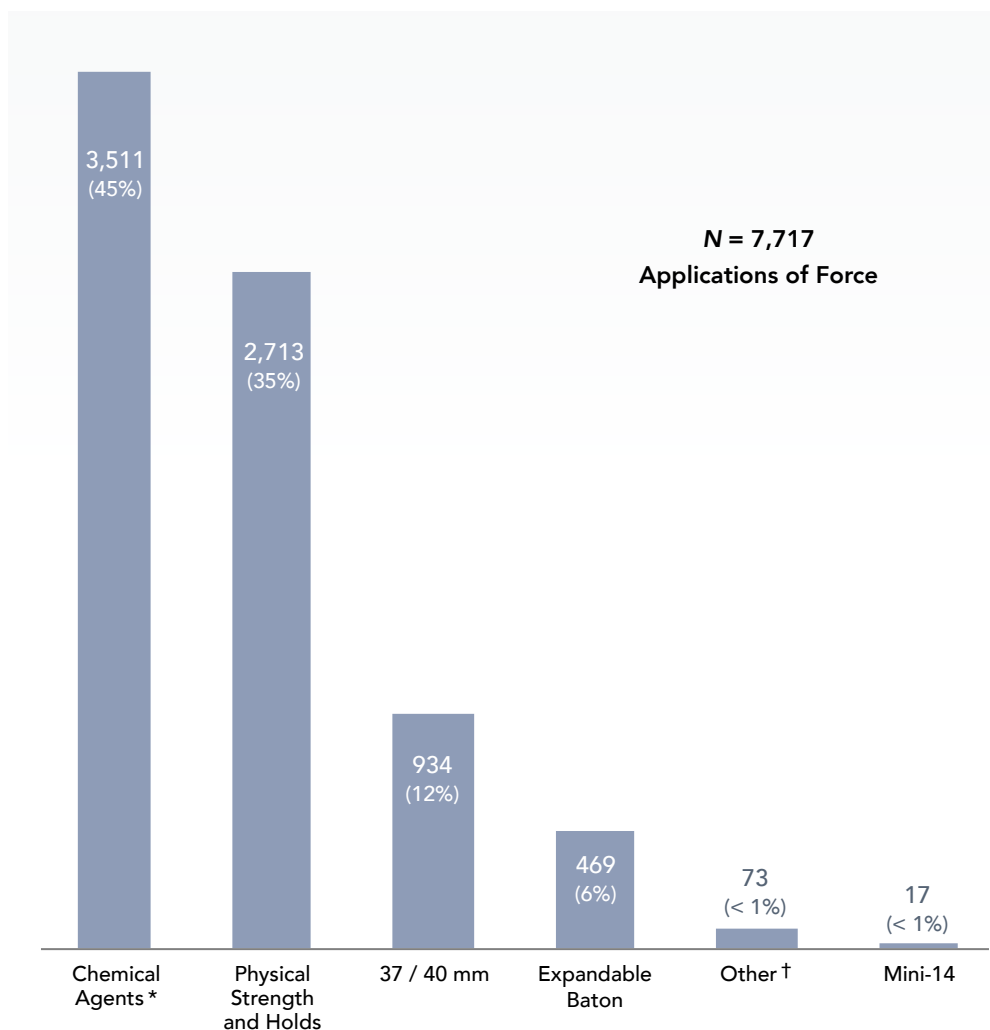
Departmental Entity	Number of:			
	Use-of-Force Incidents	Applications of Force	Staff Who Applied Force*	Inmates, Youth, or Parolees to Whom Force Was Applied*
Adult Institutions	2,092	7,056	5,078	3,914
Contract Beds Unit: In State	22	77	41	34
Contract Beds Unit: Out of State	11	58	23	42
Juvenile Facilities	136	435	298	385
Parole Regions	19	44	40	19
Office of Correctional Safety	16	47	29	16
<b>Totals</b>	<b>2,296</b>	<b>7,717</b>	<b>5,509</b>	<b>4,410</b>

\* 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.

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

As part of the 2,296 use-of-force incidents that we monitored, staff members used 7,717 applications of force. The most common force option staff members used was chemical agents (3,511), which accounted for 45 percent of the total applications of force, followed by physical strengths and holds (2,713), at 35 percent. Staff members used other force options less frequently, such as less-lethal projectiles (934), batons (469), other forms of force, such as a shield, nonconventional force, tasers (73), and the Mini-14 rifle (17) (Figure 6).

**Figure 6. Distribution of the Applications of Force in 2,296 Use-of-Force Incidents**



\* 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.

## Scope and Methodology

### Scope

In this report, the OIG presents its evaluation of the use-of-force incidents that occurred between January 1, 2019, and December 31, 2019. 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 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.

The OIG reviewed and analyzed 2,296 of the 9,692 use-of-force incidents that occurred within the department between January 1, 2019, and December 31, 2019. To reach this number, we randomly selected 1,079 incidents and used our discretion to select another 1,217 incidents. We selected incidents based on the nature of the incident (e.g., serious bodily injury to an inmate caused by force, a riot, a reported force incident involving an allegation of unnecessary or excessive force), and the workload of our inspectors. Inmates alleged unnecessary or excessive force in 235 of the 2,296 incidents that we monitored. Our review of the allegations in these incidents focused solely on the video-recorded interview requirements following the allegation, rather than the adequacy of the department's inquiry into the allegations.

Our inspectors visited every adult prison and juvenile facility,<sup>16</sup> as well as the northern and southern parole regions, and attended 933 of the 1,801 institutions' review committee meetings (52 percent) to monitor incidents that occurred in 2019.<sup>17</sup> Although OIG inspectors served as nonvoting attendees at these committee meetings, they provided real-time feedback and, when necessary, recommendations on compliance-related matters to committee chairs.

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 40 of the 60 meetings (67 percent), during which the committees reviewed incidents that occurred in 2019. As noted in the footnote above, some of these meetings occurred in early 2020.

---

16. The department currently operates 35 adult institutions and three juvenile facilities. A committee in the department's headquarters office reviews use-of-force incidents from all contract facilities.

17. Since departmental policy requires that the review committees review each incident within 30 days from the date of the incident, some of the meetings we attended occurred in 2020. For instance, if one of the incidents we monitored occurred in December 2019, we may have attended the meeting in January 2020.

## Methodology

The OIG monitors the department's adherence to its policies and procedures and training concerning use of force and the department's subsequent review process. Commencing with this reporting period, we present our assessment of the department's use-of-force incidents and its subsequent review process using data and information garnered from a new monitoring methodology and 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 requirements on methods of deploying force options.
- **Indicator 3** addresses how well staff complied with decontamination policies following the use of force, including whether the affected inmate and area were properly decontaminated.
- **Indicator 4** addresses how well medical staff evaluated inmates 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 inmates following uses of force, including inmates 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 up 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 inmates alleging unnecessary or excessive force.
- **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.

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*.<sup>18</sup> Then, using the same rating descriptors, our inspectors determined an overall rating for each incident they monitored.

The rating for each indicator, and subsequently 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 quality of the department’s handling of an incident, from the circumstances leading up to the incident, through the various levels of review until a decision by the review committee. We understand that policy or training violations do not necessarily render the department’s performance *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 inmates. On the other hand, we may assign a *superior* rating when, in our opinion, the department performed exceptionally well in multiple or critical areas.

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

---

18. 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 inmates alleges unnecessary or excessive force, Indicator 8 would not apply.

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

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

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%

## Monitoring Results

### Overall, Even Though the Department Performed Satisfactorily in Its Handling of Its Use-of-Force Incidents, Staff Continue to Comply With the Department’s Use-of-Force Policy at a Low Rate

The OIG reviewed and analyzed 2,296 staff-reported use-of-force incidents that occurred between January 1, 2019, and December 31, 2019. These incidents predominantly took place in a prison setting, but some occurred in the juvenile facilities or in the community setting.

Overall, the department determined that its staff completely followed policy in only 1,156 out of the 2,296 incidents that we monitored during this period (50 percent), as depicted in Figure 7 on the following page. In the OIG’s opinion, staff committed some type of policy violation in 673 of the incidents in which the department concluded its staff were compliant.

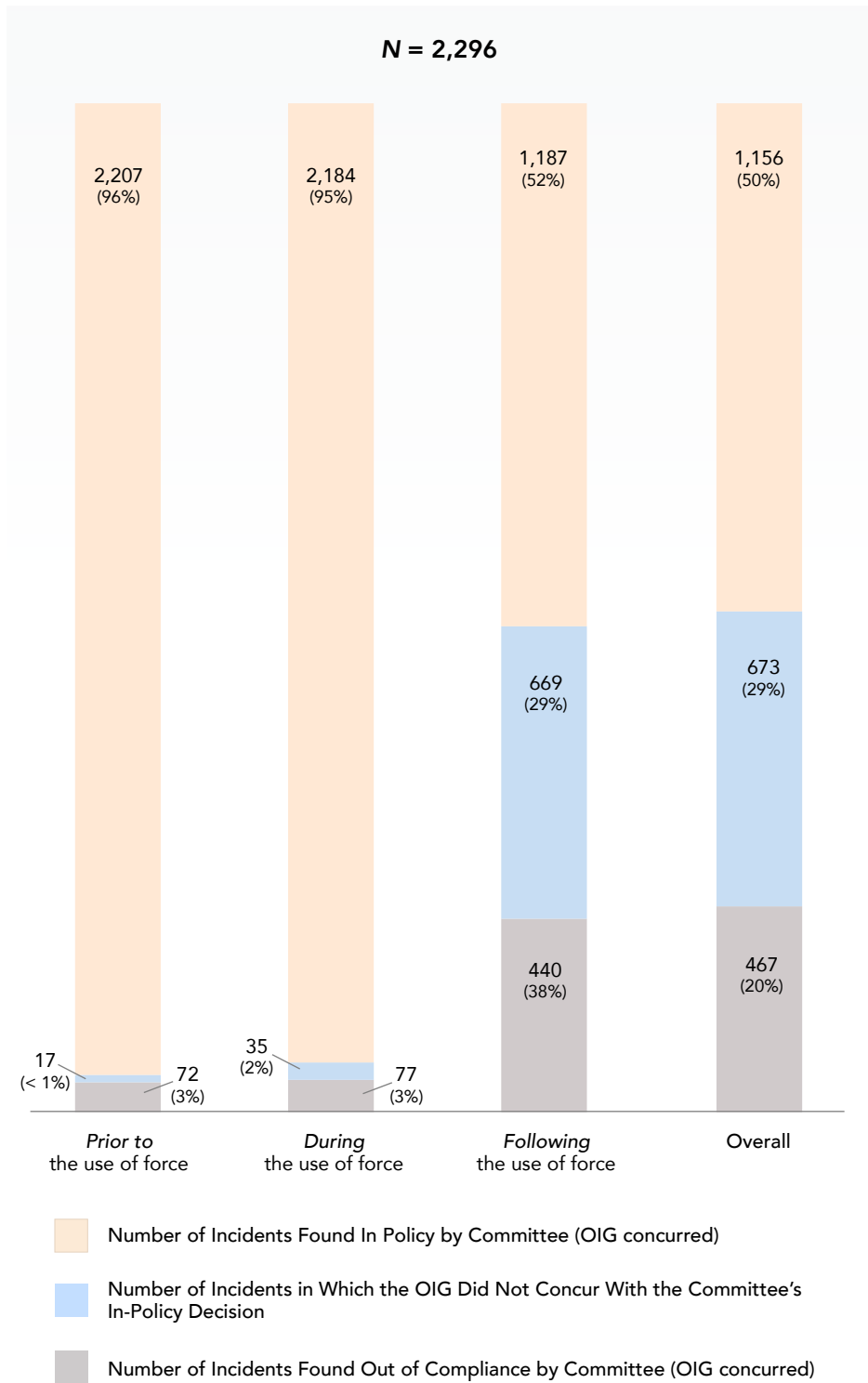
When evaluating force in relation to departmental policy, we evaluate the department’s three primary categories: (1) *prior to*, referring to the events leading up to the force; (2) *during*, referring to the actual force; and (3) *following*, referring to the events immediately following the incident through the review process. These categories help provide some measure of context to overall compliance rates.

The department concluded that staff followed policy requirements *prior to* the use of force in 2,207 incidents (96 percent). We mostly agreed with the department’s review committees’ decisions, but we determined that 17 of the 2,207 incidents had at least one policy violation relevant to this category for which the department took no action.

Regarding the policy requirements *during* the use of force, the department determined that staff followed policy in 2,184 of the incidents, a 95 percent compliance rate. Again, the OIG agreed with most of these determinations, but we also determined that 35 of those 2,184 incidents reflected at least one policy violation relevant to this category that the department did not address.

Finally, the department determined that staff complied with policy requirements *following* the use of force in 1,187 of the 2,296 incidents (52 percent). We concluded that 669 of the 1,187 incidents reflected at least one policy violation relevant to this category that the department failed to address.

**Figure 7. Total Number of Incidents Found In and Out of Compliance With the Department's Use-of-Force Policy**



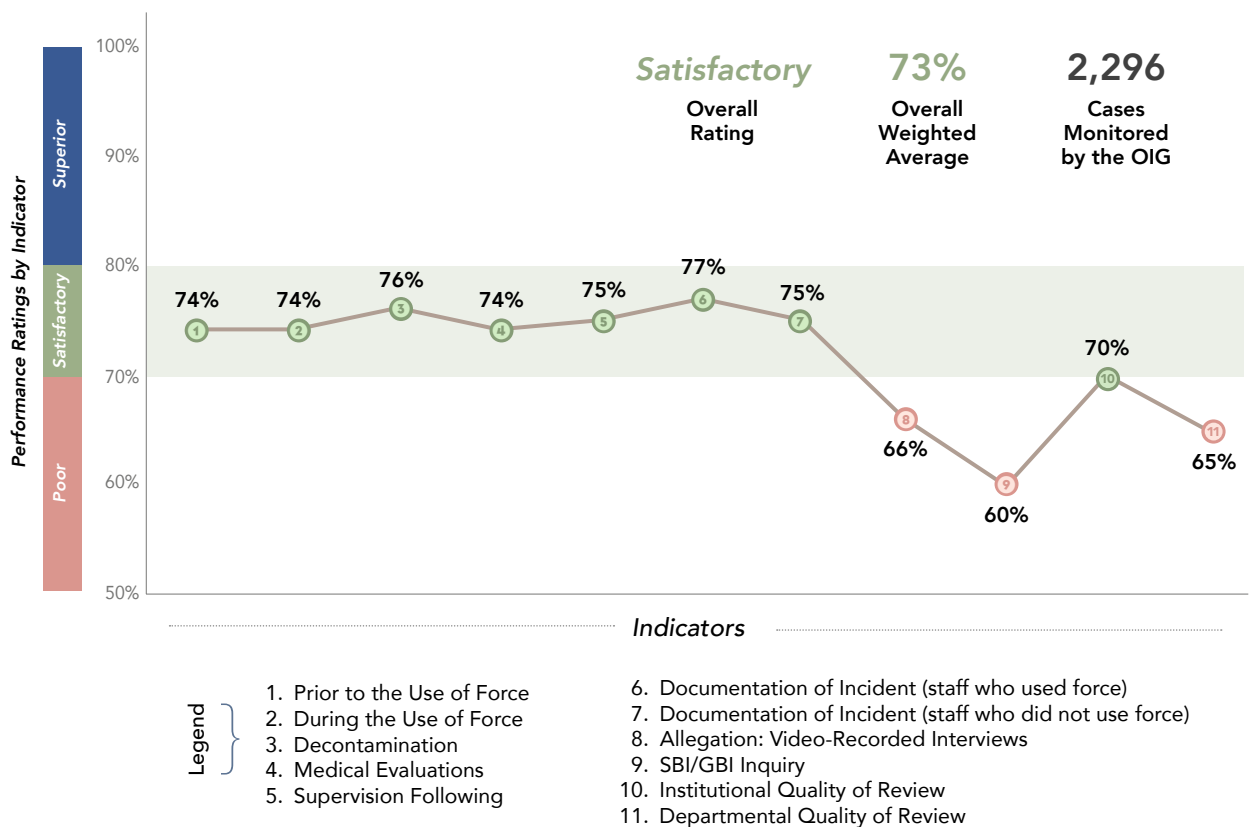
Note: Percentages may not sum to 100 percent due to rounding.

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

## The Department's Overall Performance in Handling Its Use-of-Force Incidents Was Satisfactory

The OIG determined that the department's overall performance in handling use-of-force incidents was *satisfactory*. We rated the department's overall performance as *superior* in 24 incidents, *satisfactory* in 2,063 incidents, and *poor* in 209 incidents. While we rated the vast majority of the incidents *satisfactory* overall, and we rated eight of the 11 individual indicators *satisfactory*, we found room 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 force (Indicator 9), and the reviews conducted at the department's executive level (Indicator 11).

Figure 8. The OIG's Overall Rating of the Department's Handling 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* an incident is based on a cumulative assessment of 11 indicators.<sup>19</sup> Our rating for each of the indicators was based on the answers to specific compliance- or performance-related questions. To answer the questions, we used the requirements outlined in the Department Operations Manual and other established procedures,<sup>20</sup> such as the department’s training manuals regarding the different force options.

In assessing the department’s performance *prior to* the use-of-force, we used information from answers to Indicator 1. In Indicator 1, we assess whether staff’s actions may have contributed to the need to use force. There are numerous actions that may contribute to the need to use force that fall outside of the use-of-force requirements, such as failing to properly secure a cell door or failing to properly handcuff an inmate. Because of the seriousness of the issue—staff actions that may have caused the incident—this is the only indicator in which we include our assessment of the department’s actions not directly related to the use-of-force policy.

In assessing the department’s compliance during the use-of-force, we used information from answers to Indicator 2.

We used answers to questions in the remaining indicators (Indicators 3 through 11) to assess the department’s compliance *following* the incident. Indicator 3 applied only if officers used chemical agents. Indicator 8 applied only when an inmate alleged excessive or unnecessary force, while Indicator 9 applied only if an inmate sustained serious or great bodily injury as a result of the force. Finally, Indicator 11 applied only if the incident met specific criteria requiring review by the department’s executive review committee.

We present two incidents to which we assigned an overall rating of *superior*, concluding that staff performed exceptionally well:

- In one incident, officers observed two inmates fighting in the dayroom of a housing unit during the morning medication distribution. One officer deployed two less-lethal direct impact rounds, and another officer deployed one chemical-agent grenade to stop the fight. While the incident itself is a common occurrence, in our opinion, the department performed exceptionally well in four of the eight applicable indicators. Officers and supervisors who provided decontamination thoroughly documented the efforts to decontaminate the inmates and the affected areas. Medical staff evaluated the involved inmates within three

---

19. Not all 11 indicators are applicable to every incident.

20. DOM, Article 2, Use of Force, Section 51020.1 et seq.

minutes and completed clear and thorough reports concerning the evaluation. Finally, the officers who used and observed force provided detailed, well-written reports to describe the threat and the force used and observed.

- In another incident, an officer discovered an inmate lying on his bunk with a sheet covering his head. The officer clearly described his unsuccessful attempts to establish dialogue with the inmate. The officer called his supervisor and requested a medical response. The responding sergeant also described his efforts to communicate with the inmate prior to ordering an emergency entry to the cell. When the officers entered the cell, the inmate jumped up and attempted to hit the officers with a radio, requiring the use of a shield and physical force to stop the inmate's attack. All involved officers wrote exceptional reports, clearly describing the inmate's actions, the force used and observed, and the effectiveness of the force.

In contrast, we assigned an overall rating of *poor* to the following two incidents:

- In one incident, we rated the department's overall performance *poor* because, in our opinion, officers failed to maintain correctional awareness—a failure that led to a serious assault on staff, and ultimately to a use-of-force incident. In this incident, an inmate in an “out-of-bounds” area on an exercise yard attacked a psychologist as she was reporting to her assigned post. The inmate grabbed the staff member from behind and turned her body toward him as she screamed for help. The inmate continued his attack by groping her breasts and buttocks while she attempted to fend off his attack by striking him in the face with her keys. The inmate overpowered her and forced her to the ground, landing on top of her. A nearby inmate heard the psychologist's screams, ran to her aid, and tackled the other inmate. Officers then responded and used pepper spray after the aggressor presented a threat to the officers. The OIG identified that the officer assigned to provide coverage of the area failed to be cognizant of the inmate's movement after he left the medication line and failed to exercise proper safety precautions. The warden disagreed with our position and declined to take any action against the officer. The warden also disagreed with our recommendation regarding re-evaluating the posting of officers in the area during medication distribution to ensure the safety of staff. Instead, the warden provided the victim of the sexual battery “safety awareness training.”
- In another incident, we rated the department's overall performance *poor* because in our opinion, a youth correctional counselor used unnecessary force on a ward, and we disagreed with the review committee's conclusion that the counselor's

actions were reasonable. In this incident, a ward punched a youth correctional counselor in the back of the head. The counselor gave the ward verbal orders to get on the ground and warned the ward that he would deploy pepper spray. The ward turned away, immediately placed himself in a prone position with his hands behind his back, and apologized to the counselor. The counselor placed handcuffs on the ward. A second counselor arrived and reported that he ordered the ward to cross his legs and stop moving, but the ward refused. The second counselor used physical force by applying a *figure four leg lock*, which is a technique used to control a ward's legs while the ward is on his or her stomach by placing one ankle across the back of the opposite knee, bending the opposite leg at the knee, and forcefully pushing the ward's foot toward his or her buttocks. This technique is only authorized when a ward demonstrates behavior that threatens the safety of the ward or others. We asserted, based on a video-recording of the incident and the officers' reports, that the force was unnecessary because no imminent threat existed to justify it. The facility's force review committee disagreed with us, stating that the application of force would prevent the ward from further assaulting staff. We elevated the matter to departmental executives, who initially upheld the facility review committee's conclusions. Upon the OIG insisting on multiple occasions, the department's executive-level review committee ultimately changed its position and agreed with us that the counselor's force was unnecessary and ordered corrective action. While the department eventually arrived at the same conclusion that we did, we rated this incident *poor* because of the counselor's unnecessary force and the failure by the supervisors and managers at the institution to identify and address the policy violation.



### Indicator 1. The Department's Compliance With Policies and Procedures Before the Use of Force Was *Satisfactory*

This indicator measures how well staff followed policies and procedures prior to the use of force; this assessment includes examining whether staff unnecessarily contributed to the need to use force and whether they used de-escalation techniques when appropriate. For planned, controlled uses of force, this indicator also examines how well staff coordinated with medical and mental health care staff prior to the actual force used. In this indicator, however, we do not assess the quality of the documentation subsequently generated.

Among incidents we monitored that occurred between January 1, 2019, and December 31, 2019, we found the department's compliance with its policies and procedures prior to the use of force *satisfactory*. The OIG assessed the department's performance as *superior* in nine incidents, *satisfactory* in 2,192 incidents, and *poor* in 95 incidents.

*The number of incidents in which officers may have contributed to the need for using force increased from our prior reporting periods.*

The actions of officers in 74 of the 2,296 incidents (3 percent) unnecessarily contributed to the need to use force. Due to the seriousness of the conduct, we rated Indicator 1 *poor* in the 74 incidents in which staff contributed to the need for force. Even though these officers may not have intended to use force at the time of their initial actions, their actions (or failures to act) nevertheless contributed to the outcome, putting themselves, other staff, or inmates in danger. While this percentage remains low, it represents an increase from our prior two reporting periods in which we identified staff contribution in only one percent of the incidents we monitored. We reiterate that the department should examine these events so that it can train staff to better recognize situations prior to incidents and prevent potentially dangerous situations that result.

The review committees identified 62 of the 74 instances and took actions ranging from training to disciplinary action. The OIG identified an additional 12 incidents in which we believed the staff may have contributed to the need to use force, but the review committees disagreed with our position and declined to take any action.

Indicator Rating  
**Satisfactory**

**Superior**

9 incidents  
Less than  
1 percent

**Satisfactory**

2,192 incidents  
96 percent

**Poor**

95 incidents  
4 percent

The following incidents illustrate the seriousness of staff’s contribution to the need to use force:

- An officer opened a cell door to speak with an unrestrained inmate, in violation of the institution’s local procedure for maximum custody housing, which requires officers to handcuff an inmate prior to opening the cell door. When the door opened, the inmate rushed toward the door and attacked an officer. The officer wrapped his arms around the inmate’s torso and forced him to the ground, where the inmate thrashed his body around to avoid the officer’s attempts to place him in handcuffs. A responding officer assisted the first officer and punched the inmate one time in the face. The inmate and the first officer sustained minor injuries during the incident. The warden determined that the officer violated the institution’s procedure when he opened the cell door without first restraining the inmate; the warden ordered formal counseling for the officer. While we agreed with the outcome, the seriousness of the conduct resulted in a *poor* rating.
- In another incident, officers allowed three unrestrained inmates out of their assigned cells without prior authorization, in violation of the institution’s program status procedures that were in place due to ongoing violence among different security-threat groups. The three inmates attacked another inmate with inmate-manufactured weapons, and an officer used pepper spray to stop the attack. The institution transported the injured inmate to an outside hospital for treatment of multiple stab wounds. The warden determined that the officers’ negligence in releasing the unrestrained inmates from their cells violated the institution’s procedures, endangering staff and inmates, and imposed formal discipline on the three officers. Again, despite the warden’s determination, the gravity of the officers’ negligence resulted in a *poor* rating.

*Some officers did not articulate attempts to de-escalate a potentially dangerous situation prior to using force.*

Departmental policy states: “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, in an effort to determine the best course of action and tactics to resolve the situation. Whenever possible, verbal persuasion should be attempted in an effort to mitigate the need for force.”<sup>21</sup>

---

21. DOM. Section 51020.5.

*When an imminent threat is not present, effective communication skills are an essential tool for minimizing conflict.*

Source: The California Department of Corrections and Rehabilitation, Office of Training and Professional Development, T4T - Multiple Interactive Learning Objectives, approved June 2017.

Of the 2,296 incidents we monitored, we identified 444 in which the involved officers had the opportunity to de-escalate the situation prior to using force. In 23 of those 444 (5 percent), officers did not adequately articulate their attempts.<sup>22</sup> We acknowledge that there are likely many instances in which officers successfully de-escalated a situation without needing to use force. However, since our monitoring only focuses on incidents that resulted in the use of force, those successful instances are not reflected here.

Officers complied with policy and training and articulated de-escalation techniques in 421 of the 444 instances in which officers were initially presented with a potential threat and had the opportunity to de-escalate the situation prior to using force (95 percent). Of those 421, we identified nine incidents in which the involved officers performed exceptionally well in their efforts to resolve the situation, resulting in a *superior* rating for Indicator 1 for those incidents, as illustrated in the following example:

- Officers described their interaction with an inmate in a housing unit who was a participant in the department’s mental health delivery system. One of the officers reported that the inmate was not speaking clearly and was not able to put together complete sentences. The officer further articulated that the inmate “appeared agitated as he was tensing his fists, arms, and upper body areas.” The officer clearly described his attempts to de-escalate the situation, without using force, by asking the inmate about his concerns and trying to persuade the inmate to enter a holding cell. The officer also contacted the inmate’s mental health care provider and informed the inmate that the provider would speak with him as long as he entered the holding cell. Ultimately, the officers needed to use physical force to restrain the inmate, but we recognize the officers’ efforts to resolve the situation for approximately seven minutes prior to the need to use force.

---

22. In the remaining 1,852 incidents we monitored, there was no opportunity to de-escalate the situation prior to using force due to the imminent threat presented to the officer. In these cases, such as an inmate fight or inmate attack on staff, immediate force is appropriate.

Despite the high compliance rate, there is room for improvement. The following are examples from the 23 incidents in which officers were initially presented with a potential threat, and officers did not adequately attempt to resolve the situation:

- An officer confiscated a letter from an inmate and ordered her to move to the line to receive her medication. The inmate refused and demanded that the officer return her letter. The officer again ordered the inmate to proceed to the line for her medication. The inmate refused and sat down. The officer reported that he gave the inmate a direct order to stand up, turn around, and “cuff up,” but the inmate did not comply. The officer then attempted to place the inmate in handcuffs, and after she resisted his efforts, the officer used physical force to apply handcuffs. In this incident, each level of review identified that the officer should have handled the situation differently and should have attempted to de-escalate the situation. The institution’s executive review committee ordered formal counseling for the officer, concluding that the inmate “was agitated and noncompliant, however she did not pose a threat to staff or inmates. Due to an imminent threat not being present you had time to contact your supervisor and request assistance in de-escalating the situation.” We agreed with the committee’s findings.
- In another incident, an officer reported that he placed an inmate, who was a participant in the mental health delivery system, in his assigned cell. As the officer walked away, the inmate began to hit his cell door with his fists, breaking the glass. The officer returned to the cell, opened the door and ordered the inmate to turn around so the officer could place the inmate in handcuffs. The inmate took a fighting stance with his fists up, and the officer pepper sprayed the inmate. The OIG opined that the officer had the opportunity to de-escalate the situation and possibly avoid using force. The warden agreed with our opinion and ordered training for the officer.

The review committees took appropriate action in 13 of the 23 instances, ordering interventions that ranged from training to formal counseling. We identified an additional 10 instances in which we believed the staff had the opportunity to de-escalate the situation, but the review committees disagreed with our position and declined to take any action.

In 2017, the department deployed training to all custodial and noncustodial staff to improve their communication skills and learn when to apply de-escalation techniques. This training is included in the department’s required annual use-of-force training. We encourage the department’s continued use of this training to further its goal of accomplishing custodial functions with minimal reliance on the use of force.

*During controlled use-of-force incidents, the department performed well in the planning and coordination with medical and mental health care staff.*

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.” These situations involve advanced planning and organization by custodial, medical, and mental health care staff. A controlled use of force requires both the authorization and the presence of a first- or second-level manager (or administrator of the day during nonbusiness hours) and a video recording of the incident.

A common example of when an institution might authorize a controlled use of force occurs when 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 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 infrequently (98 percent versus 2 percent, respectively, in the incidents we reviewed this period).

During this reporting period, we monitored 35 controlled use-of-force incidents. We commend the department for complying, in all incidents, with the following policy requirements: an appropriate “cool-down” period for the inmate; intervention by a mental health clinician during the cool-down period; a collaborative effort by custody, medical, and mental health care staff in developing a tactical plan; and a review of the inmate’s health record by a registered nurse.

Nevertheless, we identified at least one deviation from policy requirements in 27 of the 35 incidents. The most common deviations related to the video-recording requirements, as follows:

- The video recording did not display the accurate date and time (21 incidents);
- Staff members failed to introduce themselves on camera (11 incidents);
- Staff did not follow general video-recording requirements (13 incidents); and
- Staff did not wear appropriate safety equipment (six incidents).

Indicator Rating  
**Satisfactory**

**Superior**

No incidents

Zero percent

**Satisfactory**

2,228 incidents

97 percent

**Poor**

68 incidents

3 percent

## Indicator 2. The Department's Compliance With Policies and Procedures During the Application of Force Was Satisfactory

This indicator measures how well staff followed policies and procedures *during* the use of force; among other considerations, this indicator examines whether staff used reasonable force and whether they complied with specific, objective training requirements for target zones and distance. In controlled use-of-force incidents, we also assessed the department's compliance with strict policy requirements regarding the type and duration of the force.

Among incidents we monitored during this review period, we found the department's compliance with its policies and procedures during the use of force *satisfactory*. We assessed the department's performance as *satisfactory* in 2,228 incidents and *poor* in 68 incidents. We did not assign a *superior* rating to any incidents for this indicator, since we determined whether the force was reasonable and whether the officers complied with the objective requirements.

*In some instances, officers did not articulate an imminent threat to justify the force used.*

The department allows officers to use immediate force when an imminent threat jeopardizes the safety of persons or compromises the security of the institution. In 51 of the 2,296 incidents (2.2 percent), officers did not adequately articulate an imminent threat, leading us to question whether the force was necessary. While this is a low percentage in relative terms, it represents an increase compared with our last report, in which we determined that officers did not justify the force in 1.5 percent of the incidents.

The department self-identified unnecessary force in 31 of the 51 incidents and took action to address the violations in forms ranging from training to formal discipline. The OIG identified an additional 26 instances in which we believed an imminent threat did not exist to justify the force. In six of the 26 incidents, the review committee agreed with our opinion and concluded the force was out of policy. In the remaining 20 incidents, the committee disagreed with our opinion and found no violation of policy related to the force used. We acknowledge the difficulty of making split-second decisions during potentially dangerous situations; it is much easier to second-guess officers' actions after the fact. Nevertheless, we reiterate that any instance of unnecessary force has the potential to increase tension between staff and inmates, create a culture of mistrust, and expose the department to legal liability. Due to the seriousness of the violation, in all 51 of these incidents, we rated Indicator 2 *poor*.

- In one incident, an inmate locked in a holding cell spat at an officer, striking the officer in the neck and back of the head. The officer turned to the inmate and ordered him to stop spitting.

The officer reported that the inmate pulled down his pants, made a vulgar comment to the officer, and spat in the officer's direction, but did not make contact. The officer then unholstered his pepper spray, and "from approximately 6 feet away, [he] deployed one 2 second burst, aiming at his facial area and making direct contact to his upper torso and face." The inmate then complied with the officer's orders and stopped spitting. The warden determined that the officer's force was unnecessary or excessive based on the lack of an imminent threat to justify using pepper spray on the inmate who was locked in a holding cell. Further, following the initial instance in which the inmate spat on the officer, the officer had the ability to move away from the holding cell, removing himself from the threat of being spat on again. The warden imposed formal discipline on the officer. Although we agreed with the warden's decision to impose discipline, we found the officer's unnecessary or excessive force justified the *poor* rating.

- In another instance, a youth correctional counselor reported that while he was escorting a ward to his room following a fight, the ward attempted to pull away from the counselor's control and run toward other wards in the area. The counselor stated that he "needed to secure him to keep him from attacking a youth." The counselor reported that he then wrapped his arm around the ward's neck and used necessary force to pull him to the ground. While the counselor articulated an imminent threat to justify the use of immediate force, the superintendent determined that the counselor's actions (wrapping his arm around the ward's neck to pull him to the ground) were excessive, and he ordered counseling. As we found in the incident above, while we agreed with the outcome of the incident, we determined the officer's actions during the incident resulted in a *poor* rating for Indicator 2.

*In a few incidents, officers used more force than was reasonable to gain control of an inmate.*

While officers are authorized to use force to accomplish custodial functions, the force must not be excessive. We identified six incidents in which we believe the officers used more force than was reasonable to accomplish the stated purpose. Any instance of excessive force brings discredit to the officer and the department and exposes both to possible legal consequences.

The hiring authorities determined the officers' actions were excessive in only two of the incidents, declining to take any action in the other four. Due to the seriousness of the conduct, we rated all six of these incidents *poor*.

- In one incident, officers escorted an inmate to an office for an interview with a sergeant. During the interview, the inmate punched an officer in the face, causing other officers to physically force the inmate to the ground. The inmate resisted the officers' efforts to place him in handcuffs by swinging his arms, kicking his legs, and biting one of the officers on his hand. Officers were able to place the inmate in leg restraints<sup>23</sup> and apply one handcuff, but the inmate continued to resist by attempting to stand. A lieutenant ordered one of the eight officers present to stand on the inmate's back to keep the inmate on the ground. The officer reported that she "placed both of my feet on [the inmate's] lower back area and placed my arm onto the office refrigerator in an effort to maintain my balance." This caused the inmate to stop resisting and allowed officers to place the second handcuff on the inmate's wrist. During the institution's review committee meeting, we asserted that the officer's action of standing on the inmate's back appeared excessive due to the potential for causing serious injury. The hiring authority disagreed with our position, concluding that the officer's actions were reasonable and did not violate policy. We elevated the matter to the departmental executive review level, and the committee ultimately affirmed our position and imposed corrective action on the lieutenant.
- In another incident, a doctor ordered an inmate to remain in the institution's medical center for observation. The inmate, who was lying on a gurney and handcuffed behind his back, wearing leg restraints attached to the gurney, became upset and kicked both of his feet toward a sergeant, but did not make contact. The sergeant reported, "to subdue [the inmate's] attack and overcome his continued resistance, I lowered the side rail of the gurney, placed both of my hands on [the inmate's] shoulders and forcefully pulled him off the gurney and to the floor of the exam room. [Inmate] being handcuffed behind his back was unable to break his fall and landed on his face." The inmate sustained minor injuries to his chin. The OIG asserted that the sergeant's actions were excessive under the circumstances. The hiring authority disagreed and found no violation of policy.

---

23. Leg restraints are similar to handcuffs, but they are designed to be placed around the ankles rather than the wrists.



*In nearly all instances, staff complied with zone and distance requirements specified in departmental training.*

As described in the “Force Options” section of this report, there are specific zones, or “target areas,” on an inmate’s body and distances from which an officer is permitted to deploy force. For instance, the training curriculum states that officers may deploy a less-lethal direct impact round from a minimum of 10 feet up to a maximum of 105 feet. The only authorized target area with the less-lethal round is below the inmate’s waist. Depending on the projector, there are different minimum and maximum distances for the different chemical agents used by officers, and the target area is generally limited to the intended target’s facial area. There is no minimum distance requirement for an expandable baton since it is designed to be used in close proximity to an inmate, but the department provides a “Trauma Chart” with green, yellow, and red target areas, each with an increasing level of potential trauma (see page 8). Officers are not authorized to target the red areas unless the situation meets the criteria for deadly force. The red areas include the head, neck, spine, solar plexus, and kidneys.

In the 1,496 incidents we monitored in which a force option was used for which the department’s training guidelines specify a minimum and maximum distance, officers complied with the training requirements in 1,476 (99 percent) of the incidents. In 17 incidents, officers deployed pepper spray at less than the minimum distance. In one incident, an officer deployed pepper spray at a distance greater than the maximum effective range, and in two incidents, an officer deployed a less-lethal direct impact round beyond the maximum effective range. We considered these deviations to be minor, and while they warranted training to the involved officers, none rose to the level that would merit a *poor* rating for Indicator 2.

In the 1,606 incidents we monitored in which the force options required a target area, officers targeted the authorized zones in 1,592 (99 percent). Most of the deviations were minor in nature and did not result in a *poor* rating. For example, the department’s training guidelines state that pepper spray “must come into direct contact with the face of the target to be effective.” If officers targeted an inmate’s torso, the force was not in compliance with training, but, more importantly, the force was not used in the most effective manner to stop the imminent threat.

*During controlled use-of-force incidents, staff achieved a high rate of compliance with the requirements for deploying pepper spray.*

As noted above, departmental policy provides specific requirements regarding the deployment of chemical agents during a controlled use of force, including the following:

- The type of pepper spray projector that may be used;
- The number of seconds that an officer can apply pepper spray;
- The minimum length of time that an officer must wait between applications of pepper spray; and
- The maximum number of pepper spray applications that staff may use on an inmate during an incident.

Of the 35 controlled use-of-force incidents that we monitored, officers used pepper spray in 23 incidents (66 percent). In all 23 of those incidents, staff used an authorized pepper spray projector. In two of the 23 incidents, officers deployed pepper spray for longer than the authorized duration. In both instances, the officer deployed pepper spray for 5 seconds, 2 seconds longer than the duration allowed for that particular type of pepper spray. The review committees at both of the institutions provided training to the respective officers regarding duration requirements. In all 23 incidents, officers waited the appropriate time before deploying pepper spray a second time. Finally, in four of the 23 incidents, staff used more than the maximum number of applications allowed during the incident. Policy allows for two to four total applications of pepper spray during a single incident, depending on the type of projector used.<sup>24</sup> In the four incidents, officers used one or two more applications than allowed. In all instances, the respective review committees determined the staff were out of policy, and they provided training.

---

24. DOM, Section 51020.15.1.

### Indicator 3. The Department's Compliance With Decontamination Policies and Procedures Following the Use of Chemical Agents Was Satisfactory

Indicator 3 assesses how well staff complied with decontamination policies following the use of force, including whether staff properly offered the affected inmates the opportunity and means to decontaminate themselves, removed any spit masks during inmates' decontamination, and ensured that inmates were not left in a facedown position after being exposed to chemical agents such as pepper spray. This indicator also measures whether staff offered decontamination to nearby inmates and examines how thoroughly staff decontaminated the physical area affected by chemical agents.

Among incidents we monitored during this review period, we found the department's compliance with its decontamination policies *following* the use of chemical agents *satisfactory*. Officers used chemical agents in 1,324 of the 2,296 incidents that we monitored (58 percent). The OIG assessed the department's performance as *superior* in 88 incidents, *satisfactory* in 1,181 incidents, and *poor* in 56 incidents. Based solely on our review of staff reports, we determined that if staff meet the policy requirements or commit only minor deviations, typically the rating will be *satisfactory*. If, in our opinion, staff do an exceptional job of describing in detail the decontamination efforts of the affected inmates and the affected area, we will assign a *superior* rating. Conversely, when the reports lack information regarding the decontamination efforts, making it impossible to determine whether the requirements have been met, we will assign a *poor* rating. Below is a summary of our analysis of the different questions we ask related to decontamination following the use of chemical agents, followed by examples of *superior* and *poor* ratings for Indicator 3.

In the 93 incidents in which we negatively assessed the department in at least one area of the required decontamination, the department failed to take action to correct the deficiency in 51 of the incidents (55 percent).

*Staff achieved a high compliance rate with requirements to afford inmates proper decontamination and provide fresh clothing following exposure.*

Policy requires that any inmate exposed to a chemical agent be afforded an opportunity to decontaminate as soon as is practical.<sup>25</sup> Decontamination to relieve the effects of chemical agents may be accomplished by exposing the inmate to fresh moving air or flushing the affected body area with cool water. Policy further states that inmates exposed to chemical agents shall be allowed to change their clothes as

Indicator Rating  
**Satisfactory**

**Superior**

88 incidents

7 percent

**Satisfactory**

1,181 incidents

89 percent

**Poor**

56 incidents

5 percent

25. DOM, Section 51020.15.4.

soon as practical.<sup>26</sup> Lack of proper decontamination may unnecessarily prolong the physiological effects of the chemical agents. Of the 1,324 incidents we monitored in which officers used chemical agents, staff properly decontaminated and provided fresh clothing to the exposed inmates in approximately 97 percent of the incidents. We identified 16 instances in which officers did not document proper decontamination to the inmate and 26 instances in which officers did not document offering clean clothing.

*Officers complied with policy requirements regarding the removal of a spit mask during decontamination in almost all incidents.*



Source: Image courtesy of Correctional Peace Officers Standards and Training.

Officers may apply a spit mask to an inmate based on specific policy requirements (photo, left).

If officers use a spit mask on an inmate exposed to chemical agents, policy requires that the spit mask be removed during decontamination with water to ensure the inmate is afforded an opportunity to thoroughly rinse the affected area. When decontamination is complete, a new spit mask must be used to prevent re-exposure to the chemical agents. In the 14 incidents we monitored in which a spit mask was used following exposure, officers properly removed the mask in all but one incident.

*Most officers performed well in ensuring inmates were not placed face-down longer than necessary following exposure to chemical agents, but we identified a few instances in which inmates were left in a dangerous position longer than necessary.*

Policy states, “Once an inmate is exposed to chemical agents . . . staff shall not place them on their stomachs, or in a position that allows the inmate to end up on their stomach, for any period longer than necessary to secure (e.g. handcuff) and/or gain control of the inmate. A prone position makes it difficult for any exposed individual to breathe and may be a contributing factor in positional asphyxia. Positional asphyxia occurs when an individual’s body position interferes with respiration, resulting in death.”<sup>27</sup> We primarily relied on photographs and incident videos to identify violations. We identified five incidents for which photographs or video revealed inmates on their stomachs longer than necessary following exposure to chemical agents. While the number is small, each such incident constitutes a significant failure due to the risk of death.

26. Ibid.

27. DOM, Section 51020.16.

*In several instances, officers did not describe decontaminating the affected area, any uninvolved inmates in the area, or the location of the incident.*

In addition to the requirements to decontaminate inmates directly exposed to chemical agents, policy requires additional steps to ensure that inmates in an adjacent cell or in the general area where chemical agents are used are questioned by custody staff to determine if decontamination is warranted. Policy requires that decontamination of the affected cell and housing unit be accomplished by ventilating the area to remove airborne agents and that visible residue be cleaned by wiping with a damp cloth or mop. Decontamination of the general area is not required for incidents that occur outdoors.

Officers did not properly decontaminate the area or the housing unit in 63 of the 591 applicable incidents (11 percent). The policy requirements specify the decontamination of “the housing unit” but do not address other indoor spaces used by inmates and staff, such as classrooms or medical clinics. Some of the review committees interpret the requirement to include other indoor spaces and expect officers to document efforts to decontaminate those areas as they would a housing unit. Others interpret the policy literally and do not extend the requirement to other indoor areas. Obviously, chemical agent residue that is not properly cleaned may cause the physiological effects to linger unnecessarily. The OIG recommends the department amend its current policy to include a requirement to decontaminate other indoor areas, such as medical clinics and classrooms, following the use of chemical agents.

In many instances, there are no uninvolved inmates in the surrounding area who would require questioning about possible exposure. However, in incidents involving chemical agents in which other inmates are known to be present, such as those occurring on a dayroom floor or in a dining hall, officers are expected to question surrounding inmates regarding possible exposure. Of the 551 incidents in which officers deployed chemical agents with uninvolved inmates in the surrounding area, officers did not question the inmates in 52 incidents (9 percent). The following is an example illustrating staff’s *poor* performance in this area:

- Two inmates fought in the dayroom of a housing unit as inmates returned to the unit from their morning meal. Responding officers applied pepper spray six times, including one instantaneous blast grenade, to stop the fight. Officers documented removing the involved inmates and providing water to relieve the effects of the pepper spray. However, none of the reports, neither officers’ nor supervisors’ documented questioning inmates in the surrounding area regarding possible exposure. In addition, none of the staff described in their reports any efforts to clean the affected area or ventilate the housing unit.

On the other hand, we identified 88 instances in which staff did an exceptional job describing the efforts to decontaminate affected inmates and areas, earning a *superior* rating for these incidents in this indicator.

- In one example of a *superior* rating, officers deployed multiple applications of pepper spray to stop two inmates fighting on an exercise yard. The sergeant who responded to the incident articulated that he offered all uninvolved inmates in the general vicinity of the fight the opportunity to decontaminate, but the inmates refused. The officers assigned to escort and decontaminate the inmates clearly described the process, including one officer who reported, “I asked [inmate] if he needed to use water to assist in clearing the agents off of him, he stated ‘yes.’ I provided water from a hose in front of D-Facility Library in the grass area by holding hose in a manner that allowed him to place the top of his head, face, neck and upper body area into the stream of water provided. By alternating in facing into the wind and using the stream of water to assist in the removal process for approximately 5 minutes, he stated ‘I feel better. I don’t think I need to use the water anymore.’”
- In another example of a *superior* rating, officers used pepper spray to stop two inmates fighting inside their cell. The sergeant who responded to the incident reported that he questioned inmates in the cells near the incident to determine whether they needed to decontaminate. The officers who provided decontamination to the involved inmates clearly recorded the manner and duration of the decontamination process. One of the officers described that he cleaned the affected cell “with soap and water and the contaminated linens were exchanged for clean linens.” The control booth officer in the building described activating the building’s ventilation system to clear the area of pepper spray.

#### Indicator 4. The Department's Compliance With Policies and Procedures in Medically Evaluating Inmates Who Were Involved in a Use-of-Force Incident Was *Satisfactory*

Indicator 4 measures how well licensed nursing staff evaluated inmates following the use of force; this includes assessing how promptly nurses conduct medical evaluations after the use of force and how thoroughly nurses document those medical evaluations.

Among the incidents we monitored during this review period, we found the department's compliance with policies and procedures in medically evaluating inmates who were involved in a use-of-force incident was *satisfactory*. The OIG assessed the department's performance as *superior* in 84 incidents, *satisfactory* in 2,021 incidents, and *poor* in 191 incidents.

The licensed nursing staff who conduct medical assessments of inmates involved in use-of-force incidents must document any injuries, the injuries' locations, and their sources, if known.<sup>28</sup> They also document the incident time and date, the reason for the evaluation, any inmate comments, any decontamination, and the disposition of the examination, using the Medical Report of Injury or Unusual Occurrence form (CDCR Form 7219, Figure 9, right).

Staff's failure to identify and assess inmate injuries in a timely manner can delay necessary medical care. In our assignment of ratings for this indicator, we took into consideration the reasonableness of delays. When force is used, departmental policy requires that "a medical evaluation shall be provided as soon as practical."<sup>29</sup> Nursing staff is required to complete the medical report form and submit it to the response supervisor prior to leaving the institution.

Indicator Rating  
**Satisfactory**

**Superior**  
84 incidents  
4 percent

**Satisfactory**  
2,021 incidents  
88 percent

**Poor**  
191 incidents  
8 percent

Figure 9. Medical Report of Injury or Unusual Occurrence (CDCR Form 7219)

STATE OF CALIFORNIA MEDICAL REPORT OF INJURY OR UNUSUAL OCCURRENCE CDCR 7219 (Rev. 01/18)		DEPARTMENT OF CORRECTIONS AND REHABILITATION																																									
NAME OF INSTITUTION		LOCATION OF EVALUATION		DATE																																							
REASON FOR REPORT <input type="checkbox"/> ALLEGATION <input type="checkbox"/> ON THE JOB INJURY <input type="checkbox"/> USE OF FORCE <input type="checkbox"/> INJURY <input type="checkbox"/> OTM RETURNS																																											
<input type="checkbox"/> UNUSUAL OCCURRENCE <input type="checkbox"/> PRE AD/SEG ADMISSION <input type="checkbox"/> R&R <input type="checkbox"/> OTHER																																											
NAME	LAST	FIRST	CDCR NUMBER	PERNR / INST. ID #	VISITOR ID # (GOMS)																																						
PLACE OF OCCURRENCE	DATE OF OCCURRENCE	TIME OF OCCURRENCE	TIME SEEN	EN NOTIFIED TIME	PHYSICIAN NOTIFIED TIME																																						
BRIEF STATEMENT IN SUBJECT'S WORDS OF THE CIRCUMSTANCES OF THE INJURY OR UNUSUAL OCCURRENCE																																											
<table border="1"> <thead> <tr> <th>INJURIES FOUND?</th> <th>YES / NO</th> </tr> </thead> <tbody> <tr><td>Abrasion/Scrub</td><td>1</td></tr> <tr><td>Active Bleeding</td><td>2</td></tr> <tr><td>Broken Bone</td><td>3</td></tr> <tr><td>Bruise/Discolored Area</td><td>4</td></tr> <tr><td>Burn</td><td>5</td></tr> <tr><td>Dislocation</td><td>6</td></tr> <tr><td>Dried Blood</td><td>7</td></tr> <tr><td>Fresh Tattoo</td><td>8</td></tr> <tr><td>Cut/Laceration/Slash</td><td>9</td></tr> <tr><td>Swollen Area</td><td>10</td></tr> <tr><td>Pain</td><td>11</td></tr> <tr><td>Protrusion</td><td>12</td></tr> <tr><td>Puncture</td><td>13</td></tr> <tr><td>Kidney Area</td><td>14</td></tr> <tr><td>Skin Flap</td><td>15</td></tr> <tr><td>Pre-Existing</td><td>16</td></tr> <tr><td>Other</td><td>17</td></tr> <tr><td></td><td>18</td></tr> </tbody> </table>						INJURIES FOUND?	YES / NO	Abrasion/Scrub	1	Active Bleeding	2	Broken Bone	3	Bruise/Discolored Area	4	Burn	5	Dislocation	6	Dried Blood	7	Fresh Tattoo	8	Cut/Laceration/Slash	9	Swollen Area	10	Pain	11	Protrusion	12	Puncture	13	Kidney Area	14	Skin Flap	15	Pre-Existing	16	Other	17		18
INJURIES FOUND?	YES / NO																																										
Abrasion/Scrub	1																																										
Active Bleeding	2																																										
Broken Bone	3																																										
Bruise/Discolored Area	4																																										
Burn	5																																										
Dislocation	6																																										
Dried Blood	7																																										
Fresh Tattoo	8																																										
Cut/Laceration/Slash	9																																										
Swollen Area	10																																										
Pain	11																																										
Protrusion	12																																										
Puncture	13																																										
Kidney Area	14																																										
Skin Flap	15																																										
Pre-Existing	16																																										
Other	17																																										
	18																																										
<table border="1"> <tbody> <tr> <td>Chemical Agent Exposure?</td> <td>YES / NO</td> </tr> <tr> <td>Class Agent Exposure Area</td> <td>EX</td> </tr> <tr> <td>Decontaminated w/ Water?</td> <td>YES / NO / REFUSED</td> </tr> <tr> <td>Decontaminated w/ Air?</td> <td>YES / NO / REFUSED</td> </tr> <tr> <td>Self-decontamination instructions given?</td> <td>YES / NO</td> </tr> <tr> <td>Staff issued Exposure packet?</td> <td>YES / NO</td> </tr> <tr> <td>Q 15 min. check times</td> <td></td> </tr> <tr> <td>Initial</td> <td>1<sup>st</sup> Check</td> </tr> <tr> <td>2<sup>nd</sup> Check</td> <td>Final</td> </tr> <tr> <td colspan="2">TIME DISPOSITION</td> </tr> <tr> <td>REPORT COMPLETED BY/TITLE (PRINT AND SIGN)</td> <td>PERNR / INST. ID #</td> <td>EDO#</td> <td>ASSIGNMENT AREA</td> </tr> </tbody> </table>						Chemical Agent Exposure?	YES / NO	Class Agent Exposure Area	EX	Decontaminated w/ Water?	YES / NO / REFUSED	Decontaminated w/ Air?	YES / NO / REFUSED	Self-decontamination instructions given?	YES / NO	Staff issued Exposure packet?	YES / NO	Q 15 min. check times		Initial	1 <sup>st</sup> Check	2 <sup>nd</sup> Check	Final	TIME DISPOSITION		REPORT COMPLETED BY/TITLE (PRINT AND SIGN)	PERNR / INST. ID #	EDO#	ASSIGNMENT AREA														
Chemical Agent Exposure?	YES / NO																																										
Class Agent Exposure Area	EX																																										
Decontaminated w/ Water?	YES / NO / REFUSED																																										
Decontaminated w/ Air?	YES / NO / REFUSED																																										
Self-decontamination instructions given?	YES / NO																																										
Staff issued Exposure packet?	YES / NO																																										
Q 15 min. check times																																											
Initial	1 <sup>st</sup> Check																																										
2 <sup>nd</sup> Check	Final																																										
TIME DISPOSITION																																											
REPORT COMPLETED BY/TITLE (PRINT AND SIGN)	PERNR / INST. ID #	EDO#	ASSIGNMENT AREA																																								

Source: The California Department of Corrections and Rehabilitation.

28. DOM, Section 51020.17.6.

29. DOM, Section 51020.9.

The form must include the following:

- The inmate’s own words;
- Observations of the area where force was applied;
- Comments or information gathered from custody staff regarding the type and amount of force used;
- Description of injuries sustained and the medical treatment rendered;
- Any refusal by the inmate of medical evaluation and/or treatment;
- Any alternative assistive devices provided;
- Any medical recommendation or accommodation;
- In-cell decontamination instructions; and
- Times of 15-minute checks, if applicable.<sup>30</sup>

*Some staff performed exceptionally well ensuring that inmates received a timely medical evaluation following a use-of-force incident.*

Staff complied with policy and training and ensured inmates received a timely medical evaluation in 2,186 of the 2,296 incidents (95 percent). The following examples in which staff performed exceptionally well in their efforts to conduct timely medical evaluations on inmates resulted in a superior rating in Indicator 4 in these incidents.

- In one incident, officers observed two inmates on the ground punching each other in the face and torso. Officers were unsuccessful when ordering the inmates to stop and get down, so the officers deployed pepper spray. Officers saw that one inmate was actively bleeding from his face. Officers escorted the inmate to the medical center, where staff conducted a medical evaluation of the inmate within two minutes of the incident. He was transported via ambulance to an outside hospital for a higher level of care. The inmate sustained serious bodily injury in the form of a broken nose.
- In a second incident, officers observed three inmates punching a fourth inmate in the face and torso. An officer activated an alarm. The aggressors continued striking the victim, who was in a seated position with his arms covering his face. Officers moved closer to the inmates and observed a large amount of blood around the victim as he appeared to be slumped over with his arms to his sides. Officers used their pepper spray to stop

---

30. DOM, Section 51020.17.6.



the attack, and the inmates got down on the ground into prone positions. Medical staff arrived and transported the injured inmate to the triage and treatment area for evaluation before transporting him to an outside hospital for a higher level of care. Staff identified a ballpoint pen and one of the victim's teeth in the pool of blood where the victim was located. The victim sustained multiple puncture wounds and lacerations to his head and face along with a lost tooth. The response of medical staff was exceptional as the inmate was thoroughly evaluated within four minutes following the incident.

*Some staff did not ensure inmates received a timely medical evaluation following a use-of-force incident.*

Of the 2,296 incidents we monitored, staff failed to ensure inmates received timely medical evaluations following a use of force in 110 incidents (5 percent). We acknowledge that there are many circumstances that can reasonably delay a medical evaluation, such as large-scale riots, multiple inmates with serious injuries, and staff safety considerations; however, circumstances such as administering medication (pill-line), medical staff assigned to other areas, crime scene preservation, among other common occurrences, are not acceptable reasons for delay. Furthermore, deliberate failure on the part of custody staff to alert medical staff of possible injuries resulting from a use of force is serious misconduct. This misconduct can inhibit the department's ability to conduct thorough investigations and can promote a culture of distrust, intimidation, and fear among staff and inmates. A few examples that illustrate staff's poor performance in this area, resulting in a *poor* rating for Indicator 4, are as follows:

- Officers had ordered an inmate to return to his assigned housing. The inmate became agitated and advanced toward the officers aggressively. Officers deployed chemical agents without effect. The inmate began to punch the officers in the face and grabbed one officer, placing the officer in a choke hold and rendering him unconscious. Responding staff arrived and used physical force and hand-held batons in an attempt to stop the inmate. Officers struck the inmate 16 times with their batons, one officer struck the inmate in the head, and another used nonconventional force by striking the inmate in the head with his pepper spray cannister. The inmate released the officer, and surrounding staff tackled the inmate to the ground. Responding staff escorted the inmate to a holding cell and notified the incident commander and response supervisor that the inmate was struck in the head with a baton. Officers failed to alert medical staff until an hour after the incident, at which time it was determined that he sustained serious bodily injury and was transported to an outside hospital for a higher level of care. The inmate sustained

a cut on the top of his head that required five staples and one on his forehead requiring eight sutures. Staff who conducted the various levels of review at the institution failed to identify the inmate was not afforded a medical evaluation as soon as was practical. The OIG raised the issue of the one-hour delay during the institution's review committee meeting, but the hiring authority declined to take any action.

- In another incident, officers observed an inmate attempting to conceal suspected drugs while the inmate used the bathroom. Without warning, the inmate battered the officers while attempting to flush the suspected drugs down the inmate toilet. Staff used physical force by punching the inmate in the face and body multiple times to stop the attack. Officers forced the inmate to the ground, striking his head on a holding cell door. Officers forced the inmate to the ground a second time, this time striking his head on the concrete. The sergeant arrived on scene and observed that the inmate was unclothed and actively bleeding from his face and head area, with what appeared to be “non-life-threatening injuries.” The same sergeant instructed the inmate to stay calm and told him that he would be medically evaluated after investigative staff arrived and processed the crime scene. Staff did not medically assess the inmate until approximately 40 minutes after the incident, at which time they noted serious bodily injury in the form of a broken nose. The inmate was treated at the institution and then sent to an outside hospital for further treatment. Staff who conducted the various levels of review at the institution did not identify this delay. The OIG raised the issue at the institution's review committee. The hiring authority provided training to the sergeant to address the delayed medical assessment. Although the OIG agreed with the decision to provide training, the egregiousness of the delay warranted a *poor* rating for this indicator.
- In another incident, an agitated inmate started yelling obscenities at officers. The officers ordered the inmate to turn around to be placed in restraints. The inmate continued to yell at the officers, and one officer placed the inmate on the wall and attempted to grab his arm to place him in restraints. The inmate continued to resist by pulling his arm away, but the officer was able to secure both the inmate's hands in restraints. The inmate was escorted to a holding cell, where he fell to the ground and kicked an officer. Once inside the holding cell, the inmate began to bang his head multiple times against the back and sides of the holding cell, refusing officers' orders to stop. The inmate eventually complied with orders and was retained in the holding cell awaiting a medical evaluation. The incident commander and sergeant noted in their reports that medical staff was called on several occasions to conduct a medical evaluation of the inmate, but did not arrive until more than three hours after the incident.

The inmate sustained a laceration and swollen area on the left side of his head. Staff conducting the various levels of review at the institution failed to identify this delay. The OIG raised the issue at the institution's review committee meeting, but the hiring authority declined to take any action.

*Following medical evaluations, some staff failed to satisfactorily document inmates' injuries.*

Of the 2,261 incidents<sup>31</sup> in which we evaluated documentation of injuries, we identified 65 incidents in which staff failed to satisfactorily document the inmate's injuries (3 percent). Following medical evaluations, staff generally release inmates back to their assigned housing or to a more restrictive program, depending on the circumstances surrounding the use-of-force incidents. Inmates' injuries are time-sensitive and best captured immediately following the incident. Injuries that go unidentified are rendered, effectively, as if they did not happen, eliminating possible evidence to corroborate statements. The following example illustrates staff's poor performance while documenting inmates' injuries, resulting in a *poor* rating for Indicator 4 in this incident.

- Officers were placing an inmate in restraints when his unrestrained cellmate began to strike him multiple times on the head with a cup. The aggressor continued to strike the victim on the head, knocking him to the ground. The aggressor began to straddle the victim and continued to strike him. Fearing the victim would suffer brain trauma or serious injury, staff deployed pepper spray in the face of the aggressor. The aggressor moved away from the victim and got down on the ground. The incident commander wrote in his original report, "The state cup is made of hardened plastic, it will not bend." This statement, plus the statements regarding fear of brain injury and the inmate's inability to protect himself, added to the reported numerous strikes to the inmate's head, would have caused injuries that could have been documented. The victim's form showed no injuries. In fact, the victim's form was almost identical to the aggressor's, also showing no injuries. The same psychiatric technician evaluated both the victim and the aggressor and completed the forms (see Figures 10a and 10b, next page). Staff completing the various levels of review at the institution failed to identify this deficiency. The OIG raised the issue at the institution's review committee meeting, but the hiring authority declined to take any action.

---

31. This number is less than the 2,296 total incidents we monitored because the parole division's policy requirements differ from requirements at adult institutions and juvenile facilities, so incidents involving parolees are not applicable for this question.

Figure 10. Medical Evaluation Forms for Victim and Aggressor

Figure 10a. Victim

BRIEF STATEMENT IN SUBJECT'S WORDS OF THE CIRCUMSTANCES OF THE INJURY OR UNUSUAL OCCURRENCE  
"No comment"

Victim

INURIES FOUND?	YES	NO
Abuse/Scratch	1	
Active Bleeding	2	
Broken Bone	3	
Bruse/Discolored Area	4	
Burn	5	
Distortion	6	
Dried Blood	7	
Fresh Tattoo	8	
Cut/Laceration/Slash	9	
Swollen Area	10	
Pain	11	
Prisoners	12	
Puncture	13	
Reddened Area	14	
Skin Flap	15	
Pts-Existing	16	
Other	17	
	18	

Chemical Agent Exposure?  YES /  NO  
Chem. Agent Exposure Area: EK

Decontaminated w/ Water?  YES /  NO /  REFUSED  
Decontaminated w/ Aft?  YES /  NO /  REFUSED  
Self-decontamination instructions given?  YES /  NO  
Staff issued Exposure packet?  YES /  NO

Q 15 min. check times

Initial	1 <sup>st</sup> Check	Final
NA	NA	NA
NA	NA	NA

Figure 10b. Aggressor

BRIEF STATEMENT IN SUBJECT'S WORDS OF THE CIRCUMSTANCES OF THE INJURY OR UNUSUAL OCCURRENCE  
"No comment"

Aggressor

INURIES FOUND?	YES	NO
Abuse/Scratch	1	
Active Bleeding	2	
Broken Bone	3	
Bruse/Discolored Area	4	
Burn	5	
Distortion	6	
Dried Blood	7	
Fresh Tattoo	8	
Cut/Laceration/Slash	9	
Swollen Area	10	
Pain	11	
Prisoners	12	
Puncture	13	
Reddened Area	14	
Skin Flap	15	
Pts-Existing	16	
Other	17	
	18	

Chemical Agent Exposure?  YES /  NO  
Chem. Agent Exposure Area: EK

Decontaminated w/ Water?  YES /  NO /  REFUSED  
Decontaminated w/ Aft?  YES /  NO /  REFUSED  
Self-decontamination instructions given?  YES /  NO  
Staff issued Exposure packet?  YES /  NO

Q 15 min. check times

Initial	1 <sup>st</sup> Check	Final
NA	NA	NA
NA	NA	NA

Some staff performed exceptionally well in their efforts to satisfactorily document all inmate injuries in corroboration of timely medical assessments. Staff complied with policy and training and satisfactorily documented the inmates' injuries in 2,196 of the 2,261 incidents (92 percent). The following is an example of staff's performance contributing to a *superior* rating for Indicator 4.

- Officers observed three inmates striking a third inmate on the head and torso with their fists. An alarm was announced via the institutional radio, and the yard was ordered down via the public address system. The attacking inmates ignored the orders and continued to strike the victim. A control booth officer, using a 40mm direct impact launcher, aimed at and struck one of the aggressors in the right buttock; the projectile ricocheted and struck the same inmate's right calf. The aggressors stopped their attack and assumed prone positions on the ground. The victim and the recipient of force each had visible injuries. The medical staff thoroughly documented the inmates' injuries on the medical forms (Figures 11a and 11b, next page).

Despite the high compliance rates, there is definite room for improvement. Among the 2,261 incidents applicable for this indicator, we identified 615 in which staff failed to complete all required fields on the medical evaluation form, excluding the inmate's injuries (27 percent). Training on completing this form has been ongoing, but so far has been less than effective.

Figure 11. Medical Evaluation Forms for Recipient of Force and Victim

Figure 11a. Recipient of Force

"No statement"

Right Recipient of Force Left

INJURIES FOUND?	YES	NO
Abrasion/Scratch	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Active Bleeding	<input type="checkbox"/>	<input type="checkbox"/>
Broken Bone	<input type="checkbox"/>	<input type="checkbox"/>
Bruise/Discolored Area	<input type="checkbox"/>	<input type="checkbox"/>
Burn	<input type="checkbox"/>	<input type="checkbox"/>
Dislocation	<input type="checkbox"/>	<input type="checkbox"/>
Dried Blood	<input type="checkbox"/>	<input type="checkbox"/>
Fresh Tattoo	<input type="checkbox"/>	<input type="checkbox"/>
Cut/Laceration/Slash	<input type="checkbox"/>	<input type="checkbox"/>
Swollen Area	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Pain	<input type="checkbox"/>	<input type="checkbox"/>
Protrusion	<input type="checkbox"/>	<input type="checkbox"/>
Puncture	<input type="checkbox"/>	<input type="checkbox"/>
Reddened Area	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Skin Flap	<input type="checkbox"/>	<input type="checkbox"/>
Pre-Existing	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>

Chemical Agent Exposure? YES  NO

Chem. Agent Exposure Area EX

Decontaminated w/ Water? YES  NO  REFUSED

Decontaminated w/ Air? YES  NO  REFUSED

Self-decontamination Instructions given? YES  NO

Staff issued Exposure packet? YES  NO

Q 15 min. check times

Initial	/	1 <sup>st</sup> Check	/
2 <sup>nd</sup> Check	/	Final	/

TIME/DISPOSITION  
1306 pm RTC

Figure 11b. Victim

"No comments"

Right Victim Left

INJURIES FOUND?	YES	NO
Abrasion/Scratch	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Active Bleeding	<input type="checkbox"/>	<input type="checkbox"/>
Broken Bone	<input type="checkbox"/>	<input type="checkbox"/>
Bruise/Discolored Area	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Burn	<input type="checkbox"/>	<input type="checkbox"/>
Dislocation	<input type="checkbox"/>	<input type="checkbox"/>
Dried Blood	<input type="checkbox"/>	<input type="checkbox"/>
Fresh Tattoo	<input type="checkbox"/>	<input type="checkbox"/>
Cut/Laceration/Slash	<input type="checkbox"/>	<input type="checkbox"/>
Swollen Area	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Pain	<input type="checkbox"/>	<input type="checkbox"/>
Protrusion	<input type="checkbox"/>	<input type="checkbox"/>
Puncture	<input type="checkbox"/>	<input type="checkbox"/>
Reddened Area	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Skin Flap	<input type="checkbox"/>	<input type="checkbox"/>
Pre-Existing	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input checked="" type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>

Chemical Agent Exposure? YES  NO

Chem. Agent Exposure Area EX

Decontaminated w/ Water? YES  NO  REFUSED

Decontaminated w/ Air? YES  NO  REFUSED

Self-decontamination Instructions given? YES  NO

Staff issued Exposure packet? YES  NO

Q 15 min. check times

Initial	N/A	1 <sup>st</sup> Check	/
2 <sup>nd</sup> Check	/	Final	/

TIME/DISPOSITION  
RTC @ 1250

Indicator Rating  
**Satisfactory**

**Superior**

No incidents  
Zero percent

**Satisfactory**

2,266 incidents  
99 percent

**Poor**

30 incidents  
1 percent

### Indicator 5. The Department's Compliance With Policies and Procedures When Supervising Inmates Following a Use of Force Was Satisfactory

Indicator 5 assesses how well staff followed policies and procedures when supervising inmates following uses of force; among other considerations, this indicator measures whether staff maintained constant supervision of inmates who were in restraints or wearing a spit hood after a use of force.

Among incidents we monitored during this review period, we found the department's compliance with its policies and procedures when supervising inmates following a use of force *satisfactory*. The OIG assessed the department's performance as *satisfactory* in 2,266 incidents and *poor* in 30 incidents. We did not assign any incidents a *superior* rating in this indicator.

Departmental policy states, "If a spit hood/mask is applied to an inmate, it is imperative that constant supervision of the inmate be maintained for signs of respiratory distress. If any respiratory distress is observed, the spit hood/mask shall be removed until the signs of respiratory distress have dissipated."<sup>32</sup> The policy further requires that "restrained inmates shall never be left unsupervised."<sup>33</sup>

*In some instances, staff failed to maintain constant supervision of inmates after applying a spit hood or mask.*

Staff applied a spit hood or mask in 109 incidents we monitored. In seven of the 109 incidents, staff failed to maintain constant supervision of inmates after applying spit hoods or masks (6 percent). The following example illustrates staff's poor performance in this area, resulting in a *poor* rating for Indicator 5 in this incident:

- Officers responded to an inmate's cell to assist medical staff in taking his daily vitals. The inmate went to the back of the cell and crossed his arms, refusing to cooperate. Officers ordered the inmate to submit to restraints without effect, and he fell to the ground in a fetal position. Officers placed the inmate in restraints, at which time he began to make hacking noises as if he were going to spit. An officer placed a spit hood on the inmate and left the room, leaving the inmate unsupervised. The OIG found that the officer's report did not mention removing the hood. The warden agreed to request clarification from the officer to determine whether the inmate was left without supervision; however, after further follow-up, no action was taken.

32. DOM, Section 51020.16.

33. DOM, Section 51020.6.

*Some staff failed to maintain supervision of inmates placed or retained in restraints.*

When inmates are restrained but unsupervised, they may use the restraints to cause injuries to themselves, other inmates, or staff, or they may create security concerns. Of the 2,296 incidents we monitored, we identified 2,132 incidents in which staff applied restraints to an inmate. In 19 of these incidents, staff failed to maintain constant supervision of inmates after placing them in restraints. Although these instances accounted for less than one percent of the incidents we monitored, each had the potential for serious consequences. The following examples are incidents for which we assigned a *poor* rating for Indicator 5:

- During an escort, officers ordered a resisting inmate to get down after he pulled away from their grasp. The inmate complied and got down on the ground. Responding officers assisted the inmate to his feet and began escorting the inmate to his cell, when he again became disruptive by thrashing his body left and right. As the inmate neared the holding cell, he used his leg to push off the holding cell door into the officers. The officers used physical force to push him to the ground, and an assisting officer placed the inmate in leg restraints. The sergeant ordered that the inmate remain in restraints due to his refusal to go back to his cell, and he assigned an officer to maintain supervision of the inmate. The captain approved the inmate to remain in the holding cell for more than 25 hours, and the observing officers failed to note on the holding cell log that they maintained constant supervision. Institutional staff at all levels who reviewed the incident failed to identify the lack of supervision. The hiring authority declined to take any action. The OIG did not concur.
- In another incident, inmates were left unsupervised while in restraints. Officers had placed a group of inmates in waist chains following their battery on another inmate and escorted them to a transportation van outside the facility. As officers escorted the last inmate to the van, the inmate began to resist and pulled away from officers, who then used physical force to regain control of the inmate. The officers continued the escort and as they approached the van, they observed glass on the floor and a large hole in the sliding glass door window. Staff who completed the various levels of review at the institution failed to recognize that the inmates were left unsupervised while in restraints. The OIG identified this deviation during the institution's review committee meeting and influenced the hiring authority to take appropriate action. The hiring authority provided training to the sergeant for failing to ensure staff maintained constant supervision of inmates left in restraints. The OIG concurred.

Indicator Rating  
**Satisfactory****Superior**294 incidents  
13 percent**Satisfactory**1,892 incidents  
82 percent**Poor**110 incidents  
5 percent**Indicator 6. The Department's Compliance With Policies and Procedures Specific to Users-of-Force Reporting Requirements Was Satisfactory**

Indicator 6 measures how well staff who used force documented their actions following the use of force; this includes assessing how well staff documented the circumstances leading up to the use of force, how well staff described the perceived threat that justified the use of force, how thoroughly staff documented their actions and observations, whether staff documented approved criteria for applying a spit hood, and whether staff completed their documentation promptly and independently, without collaborating with other staff.

Among incidents we monitored during this review period, we found the department's compliance with its policies and procedures specific to users-of-force reporting requirements *satisfactory*. The OIG assessed the department's performance as *superior* in 294 incidents, *satisfactory* in 1,892, and *poor* in 110 incidents. For this indicator, we examined how well staff who *used force* documented their observations and actions following a use of force, including the articulation of precipitating events, inmates' actions, and the force *used* throughout the incident. We addressed staff *who did not use force* in Indicator 7.

Departmental policy states, "Any employee **who uses force** or observes a staff use of force shall report it to a supervisor as soon as practical and follow up with appropriate documentation prior to being relieved from duty. The CDCR 837 Crime/Incident Report form (Figure 12, next page) is used for reporting uses of force. Written reports regarding both immediate and controlled use of force shall be documented on a CDCR 837 [*emphasis added*]."<sup>34</sup> The policy further requires staff to identify any witnesses, describe the circumstances precipitating the force, consideration of mental health issues, and the nature and extent of the force used.

We assessed how each user of force documented on the incident report form the precipitating events, imminent threat, inmates' actions, forced used, response following the force, and the use of spit masks or hoods, and we assessed the timeliness of reports and other details surrounding use-of-force reporting.

***Some staff who used force did not articulate the imminent threat justifying the use of immediate force.***

The department defines immediate use of force as "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."<sup>35</sup>

34. DOM, Section 51020.17.

35. DOM, Section 51020.4.



Figure 12. CDCR 837 Crime/Incident Report Form

STATE OF CALIFORNIA										DEPARTMENT OF CORRECTIONS AND REHABILITATION														
CRIME / INCIDENT REPORT										INCIDENT LOG NUMBER														
PART C - STAFF REPORT										PAGE <u>1</u> Of _____														
CDCR 837-C (Rev. 10/15)																								
NAME: LAST					FIRST					MI		DATE OF INCIDENT					TIME OF INCIDENT							
POST #			POSITION			YEARS OF SERVICE YRS. MO.			DATE OF REPORT			LOCATION OF INCIDENT												
RDO'S		DUTY HOURS		DESCRIPTION OF CRIME / INCIDENT						CCR SECTION / RULE					<input type="checkbox"/> N/A									
YOUR ROLE			WITNESSES (PREFACE S-STAFF, V-VISITOR, O-OTHER)				INMATES (PREFACE S-SUSPECT, V-VICTIM, W-WITNESS)																	
<input type="checkbox"/> Primary																								
<input type="checkbox"/> Responder																								
<input type="checkbox"/> Witness																								
<input type="checkbox"/> Camera																								
<input type="checkbox"/> Victim																								
<input type="checkbox"/> Other:																								
<input type="checkbox"/> N/A										FORCE USED BY YOU – TYPE OF WEAPON / SHOTS FIRED / NON-CONVENTIONAL FORCE														
<input type="checkbox"/> Physical:		Lethal Weapons:		Warning:		Effect:		Less Lethal Weapons:		# Effect:		Chemical Agent:		Projector:		#Deployed:								
<input type="checkbox"/> Hand-Held Baton		<input type="checkbox"/> Mini 14						<input type="checkbox"/> 37 mm				<input type="checkbox"/> OC												
<input type="checkbox"/> X-10 BRD w/o OC		<input type="checkbox"/> .38 Cal						<input type="checkbox"/> 40 mm				<input type="checkbox"/> CN												
<input type="checkbox"/> X-10 BRD w/ OC		<input type="checkbox"/> .40 Cal						<input type="checkbox"/> L8				<input type="checkbox"/> CS												
		<input type="checkbox"/> 9 mm						<input type="checkbox"/> 40 mm Multi																
		<input type="checkbox"/> Shotgun						<input type="checkbox"/> HFWS																
<input type="checkbox"/> Non-Conventional or Force Not Listed Above:																								
FORCE OBSERVED BY YOU		<input type="checkbox"/> N/A <input type="checkbox"/> Physical <input type="checkbox"/> Hand-Held Baton <input type="checkbox"/> Chemical Agent <input type="checkbox"/> X-10 <input type="checkbox"/> Less Lethal <input type="checkbox"/> Lethal <input type="checkbox"/> Non-Conventional																						
EVIDENCE COLLECTED BY YOU		EVIDENCE DESCRIPTION						EVIDENCE DISPOSITION						BIO HAZARD		PPE								
<input type="checkbox"/> YES														<input type="checkbox"/> YES		<input checked="" type="checkbox"/> YES								
<input type="checkbox"/> NO		<input type="checkbox"/> N/A						<input type="checkbox"/> N/A						<input type="checkbox"/> NO		<input type="checkbox"/> NO								
REPORTING STAFF INJURED		DESCRIPTION OF INJURY				LOCATION TREATED (HOSPITAL/CLINIC)				FLUID EXPOSURE				SCIF 3301/3067 COMPLETED										
<input type="checkbox"/> YES										<input type="checkbox"/> BODILY <input type="checkbox"/> N/A				<input type="checkbox"/> YES										
<input type="checkbox"/> NO		<input type="checkbox"/> N/A				<input type="checkbox"/> N/A				<input type="checkbox"/> UNKOWN				<input type="checkbox"/> NO										
										<input type="checkbox"/> Other:														
NARRATIVE:																								
<input type="checkbox"/> CHECK IF NARRATIVE IS CONTINUED ON CDCR 837-C1.																								
SIGNATURE OF REPORTING STAFF					TITLE					BADGE # / ID #					DATE									
NAME AND TITLE OF REVIEWER (PRINT/SIGNATURE)					DATE RECEIVED					CLARIFICATION NEEDED <input type="checkbox"/> YES <input type="checkbox"/> NO					APPROVED <input type="checkbox"/> YES <input type="checkbox"/> NO					DATE				
DISTRIBUTION: Original: Incident Package Copy: Reporting Employee Copy: Reviewing Supervisor																								

Source: The California Department of Corrections and Rehabilitation.

An imminent threat is “any situation or circumstance that jeopardizes the safety of persons or compromises the security of the institution, requiring immediate action to stop the threat.”<sup>36</sup> Some examples include escape attempts, ongoing physical harm to one’s self or others, or active physical resistance.

Of the 2,265 incidents<sup>37</sup> we monitored in which staff used immediate force, we identified 55 incidents in which staff failed to *articulate* an imminent threat necessitating the need for immediate force (2 percent) in their reports. In this indicator, we assessed the quality of the *written articulation* of the imminent threat on the incident report form following the use of immediate force. In the following examples, the reports following immediate uses of force lacked the required articulation of imminent threat, resulting in a *poor* rating for Indicator 6 in these incidents.

- In one incident, even though a potential threat did exist, staff nevertheless failed to satisfactorily articulate the immediacy of the threat to justify immediate force. The officer had opened a holding cell door to release an inmate. The inmate refused to exit the cell, so the officer closed the door. The inmate stated, “Well fine, I’m just going to kill myself in this cell.” The officer, fearing the inmate could carry out the threat, ordered the inmate to turn around and place her hands through the cuff port to place the inmate in restraints. The inmate initially complied by placing her hands outside of the port. The officer grabbed her right hand as the inmate attempted to pull her hands away from the officer and back into the holding cell. Again, fearing the inmate would carry out the threat, the officer maintained her grip on the inmate’s wrist, turning it clockwise, causing minimal pain in an effort to make the inmate comply with orders. The inmate continued to attempt to pull her hands inside while the officer was attempting to pull her hands outside the cuff port. The officer failed to articulate an imminent threat that would require the need for immediate force. There was a potential threat of the inmate threatening to kill herself; however, there was no articulation as to how the inmate would be successful. Furthermore, the inmate was contained in the holding cell; when the inmate pulled her hands back through the port, the officer should have let go, stepped away, and closed the cuff port. The OIG acknowledged the presence of a potential threat, but raised the issue of staff failing to articulate an imminent threat during the institution’s review committee. The hiring authority disagreed and declined to take any action.

---

36. Ibid.

37. Controlled uses of force are not included in this assessment.

- In another incident, an officer assigned to observe an inmate on contraband surveillance watch called for assistance because the inmate needed to urinate. Two officers removed the inmate from the cell and removed his waist restraints. One officer removed himself from the escort to contact the sergeant while the other officer placed the inmate inside the cell. The inmate suddenly stopped urinating, removed his jumpsuit, and turned toward the officer. The officer used physical force to push the inmate back toward the toilet and ordered him to get down. The second officer returned from calling the sergeant, heard orders to get down, and assisted the officer in forcing the inmate to a seated position on the toilet. The inmate attempted to remove an item from his anal cavity, resulting in both officers using physical force to push him off the toilet. The force did not have the desired effect as the inmate stood up and the officers backed out of the cell and secured the door. The first level review identified that the initial force was appropriate as the inmate turned towards staff; however, once the inmate sat on the toilet the threat was no longer present. The hiring authority provided corrective action to the officers to address this deficiency.

Staff complied with policy and training when articulating the imminent threat in 2,210 of the 2,265 incidents (97 percent). Of those 2,210, the OIG identified a few examples of which staff performed exceptionally well in their efforts to articulate the imminent threat, resulting in a *superior* rating for Indicator 6.

- In one incident, an officer observed one inmate punching a second inmate in the face. The officer gave orders for both inmates to stop fighting and to get down with negative results. The aggressor continued to strike the victim until the victim eventually fell down, and the aggressor was able to straddle the other inmate's back. The victim was unable to protect himself and, fearing serious bodily injury could occur if the officer did not intervene, the officer fired three rounds from her less-lethal launcher to stop the inmate's attack. The officer thoroughly articulated the aggressor's actions and the victim's inability to defend himself, and provided a detailed description as to why she had to act without delay and the continued threat that required additional force.
- In another incident, an officer was escorting an inmate in restraints to the shower, when the inmate became agitated, accusing the officer of spitting in his food. Without warning or provocation, the inmate turned facing the officer and kicked him in the left shin with his right foot, resulting in the officer using physical force to force the inmate to the ground. The officer detailed the inmate's actions, including the speed and the direction in which the inmate turned towards him and why he responded without delay to the inmate's attack.

*Following use-of-force incidents, some staff who used force failed to satisfactorily document their actions or observations.*

If possible, staff must identify important information in the content of the reports, including descriptions of the following:

- Inmates' actions;
- Any force used or observed;
- Projector type and distance if chemical agents were used;
- The level of resistance by the inmate or inmates;
- The threat perceived;
- Any identified inmate disabilities; and
- Observations of decontamination.

Among the 2,296 incidents the OIG monitored this period, we identified 55 incidents in which users of force failed to satisfactorily document their observations or actions (2 percent). The following is an example of an incident we assigned a *poor* rating due to staff's failure to satisfactorily describe their own actions or observations:

- Officers who used force did not clearly describe the inmate's actions or the force the officers used throughout the incident. Staff observed two inmates walk toward officers, whisper something unintelligible, and begin punching each other in the head and upper torso. Officers activated their personal alarms and ordered the inmates to get down. In an attempt to stop the inmates from striking each other, the first officer struck one inmate in the right leg with a baton. The inmates continued to punch each other, resulting in the officer striking the inmate in the left upper leg. The use of force was effective as the inmates got down on the ground. Without warning, the inmates got back up and continued punching each other in the face, and a second officer exited his office and gave orders to stop and get down. The second officer struck the other inmate with his baton in the right shoulder. Both inmates got on the ground and officers placed them in restraints. The first officer failed to describe the inmate's actions between the two baton strikes or the specific area (front or back) of the upper leg, and we found multiple spelling, grammar, and word choice errors (Exhibit 1a, next page). The second officer failed to describe the inmate actions that caused an "immanent [*sic*] threat" that resulted in the need to use force. Furthermore, the officer failed to describe where the baton struck the inmate. The report was lacking detail and contained grammatical errors (Exhibit 1b, next page). A captain who reviewed the incident identified most of the issues referenced

above and requested and received approximately 20 clarifications among the two officers to ensure the reports contained the required elements. The hiring authority provided report-writing training to both officers to address the deficiencies.

Exhibit 1a

then gave multiple orders for the Inmates involved in the incident to stop and get down on the ground. My orders were ignored as they continued fighting. My Partner Officer [redacted] came out of the officer's office and gave multiple orders for the Inmates Involved in the incident to stop and get down on the ground. His orders were ignored as they continued fighting. I then transitioned to my state issued expandable baton and attempted strike Inmate [redacted] with a forward strike in my intended area of his right thigh, striking him in the right knee, which yield negative results. I then assed and gave orders to get down, which he ignored. I then Struck Inmate [redacted] with a reverse strike on my attended target his upper left leg. Inmate [redacted] got down. Both Inmates got down in prone position. I then provided security coverage for Officer [redacted] well he placed Inmate [redacted] in hand cuffs and conducted a

Exhibit 1b

heard Officer [redacted] yell "get down". I saw inmates [redacted] and [redacted] (later identified by state issued identification cards) in the front of the officer's podium fighting striking each other about the head and upper torso areas. Officer [redacted] activated his state issue alarm and call for a code 1 assistant

I ran to Officer [redacted] position and yield for both inmates to get down, which yield a negative result. Utilizing my state issued baton in an attempt stop imminent threat. I use a forward strike aiming for inmate [redacted] right shoulders which cause him to get down. Officer [redacted] provided coverage as I cuff and conducted a clothed body search of inmate [redacted] which yield a negative result. I provided Officer [redacted] coverage as he cuffed and conducted a clothed body search of inmate [redacted] with negative results. Officers [redacted] and [redacted] escorted both inmates from the building. This concludes my involvement of this incident

On a positive note, we found that staff complied with policy and training when describing their involvement throughout the incident and description of force used in 2,241 of the 2,296 incidents (97 percent). Of those 2,241, the OIG identified a few examples in which staff performed exceptionally well in their efforts to articulate the force they used, contributing to a *superior* rating for the respective indicators in these incidents.

- In one incident, officers observed two inmates punching a third inmate in the head and upper torso. The observation officer used the public address system to order all of the inmates on the yard to get on the ground—and all inmates complied, with the exception of the involved inmates. While the two inmates continued to strike the third inmate, responding staff arrived and strategically lined up at a safe but effective distance from the fight. Staff from the line gave orders for the inmates to stop and get down, which were unsuccessful. Three officers used chemical agent grenades to stop the attack. All three officers did an exceptional job describing the aggressors' actions as well as the victim's during the attack. Furthermore, the officers provided a detailed description of their force, including the method of deployment, distance, location, and effect. The reports were well written, clear, and concise (Exhibits 2a and 2b, next page).

Exhibit 2a

caution towards the incident in the middle of the yard. As I was responding, I observed chemical agents being deployed and a cloud of white smoke near the combatants. Due to my distance and my focus on the combatants, I did not observe which staff members deployed their chemical agents. Upon my arrival to the skirmish line, I observed the chemical agents had negative results as Inmates [REDACTED] and [REDACTED] were striking Inmate [REDACTED] to the facial and upper torso area with their fists. [REDACTED] was lying on the ground attempting to shield himself utilizing both of his arms from his assailants. Believing serious bodily injury would occur, I utilized my state issue Oleoresin Capsicum (O.C) Instantaneous Blast Grenade, with an underhand toss towards the combatants from a safe distance of approximately 20 feet away. The grenade landed and detonated approximately 3 feet away from the combatants with positive results as all three inmates separated and assumed prone positions on the ground. When it was safe to do so, Correctional

Exhibit 2b

[REDACTED] who were striking inmate [REDACTED] in his face and upper back with their fists, as [REDACTED] laid down on his stomach covering his head with his arms. Correctional Officers [REDACTED] and I responded to the incident forming a skirmish line at a safe but effective distance in the middle of the Recreational yard west of the incident facing east. From the skirmish line, staff and I gave numerous orders to the combatants to get down with negative results. Fearing serious bodily injury may occur; I utilized my Chloroacetophenone (C.N.) Han Ball Grenade, with an underhand toss from approximately 20 feet away. The grenade landed and detonated approximately 3 feet from the combatants with negative results as the combatants continued their assault on [REDACTED]. Officer [REDACTED] utilized his CN Han Ball grenade, landing and detonating near the combatants with negative results as the combatants continued their assault on [REDACTED]. Responding staff joined the skirmish line, as we continued to give verbal orders to get down with negative results. Correctional Officer [REDACTED] utilized his Oleoresin Capsicum (OC) Instantaneous Blast grenade landing and detonating it next to the combatants with positive results as the combatants separated from each other assumed prone positions. I provided coverage of the yard as responding staff

- In another incident, officers observed two inmates punching a third inmate in the torso and face. Staff observed the victim lying on the track, motionless, not defending himself, with his arms out to his side. Officers ordered all the inmates to stop fighting and get down on the ground, but the orders were ineffective. An officer, fearing great bodily injury for the victim due to a large amount of blood on the victim's face and the victim's inability to defend himself, struck the aggressors with his baton to stop the attack. The officer documented exceptionally well the aggressors' attack and the victim's inability to protect himself. The officer's report also included with great detail the re-assessment between each baton strike, the inmates' actions, the force used, and the inmates' reaction to each application of force (Exhibits 3a and 3b, next page).

Exhibit 3a

in front of [redacted] and [redacted] two inmates later identified by their state identification cards as [redacted] and [redacted] punching a third inmate in the upper torso and facial area that was laying on the ground with negative results. I immediately gave loud verbal orders for all inmates to stop fighting and get down on the ground with negative results. I drew my state issued monadnock expandable baton (M.E.B) with an [redacted] to the [redacted] position and once again or all inmate to stop fighting and get down with negative results, both inmates [redacted] and [redacted] continued striking inmate who was still lying motionless on his back not defending himself. Due to the [redacted] ent th [redacted] rious bodily injury if both inmates continued striking inmate [redacted] in his upper torso/facial area with a fist, I delivered a power forward strike aiming for inmate [redacted] left shoulder [redacted] striking m [redacted] tended target with the po [redacted] safety tip portion of my M.E.B with negative results. [redacted] s continued striking inmate [redacted] with a fist while inmate [redacted] laid motionless on the track. I recovered to an open to the sky carry position and reassess [redacted] again ordered both inmates to stop fighting and get down with negative results both inmates continued striking inmate [redacted] in the [redacted] torso facial area. Due to the continued imminent threat of serious bodily injury if both inmates continued striking inmate [redacted] with a fist in the upper torso/facial area, I delivered a second power forward

Exhibit 3b

strike aiming at inmate [redacted] right upper arm area striking [redacted] y intended target with the power safety tip portion of my M.E.B with negative results. Both inmates continued to punch inmate [redacted] who was still lying on his back not defending himself. I recovered to an open to the sky carry position and reassess [redacted] once [redacted] n ordered all inmate to stop fighting and prone out with negative results. Both inmates continued punching inmate [redacted] who was now bleeding profusely from his facial area. Due to the continued threat of serious bodily injury if both inmates continued to punch inmate [redacted] in his upper torso and facial area. I delivered a third power forward strike aiming for inmate [redacted] right thigh area, st [redacted] intended target with the power safety tip portion of my M.E.B with negative results. Both inmates continued to punch inmate [redacted] who was not defending himself. I recovered to an open to the sky carry position and reassess [redacted] I once again ordered a [redacted] ate to stop fighting and prone out with negative results. Both inmates continued punching inmate [redacted] who was still bleeding profusely from his facial area. I delivered a fourth power forward strike aiming for inmate [redacted] right [redacted] area striking my intended target with the power safety tip portion of my M.E.B with positive results. I recovered [redacted] pen to the sky carry [redacted] on and reassessed. Both inmates assumed a prone position. [redacted] diately advis [redacted] central control via institutional radio that [redacted] was requesting the medical emergency response vehicle. [redacted] in front of [redacted] Due to my focus on the incident, I was u [redacted] to observe any other use of force being used by

*Some staff who used force did not articulate approved criteria when applying a spit hood or mask.*

We identified 67 incidents in which staff who used force applied a spit hood or mask. In 11 of those (16 percent), staff who used force failed to articulate policy-specified criteria to justify the use of the spit hood or mask. The inappropriate use of a spit hood or mask can suggest punitive motives on the part of staff as well as put inmates at risk of respiratory distress. Despite the risks, the OIG acknowledges that, when used appropriately, these hoods and masks are effective tools to provide needed protection to staff when the criteria are met.

Departmental policy directs staff on acceptable criteria when considering the use of a spit hood, stating, in part, that a spit hood or mask shall not be placed on an inmate for whom any of the following applies:

- Is in a state of altered consciousness;
- Displays visible signs of seizure; or
- Is vomiting or exhibiting signs of beginning to vomit.<sup>38</sup>

38. DOM, Section 51020.16.

Departmental policy allows staff to apply a spit hood or mask if there is verbal or physical intent by the inmate to contaminate others with spit or other bodily fluids from the nose or mouth; if the inmate is not able to control expelling fluid from the nose or mouth; or if the inmate is on authorized security precautions.<sup>39</sup> The following is an example that demonstrates staff's unauthorized use of a spit hood or mask, contributing to a *poor* rating for this indicator in this incident:

- Officers questioned an inmate who was refusing to go into his assigned cell. The inmate was adamant about having a cell to himself and threatened to hurt another cellmate if he were placed in the same cell. Officers gave the inmate an order to submit to restraints, which was ineffective, and the inmate walked into the sally port with clenched fists. Officers attempted to give the inmate additional orders to come out of the sally port and submit to restraints; these orders were also ineffective. A control booth officer heard the inmate arguing with the officer and ordered the inmate to “prone out” on the floor. The inmate partially complied, getting down on the ground, but stayed on his elbows. Officers grabbed the inmate’s arm to place him in restraints, and the inmate attempted to pull away, resulting in additional physical force to place the inmate’s arms in restraints and maintain control until responding staff arrived. The sergeant arrived and ordered the inmate to be placed in leg restraints. The inmate refused, stating, “You aint [sic] putting those restraints on me bitch.” The inmate continued to resist and required multiple staff to use force to secure him in restraints. The sergeant ordered a spit hood be placed on the inmate as a “precautionary measure” due to the inmate’s failure to comply with orders and continued resistance. The use of the spit hood did not meet the criteria for placement. All internal levels of review failed to identify the inappropriate use of the spit hood. The OIG raised the issue during the institution’s review committee, and the hiring authority agreed to provide training to address the deficiency.

*In nearly all incidents, staff who used force submitted reports within required time frames.*

Timely submission of reports is not only required by policy, but is critical to ensure appropriate review of every use-of-force incident.<sup>40</sup> Of the 2,296 incidents we monitored, the OIG identified 28 incidents in which staff who used force failed to submit their report prior to being relieved from duty (one percent).

---

39. Ibid.

40. DOM, Section 51020.17.1.



*Following a use-of-force incident, some staff who used force failed to complete their reports independently and free of any collaboration, copying the wording of other staff.*

Of the 2,296 incidents we monitored, we identified 12 instances in which staff who used force cloned one another's reports (one percent). Despite the low percentage, even one such incident is too many. It is imperative that officers write their reports from a standpoint of their own individual recollection, not that of others. We acknowledge that similar actions or events will occur when completing reports of the same incident. However, although these can be similar in nature, they would never be almost identical to those of their counterparts. The following is an example demonstrating staff's poor performance and intent to collaborate, resulting in a *poor* rating for Indicator 6 in this incident:

- An officer heard a commotion and observed two inmates punching each other in the face and torso. The officer gave orders for the inmates to stop fighting and get down, requiring two officers to use pepper spray to quell the incident. The officers' reports were very similar and contained exactly the same words in exactly the same order (Exhibits 4a and 4b, below).

Exhibit 4a

NARRATIVE: On [REDACTED], at approximately [REDACTED], while conducting my duties as [REDACTED], I responded to an alarm on [REDACTED]; more specifically while passing out [REDACTED], I was on the [REDACTED] and heard commotion coming from the [REDACTED]. I rushed up to the stairs and observed inmate [REDACTED] and inmate [REDACTED], who were both later positively identified by their state issued CDCR identification cards, striking each other in the facial area and upper torso area. I ordered both inmates, several times, to "Get down!" to which they did not comply with my orders. The imminent threat I perceived prior to utilizing force was that if I did not intervene, inmate [REDACTED] and inmate [REDACTED] were going to continue to batter each other and it would ultimately result in serious bodily injury (SBI). In order to stop the imminent threat of SBI I un-holstered my state issued MK-9 OC pepper spray and deployed a one(1), two(2) second burst, from approximately 8 feet, aiming towards both inmates' facial area. The pepper spray had the desired affect as it struck both inmates in the facial area and both inmates got down into the prone position. I handcuffed inmate [REDACTED] and performed a clothed body search with negative results for contraband. I relinquished custody of inmate [REDACTED] to an unknown code one responder to be escorted out of the unit and decontaminated with copious amounts of cool running water. This concludes my involvement in this matter.

Exhibit 4b

NARRATIVE: On [REDACTED], at approximately [REDACTED], while passing out [REDACTED], I was on the [REDACTED] and heard commotion coming from the [REDACTED]. I rushed down the stairs and observed inmate [REDACTED] and inmate [REDACTED], who were both later positively identified by their state issued CDCR identification cards, striking each other in the facial area and upper torso area. I ordered both inmates, several times, to "Get down!" to which they did not comply with my orders. The imminent threat I perceived prior to utilizing force was that if I did not intervene, inmate [REDACTED] and inmate [REDACTED] were going to continue to batter each other and it would ultimately result in serious bodily injury (SBI). In order to stop the imminent threat of SBI, I un-holstered my state issued MK-9 OC pepper spray and deployed a one (1), two (2) second burst, from approximately 7 feet, aiming towards both inmates' facial area. The pepper spray had the desired affect as it struck both inmates in the facial area and both inmates got down into the prone position. I activated my Personal Alarm Device, and transmitted a radio call via institutional radio, "[REDACTED], this is [REDACTED], I have a one on one fight on the [REDACTED], I'm requesting code one response." When code one response entered the unit, both inmates were handcuffed and escorted out of the unit to be decontaminated with copious amounts of cool running water. I could not positively identify the two escorting officers who escorted both inmates out of the unit. The tier was decontaminated with water, cleaning supplies, and fresh air. This concludes my report

Indicator Rating  
**Satisfactory**

**Superior**

129 incidents

6 percent

**Satisfactory**

2,007 incidents

87 percent

**Poor**

160 incidents

7 percent

### Indicator 7. The Department's Compliance With Policies and Procedures Specific to Nonusers-of-Force Reporting Requirements Was Satisfactory

Indicator 7 measures how well *staff who did not use force* documented their observations and actions following a use of force; this includes, among other considerations, assessing staff's description of precipitating events, of inmates' actions, of the use of spit hoods, and of the force *observed* throughout the incident, as well as evaluating the independence and promptness of the documentation. This indicator also assesses how well medical staff met controlled use-of-force reporting requirements.

Among incidents we monitored during this review period, we found the department's compliance with its policies and procedures specific to nonusers of force reporting requirements was *satisfactory*. The OIG assessed the department's performance as *superior* in 129 incidents, *satisfactory* in 2,007, and *poor* in 160 incidents.

In addition to the reporting requirements previously outlined in Indicator 6, departmental policy provides specific reporting requirements for controlled uses of force, including a description of any involvement of licensed mental health practitioners prior to or during the use of force incident, whether de-escalation strategies were attempted, and the outcomes of any strategies.<sup>41</sup>

*Following use-of-force incidents, some staff who observed force failed to satisfactorily document their actions or observations.*

As detailed in Indicator 6, staff must identify important information in the content of the reports. Among the 2,129 incidents the OIG monitored this period, we identified 97 in which observers of force failed to satisfactorily document their observations or actions (5 percent); 167 incidents were excluded from this total because there were no observers of force in those incidents. In the following example, staff who observed force failed to satisfactorily articulate their observations on the incident report form, resulting in a *poor* rating for Indicator 7 in this incident.

- An officer who observed force failed to articulate how an inmate was forced to the ground. Officers had ordered a group of inmates to line up against the fence and to submit to a clothed body search. All but one of the inmates complied and placed their hands on the fence, but the other inmate refused to open his hands and kept his fists clenched. An officer attempted to place the inmate in restraints when he observed a blue object in the inmate's hand. The inmate aggressively pulled his hands away from the officer and spun to his right. The officer

41. DOM, Section 51020.17.

maintained control of the restraints, which were attached to the inmate's left wrist, and pulled them behind his back. The officer placed his right hand in the middle of the inmate's back and used his right foot to sweep the inmate's legs to the left while pushing the inmate, forcing the inmate to the ground. The inmate swallowed what was in his hand and continued to resist while on the ground until responding staff arrived and secured his right hand in restraints. The officer who observed this incident failed to satisfactorily report how the inmate was forced to the ground, writing only that "the officer attempted to guide the inmate to the ground." The OIG noted the officer's lack of detail during the institution's review committee meeting and recommended obtaining clarification on how the officer "attempted to guide the inmate to the ground." The hiring authority disagreed and declined to take any action.

Staff complied with policy and training in 2,032 of the 2,129 incidents (95 percent) when articulating their involvement throughout the incident and describing the force observed. We identified a few examples in which staff performed exceptionally well in articulating the force they observed, contributing to a *superior* rating for Indicator 7 in these incidents.

- In one incident, observers of force did an exceptional job of reporting their observations of force and detailing the victim's and aggressors' actions throughout the incident. Officers observed two inmates punching a third on the head and face. The victim was bent forward at the waist while holding up his hands to shield his face from the continued punches. An officer responded and deployed chemical agents to stop the attack.
- In another incident, nonusers and observers of force wrote detailed reports about the force observed, the inmate's actions, and investigative staff's response following the force. Officers observed two inmates striking a third in the upper torso area and face using inmate-manufactured weapons. An officer described in detail that the attackers used weapons in their right hands, gripping them with their thumbs upward and the sharpened part down, and that the inmates used an overhand stabbing motion to strike the victim. An officer fired one less-lethal round at the fighting inmates, stopping the attack. Investigative staff arrived, secured the crime scene, and recovered multiple pieces of evidence, including two inmate-manufactured weapons. The inmate sustained multiple life-threatening stab wounds to his chest and back and was subsequently airlifted to an outside hospital for a higher level of care.

*Following a use-of-force incident, some staff who did not use force failed to complete their reports independently and free of any collaboration, instead copying the wording of other staff.*

Of the 2,233 applicable incidents we monitored, we identified 22 instances in which nonusers of force plagiarized the reports of others (one percent). As previously noted in Indicator 6, even one such incident is unacceptable. The following is an example illustrating staff's plagiarism, resulting in a *poor* rating for Indicator 7 in this incident:

- Officers observed an inmate cutting his wrist with a razor blade. An officer activated the alarm, and responding officers ordered the inmate to stop and drop the razor. The inmate refused and continued cutting his wrist, resulting in one of the officers using pepper spray to prevent the inmate from causing serious or great bodily injury to himself. The force was effective as the inmate stopped his actions and dropped the razor. The reports completed by both the officer who used the pepper spray and the officer who observed the force were nearly identical in many areas (Exhibits 5a and 5b, next page). The word *negative* was misspelled as *neagative* in both reports. All levels of review failed to identify the collaboration. The OIG raised the issue during the institution's review committee meeting, and the hiring authority provided a counseling memorandum to both officers to address the collaboration.

Exhibit 5a

NARRATIVE: On [REDACTED] at approximately [REDACTED], while performing my duties as [REDACTED] security patrol officer 1, Officer [REDACTED], [REDACTED] and I observed a couple inmates coming off the patio area informing us there was an inmate acting bizzare. We immediatley resposned to the patio. I observed inmate [REDACTED] actively cutting himself on the left wrist Officer [REDACTED] gave Inmate [REDACTED] a loud verbal command to stop cutting and prone out, [REDACTED] refused and said" NO". Officer [REDACTED] advised Central Control via institutional radio that we have a code 1 cuttter in [REDACTED] as Officer [REDACTED] activated Personal Alarm Device (PAD) . [REDACTED] continued to actively cut his upper left inside arm. Officer [REDACTED] gave [REDACTED] another loud verbal command to stop cutting himself, [REDACTED] refused, this is when officer [REDACTED] pulled state issued O.C pepper spray from [REDACTED] holster and gave [REDACTED] a third loud verbal command to put the razor down and prone out, with negative results from inmate [REDACTED] . In order to stop the imminent threat of [REDACTED] actively cutting himself, to gain compliance with a lawful order, and effect custody, officer [REDACTED] sprayed a 1-2 second burst of OC to the facial region of [REDACTED], approximately 6 feet away hitting intended target. Inmate [REDACTED] dropped the razor blade and proned out. Officer [REDACTED] placed [REDACTED] in handcuffs while OFFICER [REDACTED] and I provided coverage. Officer [REDACTED] Performed a search of inmate [REDACTED] for weapons and contraband with neagative results. Officer [REDACTED] instructed [REDACTED] to roll

Exhibit 5b

NARRATIVE: On [REDACTED], at approximately [REDACTED], while performing my duties as [REDACTED] Officer [REDACTED], [REDACTED] and I observed a couple inmates coming off the patio area informing us there was an inmate acting bizzare. We immediatley resposned to the patio. I observed inmate [REDACTED] actively cutting himself on the left wrist I immediatley gave Inmate [REDACTED] a loud verbal command to stop cutting and prone out [REDACTED] refused and said, " NO". I advised Central Control that I had a code 1 cuttter in [REDACTED] as Officer [REDACTED] activated Personal Alarm Device (PAD) . [REDACTED] continued to actively cut on his upper left arm. I gave [REDACTED] another loud verbal command to stop cutting himself, [REDACTED] refused. At this point I pulled my state issued MK9 Oleresin Capsicum (OC) pepper spray from my holster and gave [REDACTED] a third loud verbal command to put the razor down and prone out, with negative results from inmate [REDACTED] . In order to stop the imminet threat of [REDACTED] actively cutting himself, to gain compliance with a lawful order and effect custody I dispersed (1); 2-3 second burst of OC from approximately 6-7 feet away to [REDACTED] facial area hitting my intended target. Inmate [REDACTED] dropped the razor blade and proned out. I placed [REDACTED] in handcuffs while OFFICER [REDACTED] and OFFICER [REDACTED] provided coverage. I Preformed a search of inmate [REDACTED] for weapons and contraband with neagative results. I instructed [REDACTED] to roll over on his right side and instructed him to bring his knees up to his chest. I placed

*In most incidents, staff who did not use force submitted reports within required time frames.*

Of the 2,167 applicable incidents we monitored, we identified 69 incidents in which officers who observed force failed to submit their reports prior to leaving the institution after their shift (3 percent).

*Some staff did not articulate approved criteria when applying a spit hood or mask.*

We identified 41 incidents in which nonusers of force applied a spit hood or mask to an inmate. In four of those 41 incidents (10 percent), staff failed to describe the required criteria, leading us to question whether the placement of the spit hood was justified.

*In some instances, medical staff failed to satisfactorily document their involvement during controlled uses of force.*

Our assessment of medical staff's *actions* during a controlled use of force were discussed earlier in Indicator 2. We identified 35 incidents in which medical staff had the opportunity to document their involvement during a controlled use of force. Of the 35 incidents, we identified 11 in which staff failed to satisfactorily document required elements (31 percent). For the purpose of this indicator, we assessed the quality of medical staff's written articulation of their involvement during controlled uses of force, specific to three requirements:

- Health care staff who provided intervention failed to articulate the required elements (four incidents);
- Licensed nursing staff failed to articulate on the incident report their review of the inmate's health record regarding increased risk for adverse outcomes (eight incidents);
- A licensed mental health care practitioner failed to articulate on the incident report if the inmate had the ability to understand orders, had difficulty complying with orders based on mental health issues or was at an increased risk of a mental health crisis (six incidents).

### Indicator 8. The Performance of Staff When Conducting Video-Recorded Interviews Following Allegations of Unnecessary or Excessive Force Was *Poor*

Indicator 8 measures how well staff followed policies and procedures when conducting video-recorded interviews of inmates alleging unnecessary or excessive force; these requirements include interviewing the inmate on camera within 48 hours of the use of force, capturing the inmate’s injuries on camera, and stopping the interview to get medical attention and documentation for the inmate if the inmate identifies new injuries during the interview.

Among incidents we monitored during this review period, we found the performance of staff when conducting video-recorded interviews following allegations of unnecessary or excessive force was *poor*. Of the 235 incidents applicable to this indicator, the OIG rated 148 *satisfactory*, and 87 *poor*; we assigned no *superior* ratings.

Departmental policy requires staff to video-record an interview with an inmate who alleges unnecessary or excessive force; policy also identifies specific requirements of those conducting the recording.<sup>42</sup> Staff must interview the inmate as soon as possible, but no later than 48 hours<sup>43</sup> from the discovery of the allegation. The policy further requires staff to record any visible or alleged injuries and mandates that the interviews be conducted by supervisors, such as sergeants or lieutenants, who did not themselves use or observe the force during the incident. Finally, staff must not inhibit or discourage the inmate from providing relevant information. The interview worksheet (CDCR Form 3013-2, Inmate Interview for Allegation Worksheet, Figure 13, next page) used by the interviewer includes additional requirements, including conducting the interview in a location free of outside influence, noise, and distractions.

The policy requirements ensure that allegations of staff misconduct are promptly addressed, thoroughly documented, and handled in an unbiased manner. For instance, the requirement to video-record the inmate within 48 hours ensures that potential visual evidence of the inmate’s alleged injuries is captured. Promptly and properly documenting evidence may support an inmate’s claim of unnecessary or excessive force, but a lack of visible injuries may *refute* an inmate’s allegation against staff. For example, an inmate’s allegation that officers repeatedly punched him in the face loses credibility if there are no visible injuries. If staff do not video-record the inmate within the required time frames and complete proper documentation, the department is more vulnerable to allegations

Indicator Rating  
**Poor**

**Superior**  
No incidents  
Zero percent

**Satisfactory**  
148 incidents  
63 percent

**Poor**  
87 incidents  
37 percent

42. DOM, Section 51020.17.3.

43. The Division of Juvenile Justice requires a video-recorded interview and photographs of the ward within 24 hours of the discovery of the allegation.

of a cover-up. Requirements that uninvolved supervisors conduct the interview in a confidential setting lessen the potential for bias and promote an opportunity for the inmate to openly speak about the allegation.

**Figure 13. Inmate Interview for Allegation Worksheet (CDCR Form 3013-2)**

STATE OF CALIFORNIA INMATE INTERVIEW FOR ALLEGATION WORKSHEET CDCR 3013-2 (Rev. 10/15)		DEPARTMENT OF CORRECTIONS AND REHABILITATION Page 1 of 1	
<b>Inmate Interview for Allegation Worksheet</b>			
Per DOM 51020.17.3, a Custody Supervisor shall conduct a video recorded interview with the inmate when either of the following conditions exists:			
1) The inmate has sustained Great Bodily Injury or Serious Bodily Injury that could have been caused by a staff use of force.			
2) The inmate has made an allegation of unnecessary or excessive use of force.			
The interview shall be conducted no later than 48 hours from discovery of the injury or allegation.			
<b><u>INTERVIEW FORMAT FOR ALLEGATION OF UNNECESSARY OR EXCESSIVE FORCE:</u></b>			
The interview and video recording shall be conducted by a Custody Supervisor who did not use or observe the force used and was not involved in the incident. If the incident is a DA referral, you should provide/remind the inmate of a Miranda Admonishment prior to the interview. The location of the interview shall be conducted in a location free of outside influence, noise and distractions. The Custody Supervisor shall not interfere with the inmate's ability to be interviewed. It is the responsibility of the Custody Supervisor to prepare and submit a report (CDCR 3014) to the Manager. This report shall address all reports reviewed and information gathered in relationship to the interview subject. Further, it is the responsibility of the Custody Supervisor to summarize the interview statements and the results of the fact-finding. The CDCR 3014 shall include a conclusion and make a recommendation to the Manager as to further actions to be taken.			
Prior to commencing the interview, the Custody Supervisor shall ensure that a CDCR 7219 has been completed. During the interview, 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. If there are injuries in view that are not noted on the CDCR 7219, cease the video recording and have the inmate evaluated by medical again and obtain an updated CDCR 7219. Restart the videotaped interview with the new CDCR 7219 and review all the injuries.			
At the onset of the recording, the Custody Supervisor will:			
<i>(Complete the items below)</i>			
1. Introduce themselves and the camera operator.			
<b>Interviewer:</b>		<b>Camera Operator:</b>	
2. Give the date and time the interview commenced: <b>Date:</b>		<b>Time:</b>	
3. Indicate to the inmate the reason for the video recorded interview:			
<b>Reason:</b>			
4. Ask inmate to give their full name and CDCR number: <b>Name:</b>		<b>CDCR#:</b>	
The following questions will then be asked:			
<i>(Complete the items below)</i>			
1. On this <b>date:</b> at approximately <b>hours:</b> You were involved in an incident which occurred at the following <b>location:</b>			
2. This incident has been assigned CDCR Incident Log number:			
3. According to the documentation provided on the CDCR 7219, you sustained an injury that lead to this interview. Please describe the injury: :			
4. Do you have any other injuries?			
5. In your own words, explain what happened and how you received your injuries. You need to be as <i>specific</i> as possible:			
6. Can you identify staff witnesses?			
7. Can you identify inmate witnesses?			
8. Have you filed an appeal on this issue? (Ask only if time has passed to allow the inmate to do so):			
Custody Supervisor's Name (Printed Name and Signature)		Title	Date

Source: The California Department of Corrections and Rehabilitation.



Table 4 below lists specific policy requirements for the Division of Adult Institutions; next to each policy requirement is the percentage of incidents we found in which staff did not follow that policy requirement. Of the 228 required video-recorded interviews, we found at least one instance of noncompliance in 85 incidents (37 percent).

**Table 4. Inmate Allegation Video-Recorded Interview Compliance Rates**

Division of Adult Institutions	Compliance rate
Staff conducted the video-recorded interview within time requirements	79%
Interview conducted by staff uninvolved in the incident	92%
Reasonable attempt to capture visible and alleged injuries on video	83%
Interviewer stopped the video for a new medical evaluation if new injuries identified	35%
Interviewer did not inhibit the inmate from providing relevant information	99%
Interview conducted free of distractions	94%
Interview conducted in a confidential setting	93%

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

The department achieved high compliance rates in the areas that may lead to potential bias if policies are not followed, including uninvolved supervisors conducting the interviews (92 percent); not inhibiting the inmate from providing relevant information (99 percent); conducting the interview free of distractions (94 percent); and conducting the interview in a confidential setting (93 percent). However, considering the requirements to ensure prompt and adequate documentation of the allegation and injuries, improvement is needed. Staff complied with the video-recorded interview time requirements in only 79 percent of the incidents and captured all visible and alleged injuries on video in only 83 percent of the incidents. Finally, staff stopped the video for a new medical evaluation following the identification of new injuries in only 35 percent of the applicable incidents.

Not all incidents in which we identified a deviation resulted in a *poor* rating. However, in incidents involving multiple violations or egregious violations of the video-recorded interview policy, we assigned a *poor* rating, as illustrated in the following examples:

- In one incident, officers reported that an inmate threw a cup of urine and feces at the officers. An officer reported pepper-spraying the inmate when the inmate attempted to retrieve additional matter from the toilet. The inmate got on the ground, but resisted three officers' efforts to place him in handcuffs, resulting in the officers using physical force to control the inmate and place him in handcuffs. On the day of the incident, the medical evaluation form included the inmate's statement, "They assaulted me." Despite the inmate's clear allegation of excessive force, staff failed to video-record an interview until 11 days after the incident. During the interview, the inmate alleged that an officer stood on his leg restraints and jumped on them. He further alleged that another officer repeatedly punched him in the head. While there was other evidence in this incident to refute the inmate's allegation of excessive force, had the video-recorded interview been the only source, it would have been too late to have been useful.
- In another example, an inmate attacked an officer by punching him in the face and choking him unconscious. Other officers reported using pepper spray, physical force, and batons to stop the inmate's attack. The inmate alleged that an officer pepper-sprayed him for no reason and that he sustained injuries from other officers who struck him in the head and chest with batons. The inmate further alleged that officers began to hit him prior to placing him in a holding cell. The inmate claimed to have a "busted mouth," an alleged injury that staff made no attempt to capture on camera. In addition, staff interviewed the inmate in a hallway in the presence of unknown staff. Finally, just as the camera turned off, the video captured the inmate asking, "Can I just . . .," which led the OIG to question whether the inmate had additional relevant information to provide that the department failed to address.

### Indicator 9. The Department's Compliance With Policies and Procedures When Staff Conducted Inquiries Into Serious or Great Bodily Injury That Could Have Been Caused by Staff's Use of Force Was Poor

Indicator 9 measures 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*; this includes assessing how promptly staff notifies the OIG and evaluating how well staff follow video-recording requirements, such as interviewing the inmate on video within 24 hours of the incident and making a reasonable attempt to capture injuries on the video recording.

Among incidents we monitored during this review period, we found the department's compliance with its policies and procedures when staff conducted inquiries into serious or great bodily injury that could have been caused by staff's use of force was *poor*. Of the 59 incidents applicable to this indicator, the OIG rated 24 *satisfactory* and 35 *poor*. We assigned no *superior* ratings.

After an incident in which an inmate sustains serious or great bodily injury that may have been caused by staff's use of force, departmental policy requires that the department notify the OIG as soon as possible, but no later than one hour from the time the serious or great bodily injury is discovered.<sup>44</sup> Second, policy requires that a supervisor who did not use or observe force during the incident conduct a video-recorded interview with the inmate no later than 48 hours from the discovery of the injury. The specific policy requirements for the video-recorded interview are the same as those required for an interview following an allegation of unnecessary or excessive force that we discussed in Indicator 8, including video-recording any visible or alleged injuries and not inhibiting the inmate from providing relevant information. In addition, the policy requires that "a video-recorded interview of an inmate shall be conducted in accordance with the Inmate Interview for GBI [Great Bodily Injury] and SBI [Serious Bodily Injury] Worksheet."<sup>45</sup> This worksheet (CDCR Form 3013-1, Figure 14, page 74) is a guide for supervisors assigned to conduct interviews and includes specific references to additional procedures, including ensuring that the medical staff have evaluated the inmate prior to the interview and conducting the interview in a location free of outside influence, noise, and distractions. The interview worksheet also includes the requirement that a custody supervisor prepare and submit a report (Report of Findings, Inmate Interview, CDCR Form 3014, Figure 15, page 75), which must address "all reports reviewed and information gathered in relationship to the interview subject. Further, it is the responsibility of the Custody Supervisor to summarize the interview statements and the results of the fact-finding. The CDCR 3014 shall include a conclusion and make a recommendation to the Manager as to further actions to be taken."

44. DOM, Section 51020.18.2.

45. DOM, Section 51020.17.3.

Indicator Rating  
**Poor**

**Superior**

No incidents

Zero percent

**Satisfactory**

24 incidents

41 percent

**Poor**

35 incidents

59 percent

Figure 14. Inmate Interview (CDCR Form 3013)

STATE OF CALIFORNIA <b>INMATE INTERVIEW FOR GBI AND SBI WORKSHEET</b> CDCR 3013-1 (Rev. 10/15)	DEPARTMENT OF CORRECTIONS AND REHABILITATION  Page 1 of 1	
<b>Inmate Interview for GBI and SBI Worksheet</b>		
<p>Per DOM 51020.17.3, a Custody Supervisor shall conduct a video recorded interview with the inmate when either of the following conditions exists:</p> <ol style="list-style-type: none"> <li>1) The inmate has sustained Great Bodily Injury or Serious Bodily Injury that could have been caused by a staff use of force.</li> <li>2) The inmate has made an allegation of unnecessary or excessive use of force.</li> </ol> <p>The interview shall be conducted no later than 48 hours from discovery of the injury or allegation.</p>		
<b><u>INTERVIEW FORMAT FOR GBI AND SBI:</u></b>		
<p>The interview and video recording shall be conducted by a Custody Supervisor who did not use or observe the force used and was not involved in the incident. If the incident is a DA referral, you should provide/remind the inmate of a Miranda Admonishment prior to the interview. The location of the interview shall be conducted in a location free of outside influence, noise and distractions. The Custody Supervisor shall not interfere with the inmate's ability to be interviewed. It is the responsibility of the Custody Supervisor to prepare and submit a report (CDCR 3014) to the Manager. This report shall address all reports reviewed and information gathered in relationship to the interview subject. Further, it is the responsibility of the Custody Supervisor to summarize the interview statements and the results of the fact-finding. The CDCR 3014 shall include a conclusion and make a recommendation to the Manager as to further actions to be taken.</p>		
<p>Prior to commencing the interview, the Custody Supervisor shall ensure that a CDCR 7219 has been completed. During the interview, 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. If there are injuries in view that are not noted on the CDCR 7219, cease the video recording and have the inmate evaluated by medical again and obtain an updated CDCR 7219. Restart the videotaped interview with the new CDCR 7219 and review all the injuries.</p>		
At the onset of the recording, the Custody Supervisor will:		
<i>(Complete the items below)</i>		
1. Introduce themselves and the camera operator. <b>Interviewer: ___ Camera Operator: ___</b>		
2. Give the date and time the interview commenced: <b>Date: ___ Time: ___</b>		
3. Indicate to the inmate the reason for the video recorded interview: <b>Reason: ___</b>		
4. Ask inmate to give their full name and CDCR number: <b>Name: ___ CDCR#: ___</b>		
The following questions will then be asked:		
<i>(Complete the items below)</i>		
1. On this date: You were involved in an incident which occurred at the following location:		
2. This incident has been assigned CDCR Incident Log number:		
3. According to the documentation provided on the CDCR 7219, you sustained an injury that lead to this interview. Please describe the injury:		
4. In your own words, explain what happened and how you received your injuries. You need to be as <i>specific</i> as possible:		
5. Can you identify staff witnesses?		
6. Can you identify inmate witnesses?		
Custody Supervisor's Name (Printed Name and Signature)	Title	Date

Source: The California Department of Corrections and Rehabilitation.

Figure 15. Report of Findings – Inmate Interview (CDCR Form 3014)

INCIDENT SITE/LOCATION		INCIDENT / APPEAL / FF LOG #	
DESCRIPTION OF THE INCIDENT		INCIDENT DATE	
NAME AND TITLE OF INTERVIEWER		NAME AND TITLE OF CAMERA OPERATOR	
INMATE NAME AND CDCR#	DATE OF INTERVIEW	NAME AND TITLE OF TRANSLATOR (IF UTILIZED)	

The Report of Findings shall be conducted by custodial supervisors (sergeants or lieutenants) who did not use, or observe the force used, in the incident.

INMATE INTERVIEW			Yes	No	N/A
1.	Did the inmate refuse to participate in the interview? If so, please provide the name and title of staff who asked the inmate to participate. <b>Name:</b> _____ <b>Title:</b> _____		<input type="checkbox"/>	<input type="checkbox"/>	
2.	What is the reason for the interview? <input type="checkbox"/> Serious Bodily Injury <input type="checkbox"/> Great Bodily Injury <input type="checkbox"/> Allegation				
a. If there was an allegation, describe the allegation: <b>Description:</b> _____					
3.	Summarize the statements made by the inmate during the interview: <b>Summary:</b> _____				

INMATE WITNESSES INTERVIEWED			Yes	No	N/A
1.	Did the inmate being interviewed request inmate witnesses. If yes, fill in the information below: <b>Inmate Name:</b> _____ <b>CDCR#:</b> _____ <b>Housing:</b> _____ <b>Date Interviewed:</b> _____ <b>Inmate Name:</b> _____ <b>CDCR#:</b> _____ <b>Housing:</b> _____ <b>Date Interviewed:</b> _____ <b>Inmate Name:</b> _____ <b>CDCR#:</b> _____ <b>Housing:</b> _____ <b>Date Interviewed:</b> _____ <b>Inmate Name:</b> _____ <b>CDCR#:</b> _____ <b>Housing:</b> _____ <b>Date Interviewed:</b> _____		<input type="checkbox"/>	<input type="checkbox"/>	
2.	Did any inmates refuse to participate in the interview? If so, please provide the name and title of staff who asked the inmate to participate: <b>Staff Name:</b> _____ <b>Title:</b> _____ <b>Inmate Refused:</b> _____ <b>Staff Name:</b> _____ <b>Title:</b> _____ <b>Inmate Refused:</b> _____ <b>Staff Name:</b> _____ <b>Title:</b> _____ <b>Inmate Refused:</b> _____ <b>Staff Name:</b> _____ <b>Title:</b> _____ <b>Inmate Refused:</b> _____		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.	Summarize the statements made by the witnesses during the interview: <b>Summary:</b> _____				

Source: The California Department of Corrections and Rehabilitation.

Table 5 below displays the specific policy requirements with the percentage of incidents in each category in which we determined staff followed policy and procedures.

**Table 5. Serious Bodily Injury Video-Recorded Interview Compliance Rates**

OIG Notification Requirement	If serious or great bodily injury occurred, did the institution timely notify the OIG?	55%
Video-Recording Requirements	Did staff conduct a video recorded interview within 48 hours?	72%
	Did staff ensure a 7219 was completed prior to the interview?	94%
	Did the interviewed or camera operator introduce themselves?	96%
	Did an uninvolved supervisor conduct the interview?	90%
	Did the interviewer make a reasonable attempt to capture injuries?	62%
	Did staff stop the video and have a new 7219 completed?	21%
	Did staff openly conduct the interview, not to inhibit the inmate?	96%
	If inmate refused, was the refusal captured on video?	100%
	Did staff conduct the video in a confidential setting?	96%
	Did staff conduct the video free of distractions and outside noise?	92%
Inquiry Requirements	Was the inquiry assigned to an uninvolved supervisor or manager?	92%
	Were all pertinent staff and inmate interviews attempted?	90%
	Did staff conduct a thorough inquiry into the cause of the SBI?	83%
	Did staff adequately review all documents and recordings?	94%
	Did staff adequately determine the outcome, including referral to OIA?	77%

Notes: **7219** refers to the department's Medical Report of Injury or Unusual Occurrence form (No. 7219; see page 45, this report). **SBI** refers to serious bodily injury. **OIA** refers to the Office of Internal Affairs.

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

As was the case in Indicator 8, the department's deficiencies were primarily in the areas intended to ensure prompt and adequate documentation of the inmate's injuries. Staff met the time requirements for the video-recorded interview in only 72 percent of the incidents and captured the inmate's injuries on video in only 62 percent of the incidents. Finally, staff stopped the video to obtain a new medical evaluation following the identification of additional injuries in only 21 percent of the applicable incidents.

Not all incidents in which we identified a deviation resulted in a *poor* rating. However, in incidents involving multiple violations, or egregious ones, we assigned a *poor* rating, as illustrated in the following examples:

- In one incident, an inmate refused a sergeant's orders to sit on the ground during an emergency on a yard, as required by procedures. The sergeant attempted to place the inmate in handcuffs, but the inmate pulled away from the sergeant's control; the sergeant wrapped his arms around the inmate's torso and forced the inmate to the ground. The sergeant landed on top of the inmate and the inmate's face hit the ground. The sergeant and an officer used physical force while on the ground to overcome the inmate's resistance and apply handcuffs. The inmate sustained a broken tooth and a laceration to his lip that required seven sutures. Staff did not video-record all of the inmate's alleged injuries during the interview and did not stop the video to have the inmate medically evaluated after the inmate alleged additional injuries. In addition, the inmate identified an officer as a witness, but the sergeant conducting the inquiry did not interview the witness or explain why he did not attempt to interview the witness.
- In another incident, an inmate head-butted an officer during an escort, resulting in three officers and a sergeant using physical force to place the inmate on the ground and apply handcuffs. The inmate sustained a broken eye socket and a laceration on his face as a result of the force. Staff did not attempt to video-record an interview with the inmate until 11 days after discovering the serious bodily injury. The inmate refused to participate in the interview, but the sergeant conducting the interview failed to make a reasonable attempt to video-record the inmate's injuries.

Indicator Rating  
**Satisfactory**

**Superior**

No incidents  
Zero percent

**Satisfactory**

1,872 incidents  
81 percent

**Poor**

424 incidents  
18 percent

### Indicator 10. The Department's Compliance With Policies and Procedures at the Institutional Levels of Review Was *Satisfactory*

Indicator 10 measures how well the institution reviewed and evaluated the use of force; this assessment includes evaluating the adequacy of each level of review as well as the decision of the institution's executive review committee.

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 was *satisfactory*. The OIG found the department's performance *satisfactory* in 1,872 incidents (81 percent) and *poor* in 424 incidents (18 percent). We assigned no *superior* ratings.

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 in order to reach a judgment whether the force used was in compliance with policy, procedure and training and follow-up action if necessary."<sup>46</sup> At the culmination of the five levels of review, the executive review committee makes a final determination on each incident.

This multiple-level process of scrutiny is designed to ensure that deviations from policy regarding serious incidents such as uses of force do not go unaddressed. Failures to identify use-of-force policy deviations allow staff who do not follow policy to avoid accountability. Furthermore, deviations that are not uncovered until the committee level represent failures at lower levels of review.

#### *The reviewing supervisors and managers often did not identify deviations from use-of-force policy, procedures, or training.*

We assessed how well the institutions' reviewers at all levels identified and addressed deviations from policy. We found that at each level, reviewers failed to address policy violations that the OIG identified.

In Table 6 on the next page, we identify the number of deficiencies that reviewers at each level did not identify. Of the 2,296 incidents we monitored, we found 799 incidents (35 percent) in which one or more reviewer did not identify a deficiency. In most cases, if the first-level reviewer did not identify the deficiency, reviewers in the subsequent levels of review also missed the issue, resulting in a total of 3,113 instances in which a reviewer did not identify a deficiency. For example, if the first-level reviewer did not identify that staff failed to ensure decontamination of a housing unit following the use of chemical

46. DOM, Section 51020.19.



agents, and the subsequent reviews also did not address the deviation, that represents five instances in which the reviewers missed the opportunity to address the issue.<sup>47</sup>

**Table 6. Policy Violations Not Identified at a Level of Review**

Level of Review	DAI	DJJ	DAPO/OCS	Total
Incident Commander	698	68	6	772
First-Level Manager's Review	631	64	6	701
Second-Level Manager's Review	590	56	5	651
Use-of-Force Coordinator's Review	472	N/A	N/A	472
Institutional Executive Committee Review	463	48	6	517
<b>Total Policy Violations</b>	<b>2,854</b>	<b>236</b>	<b>23</b>	<b>3,113</b>
<b>Total Use-of-Force Incidents Assessed by the OIG</b>	<b>2,125</b>	<b>136</b>	<b>35</b>	<b>2,296</b>

Note: DAI stands for the Division of Adult Institutions; DJJ, the Division of Juvenile Justice, and DAPO/OCS, the Division of Adult Parole Operations/Office of Correctional Safety.

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

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

- In one incident, an officer reported that while escorting an inmate to the institution's medical center for a mental health evaluation, the inmate attempted to pull away from his control, causing the officer to use physical force to place the inmate face-down on the ground. The inmate sustained a minor injury to her arm, but during the medical evaluation following the incident, the inmate reported to a nurse, "I did not resist nobody. [Officer] dropped me." We believed the inmate's statement constituted an allegation of unnecessary force, which should have triggered the video-recorded interview requirements. None of the reviewers at any institutional level of review identified the allegation. In fact, the

47. For the Division of Adult Institutions, the five levels would include a lieutenant, a captain, an associate warden, a use-of-force coordinator, and the review committee.

critique at each level of review includes a standard question about allegations of unnecessary or excessive force, and each reviewer indicated the question was “not applicable,” and each reviewer concluded that staffs’ actions prior to, during, and following the incident were in compliance with policy. During the institution’s review committee meeting, we asserted that the inmate’s statement was an allegation of unnecessary force. The committee disagreed with our opinion and declined to take any action.

- In another example, following a group therapy session, a therapist left the classroom to inform officers that the session had ended. During this time, the inmates were left unsupervised and restrained to their chairs. One inmate freed himself from his restraints, picked up a chair and threw it at another inmate, followed by punching the inmate in the face several times. An officer responded and used pepper spray to stop the inmate’s attack. Following the incident, there were numerous discrepancies in the reports from the officers and the recreational therapist regarding the supervision of the inmates and discrepancies regarding the staff present who may have observed the force. None of the levels of review identified the lack of supervision that contributed to the need to use force and none addressed the lack of clarity—and possible dishonesty—in the reports. During the institution’s review committee, we recommended that the committee refer the matter to the Office of Internal Affairs for investigation. The hiring authority disagreed with our opinion and took no action to address any of the violations or discrepancies.

### Indicator 11. The Department's Compliance With Its Policies and Procedures Regarding Department-Level Executive Review of Use-of-Force Incidents Was *Poor*

Indicator 11 measures how well the department reviewed and evaluated the use of force; this assessment includes evaluating the timeliness and adequacy of review by the department's executive review committee. Among incidents we monitored during this review period, we found the department's compliance with its policies and procedures regarding department-level executive review of use-of-force incidents to be *poor*. Of the 113 incidents applicable to this indicator,<sup>48</sup> the OIG assessed the department's performance as *satisfactory* in 47 incidents and *poor* in 66 incidents; we assigned no *superior* ratings.

The department executive review committees are required to review significant incidents, such as those involving warning shots, serious bodily injury, great bodily injury, or death that could have been caused by staff members' use of force.<sup>49</sup> In addition to this requirement, the department executive review committees may review other use-of-force incidents referred to them from the institutions' or facilities' review committees or requested by the department. Policy requires that at the departmental level, a review occur within 60 days after the institution's review committee completes its review,<sup>50</sup> unless the incident took place at a facility within the Division of Juvenile Justice, in which case there is no policy-mandated time frame. Of the 95 incidents we monitored that the department executive committees reviewed, they identified use-of-force deviations not previously found by the institutions' reviews in 65 incidents (68 percent).

#### *The Department Executive Review Committee failed to review all incidents as required by policy, and those it did review were often untimely.*

Specific to the Division of Adult Institutions, the Department Executive Review Committee reviewed only 55 of the 73 incidents that we determined met the criteria for review (75 percent). To clarify the significance of this poor performance, this means that a quarter of the OIG-monitored use-of-force incidents requiring the highest level of review were not addressed at the departmental executive level.

The Department Executive Review Committee also failed to review the incidents within the required 60-days after the institutions finalized their reviews in 34 of the 55 incidents (62 percent). Failure to promptly review

Indicator Rating  
**Poor**

**Superior**  
No incidents  
Zero percent

**Satisfactory**  
47 incidents  
42 percent

**Poor**  
66 incidents  
58 percent

48. The 113 incidents applicable to this indicator includes 73 incidents within the Division of Adult Institutions that we determined met the criteria for review and 40 incidents within the Division of Juvenile Justice.

49. DOM, Section 51020.19.6.

50. Ibid.

incidents may leave significant policy violations unchecked and delay in imposing necessary corrective action.

*The Division Force Review Committee reviewed all of the required incidents from juvenile justice institutions, but the lack of a time frame in its policy resulted in unreasonable delays.*

Of the 40 incidents we monitored that met the criteria for review by the Division Force Review Committee, the committee reviewed 100 percent of the incidents. The criteria for the Department of Juvenile Justice requires the Division Force Review Committee to review a minimum of 10 percent of serious use-of-force incidents meeting specified criteria, including, self-injurious behaviors, serious injuries sustained by a ward or staff, incidents involving only one ward, use of pepper spray on a ward with a mental health designation, and incidents in which a ward alleges unreasonable force.<sup>51</sup> During this reporting period, the Department of Juvenile Justice clearly identified certain incidents of significance that required review by departmental executives; even so, there is no requirement for the higher-level committees to review these incidents within a certain time frame. The Division Force Review Committee reviewed the incidents an average of 141 days after the facility's review, with some occurring up to 266 days after. As noted above, failure to promptly review incidents delays the department's ability to correct any inappropriate actions.

---

51. Division of Juvenile Justice, Crisis Prevention and Management.

## Recommendations

For the January to December 2019 reporting period, we offer four recommendations to the department.

**Nº 1. The department should revise its current policies pertaining to decontamination of the housing unit to include all indoor areas.**

The current policy is unsatisfactory because it only requires staff to decontaminate an affected cell and housing unit after the use of chemical agents. In our opinion, the spirit of the policy requires decontaminating any indoor area where chemical agents were deployed. We identified many instances in which chemical agents were used indoors but the areas were not decontaminated due to the unsatisfactory policy language. We recommend revising the current policy to include *all indoor areas*, including dining halls, classrooms, and chapels.

**Nº 2. The department should revise its current policies pertaining to involved staff's reporting requirements to ensure the same elements are required for all force options.**

The department's use-of-force policy lacks consistency when requiring staff to articulate specific details of their actions or observations, depending upon the type of force used or observed. For incidents involving some force options, staff must identify important details, including descriptions of the specific force used or observed, whether or not chemical agents were involved, the type of projector, and the distance from targets, among other requirements. However, policy only requires staff to identify the distance if the force was in the form of a projector, eliminating this requirement for all nonprojector force options.

**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, procedure, and training.**

In many instances, reviewers at all levels, from the incident commander to the institution's review committee, failed to identify use-of-force policy deviations. Furthermore, reviewers concurred with the reviewers at the prior level all the way through the multi-level review process, leaving the deviations to be identified by the use-of-force coordinator, a noncustody staff member, or the institution's review committee. These missed deviations led the OIG to question whether the reviewers require more training on their responsibilities in this area, or whether the department fails to hold accountable reviewers who neglect their responsibilities.

This process delays review and closure of incidents and bottlenecks the process at one level, often the use-of-force coordinator or the last institutional level of review, the committee. We recommend that the department track and monitor those levels of review and impose progressive discipline upon those reviewers who frequently fail to complete satisfactory reviews.

**Nº 4. The Department of Juvenile Justice should adopt a policy to ensure eligible incidents are reviewed by the executive review committee within 60 days following the facility's review.**

In almost all of the incidents reviewed by the Division Force Review Committee, the OIG identified a missed opportunity for the executive and final level of review to timely identify use-of-force deviations. The Division Force Review Committee conducted its reviews an average of 141 days after the facility's review. Only one incident was reviewed within 60 days, the standard required by the Division of Adult Institutions, and many were reviewed more than 200 days after closure by the facility. The OIG urges the Department of Juvenile Justice to adopt a policy and practice similar to that of the Division of Adult Institutions to ensure eligible incidents are reviewed at an executive level within 60 days after the facility's review.

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

OFFICE *of the* INSPECTOR GENERAL

*Roy W. Wesley*  
Inspector General

*Bryan B. Beyer*  
Chief Deputy Inspector General

STATE *of* CALIFORNIA  
July 2020

OIG