Roy W. Wesley, *Inspector General*

Bryan B. Beyer, *Chief Deputy Inspector General*

OIG | OFFICE *of the* INSPECTOR GENERAL

Independent Prison Oversight

November 2021

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

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STATE of CALIFORNIA
OIG | OFFICE of the INSPECTOR GENERAL

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

Independent Prison Oversight

Regional Offices
Sacramento
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November 18, 2021

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 fourth annual report, as mandated by California Penal Code sections 6126 (j) and 6133 (b) (1); the present report addresses the California Department of Corrections and Rehabilitation's (the department) use-of-force incidents that occurred between January 1, 2020, and December 31, 2020.

Our monitoring methodology assesses the department's process for reviewing uses of force prior to, during, and following each incident that we monitored. For this reporting period, we monitored 1,131 of the department's 6,823 use-of-force incidents that occurred in 2020, and we concluded that the department's performance was overall *satisfactory*. We assessed the department's performance as *superior* in eight incidents, *satisfactory* in 960 incidents, and *poor* in 163 incidents.

Based on concerns we identified in our monitoring, we provided four recommendations to the department: (1) implement a policy requiring that a diagram or schematic be visible within elevated posts to delineate the maximum range for the use of less-lethal rounds; (2) revise its medical report of injury form to include the time of medical triage, if applicable, in providing documentation of medical evaluations conducted on incarcerated persons involved in use-of-force incidents; (3) coordinate with California Correctional Health Care Services to implement a statewide process that would (a) promptly determine whether an incarcerated person received serious or great bodily injury that could have been caused by staff's use of force, and (b) ensure that a custody supervisor completes a fact-finding investigation prior to an institution executive committee review; and (4) update its current notification policy to include timely notification to the appropriate mission associate director or designee whenever an incarcerated person has suffered serious or great bodily injury that could have been caused by a staff use of force.

Sincerely,

Roy W. Wesley
Inspector General

Gavin Newsom, Governor

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The Inspector General shall monitor the department's process for reviewing uses of force and shall issue reports annually.

— *State of California*
(Penal Code section 6126(j))

Use-of-Force Policy: Definitions of Common Terms	
Reasonable force	The force that an objective, trained, and competent correctional employee, faced with similar facts and circumstances, would consider necessary and reasonable to subdue an attacker, overcome resistance, effect custody, or gain compliance with a lawful order.
Unnecessary force	The use of force when none is required or appropriate.
Excessive force	More force than is objectively reasonable to accomplish a lawful purpose.
Immediate use of force	The force used to respond without delay to a situation or circumstance that constitutes an imminent threat to institution/facility security or the safety of persons.
Imminent threat	Any situation or circumstance that jeopardizes the safety of persons or compromises the security of the institution, requiring immediate action to stop the threat. Some examples include, but are not limited to, an attempt to escape, ongoing physical harm, or active physical resistance.
Controlled use of force	The force used in an institutional or facility setting when an 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* (hereafter: DOM), accessible on the **world wide web**.

Other Terms Used in This Report	
Hiring authority	The secretary of the department, the general counsel, an undersecretary, or any chief deputy secretary, executive officer, chief information officer, assistant secretary, director, deputy director, associate deputy director, associate director, warden, superintendent, health care manager, regional health care administrator, or regional parole administrator.
Custody staff	Sworn peace officers at all levels within an institution or facility.
Noncustody staff	All nonsworn employees, including administrative, medical, and educational staff within an institution or facility.
Contract facilities	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

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

Summary

This is the Office of the Inspector General's fourth 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, 2020, and December 31, 2020.

Our monitoring methodology assesses the department's process for reviewing uses prior to, during, and following each incident that we monitored. Our 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 staff 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 incarcerated person involved in a use-of-force incident; (5) how well staff complied with requirements to supervise an incarcerated person in restraints or a spit hood following a use-of-force incident; (6) how well staff who used force documented their actions in the required report following an incident; (7) how well staff who did not use force documented their actions and observations in the required report following an incident; (8) how well staff conducted video-recorded interviews of incarcerated persons alleging unnecessary or excessive force;[1] (9) how well staff conducted inquiries following an incident in which an incarcerated person sustained serious or great bodily injury that may have been caused by staff's use of force; (10) how well the institutions reviewed and evaluated each incident; and (11) how well the department's executive level committee reviewed required incidents.

Our monitoring of the department's compliance with its use-of-force policies and procedures is limited to the documentation and other evidence the department maintains and makes available to us. Often, use-of-force incidents are not captured on video. In addition, we are not authorized to conduct our own investigations into these incidents. Therefore, our assessments rely on departmental staff's written accounts of the use-of-force incidents and other evidence we are able to obtain from the department after the incident.

For this reporting period, we monitored 1,131 of the department's 6,823 use-of-force incidents and concluded that the department's performance was overall *satisfactory*. We assessed the department's performance as *superior* in eight incidents, *satisfactory* in 960 incidents,

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

and *poor* in 163 incidents. In the eight incidents in which we assessed the department's performance as *superior*, staff performed exceptionally well in multiple areas, such as attempting to de-escalate the situation prior to using force, decontaminating involved incarcerated persons and the exposed area following the use of chemical agents, and describing in the required reports the force used and observed. In the 163 incidents in which we assessed the department's overall performance as *poor*, we identified multiple failures within a single incident, such as not following decontamination protocols after using chemical agents, medical staff not evaluating incarcerated persons as soon as practical following an incident, and the levels of review failing to identify and address policy violations. The incidents in which we assessed the performance as *poor* also included incidents in which we identified a single violation that was particularly egregious, such as officers using unnecessary force or staff failing to recognize and address an incarcerated person's allegation of unreasonable force.

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 4 percent of the incidents we monitored, representing an increase from the approximately 3 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 2.2 percent of the incidents in our prior report, to approximately 3.3 percent of the incidents in this reporting period.

We assessed the department's performance in several areas during the use of force, including staff's compliance with the requirements to deploy force within prescribed training standards. We found that staff performed satisfactorily overall, but noted discrepancies in documenting the distance when deploying less-lethal direct impact rounds. We found that some institutions inconsistently documented the actual distance of deployment. Consequently, we provide a recommendation to the department to post a simple diagram of the exercise yard in each control booth and observation tower in every institution to ensure compliance with training requirements.

The department performed satisfactorily in following its policies and procedures in medically evaluating incarcerated persons who were involved in a use-of-force incident. However, we found in 58 incidents (5 percent of total incidents monitored), nursing staff failed to ensure a timely medical evaluation. While in some of these incidents the incarcerated person was treated immediately (triage), the medical report of injury did not document this initial encounter. Consequently, we provide a recommendation to the department to include the time of medical triage, if applicable.

One area of concern we identified is the department's inconsistent identification, assessment, and fact-finding when a serious or great bodily injury occurred that could have been caused by staff use of force. We found medical assessments were not being requested or conducted to identify whether a serious or great bodily injury was found, or if no or less significant injuries were noted. Consequently, we provide a recommendation to the department to ensure prompt identification and assessment by medical staff of an incarcerated person who may have received a serious or great bodily injury, which may have been caused by staff use of force, and if so, ensure a custody supervisor conducts the required fact-finding review prior to institution executive review.

Finally, the department's policy requires that incidents in which staff use of force causes serious or great bodily injury to an incarcerated person be reviewed at a higher level following the institution's review. We found that department executive review was not performed for 21 percent of the incidents which we felt met these criteria. This is similar to our prior report which found 25 percent of these incidents were not addressed at the departmental executive level. This area needs improvement; therefore, we provide a recommendation for the department to update its policy to also notify the respective mission associate director, or designee, whenever an incarcerated person has suffered serious or great bodily injury that could have been caused by staff use of force.

Use-of-Force Statistics, 2020

The OIG monitored 1,131 of the 6,823 use-of-force incidents that occurred (17 percent).

The OIG attended 514 of the 657 review committee meetings (78 percent).

Approximately 82 percent of the use-of-force incidents we monitored (926 of 1,131) occurred at the adult institutions and contract facilities housing adult incarcerated persons, with the remainder involving juvenile facilities (177), parole regions (18), and the Office of Correctional Safety (10).

Of the 926 incidents we monitored that occurred at the adult institutions and contract facilities, approximately 38 percent occurred at one of the following five State prisons: California State Prison, Sacramento (103); Kern Valley State Prison (64); California State Prison, Los Angeles County (62); Salinas Valley State Prison (61); and California Correctional Institution (60).

The 1,131 incidents we monitored involved 4,161 applications[2] of force. Chemical agents[3] accounted for 1,678 of total applications (40 percent), while physical strength and holds accounted for 1,612 (39 percent). The remaining 21 percent of force applications consisted of options such as less-lethal projectiles, baton strikes, tasers, and the Mini-14 rifle.[4]

2. This refers to the number of times a staff member used a force option in an incident; e.g., two baton strikes in one incident is counted as two applications.

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

4. Percentages may not sum to 100 percent 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[5] (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.[6]

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. However, as mandated by the California Penal Code section 6126 (j), the OIG continues to monitor the department's process for reviewing uses of force. This report includes use-of-force incidents that occurred in 2020, and presents our analysis of how well the department followed its own policies and training.

Use-of-Force Options

An incarcerated person's behavior can be unpredictable, and at times, departmental staff must use force to gain an incarcerated person's compliance to ensure the safety of other incarcerated persons 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 incarcerated person's demeanor, mental health status and medical concerns (if known), and the incarcerated person'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 incarcerated person, the number of staff and incarcerated persons involved, and the incarcerated person's ability to understand.[7] Departmental policy includes a number of force options, which are described in further detail on the following pages.

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

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

7. 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 causes different physiological reactions. Of these three, pepper spray is the most common type of chemical agent used by staff during use-of-force incidents, while CS is only authorized in limited circumstances. The chemical agents provide staff the ability to use force while maintaining distance from the threat, such as a group of fighting incarcerated persons.

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 that departmental staff use, 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 an incarcerated person's 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

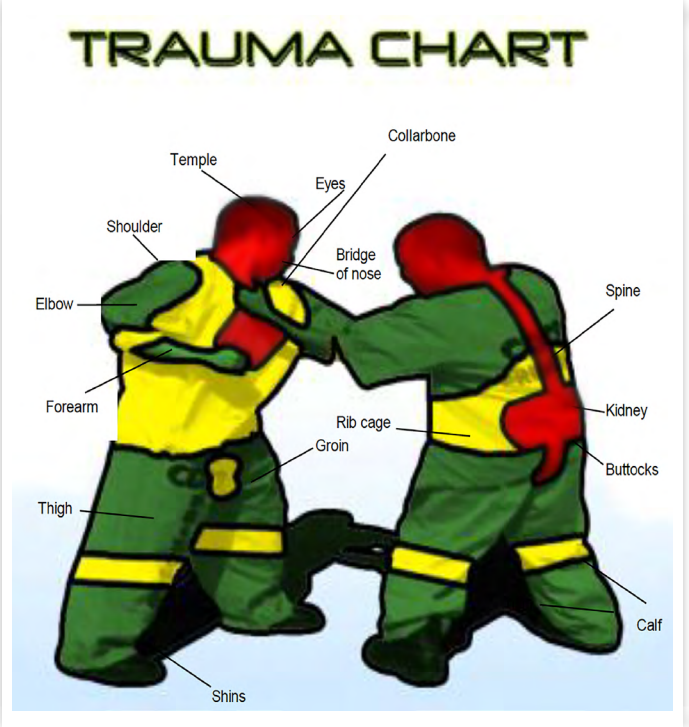
Source: Chemical Agents: Instructor Guide—Version 2.0, Basic Correctional Officer Academy, Office of Training and Professional Development (Sacramento: California Department of Corrections and Rehabilitation, June 2014).

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 incarcerated person contact. The hand-held baton is an impact weapon designed to strike or jab an incarcerated person 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 are 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."[8] Physical strength and holds encompass a wide variety of techniques trained by the department, including:

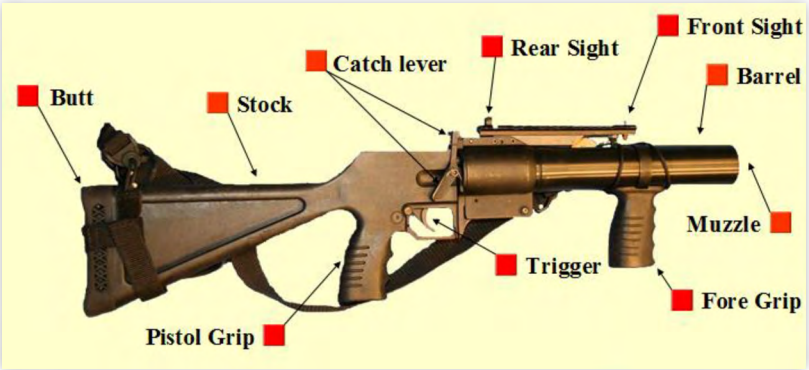
- Control holds, which staff may use to maintain control of a resistive incarcerated person during an escort;
- Takedown techniques, which may be used to force an incarcerated person to the ground; and
- Punches and kicks, which staff may use in self-defense when attacked by an incarcerated person.

8. 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 death."[9]

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.[10]



Source: The California Department of Corrections and Rehabilitation.

- 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.

9. The impact munitions training manual, prepared by the department's Office of Training and Professional Development, Basic Correctional Officer Academy, 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.)

10. 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.[11] When presented with a situation in which deadly force is authorized, an officer may aim and fire a lethal weapon directly at the incarcerated person, or the officer may fire a *warning shot*, which is a lethal round fired in a safe area of the institution, such as the side of a building or an unoccupied area on an exercise yard.

11. DOM, Section 51020.5.

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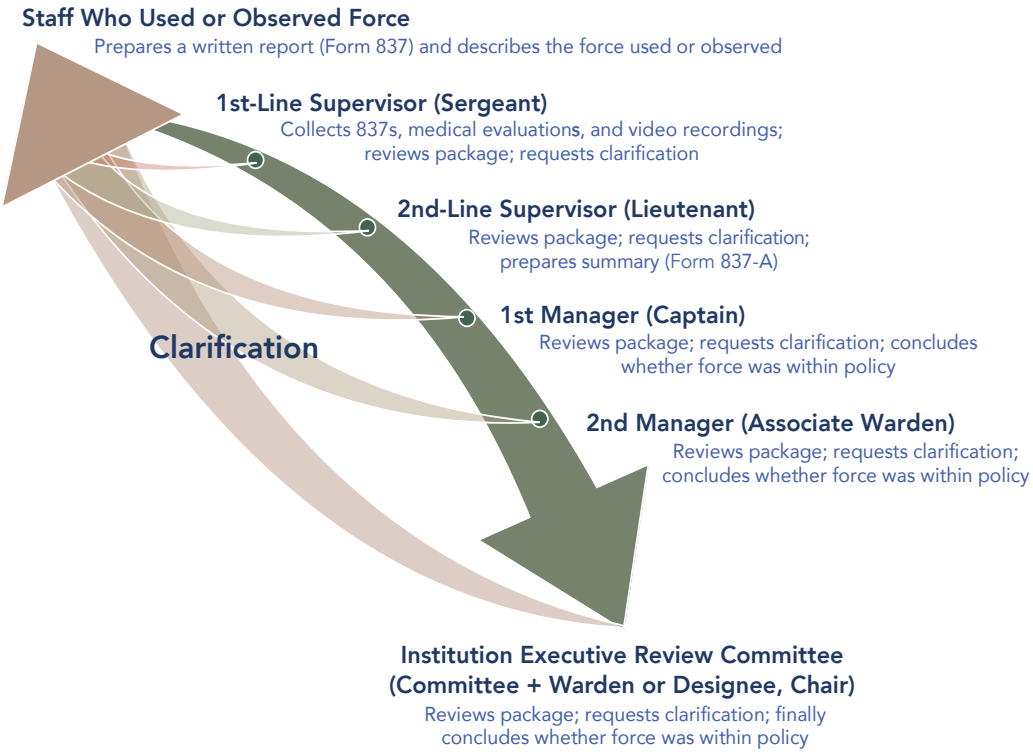
Reporting and Review Requirements

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[12] 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 incarcerated person's (or incarcerated persons') actions and the staff member's (or members') perception of the threat that led to the use of force, a description of the specific force used or observed, and a description of the incarcerated person'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

12. 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 incarcerated persons 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 Center and Camps* (Males), 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.[13] The department's policy allows this committee up to 60 days to complete its review.[14]

Levels of Review: Juvenile Facilities

Force Review Committee: For each of the juvenile facilities,[15] 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.

13. Memorandum, "Revised Department Executive Review Committee Expectations," dated September 20, 2017. At that time, this document was signed by then-Director of the Division of Adult Institutions Kathleen Allison. Ms. Allison has since been promoted and is now Secretary of the department.

14. DOM, Section 51020.19.6.

15. 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)

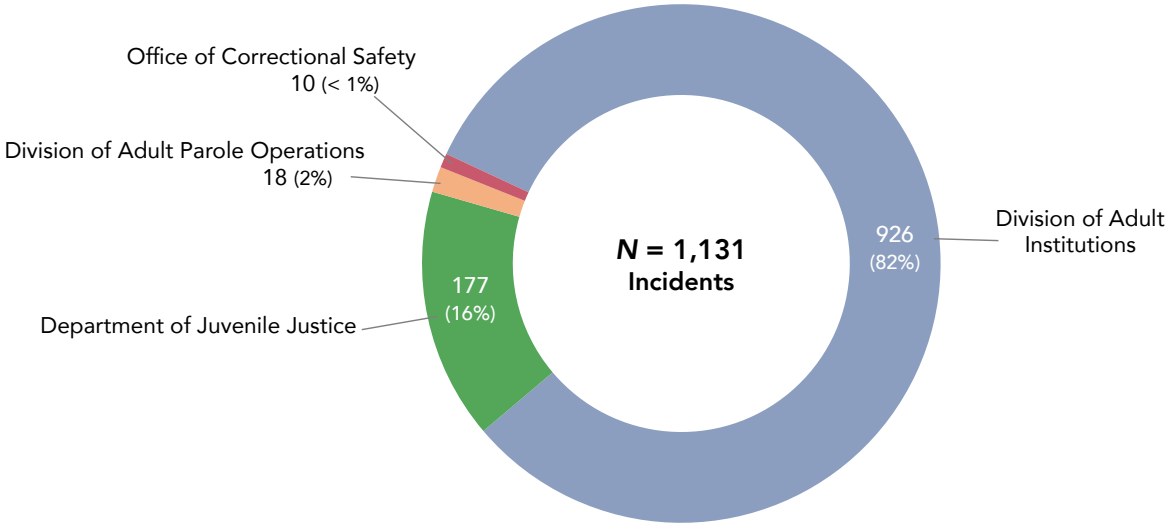
Deadly Force Review Board: The Office of Internal Affairs conducts criminal[16] and administrative investigations into every use of deadly force (except for certain types of warning shots inside an institution) and every death or great bodily injury that could have been caused by a staff use of force, 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 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 1,131 of the 6,823 use-of-force incidents that occurred within the department between January 1, 2020, and December 31, 2020. The majority of the incidents occurred at adult institutions (926), with a smaller share occurring in juvenile facilities (177) and within the communities where offenders were on parole (18) (Figure 4, below). We also reviewed a few incidents of force applied by the department's Office of Correctional Safety (10), which acts as a liaison with other law enforcement entities and apprehends fugitives in the community.

16. 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.

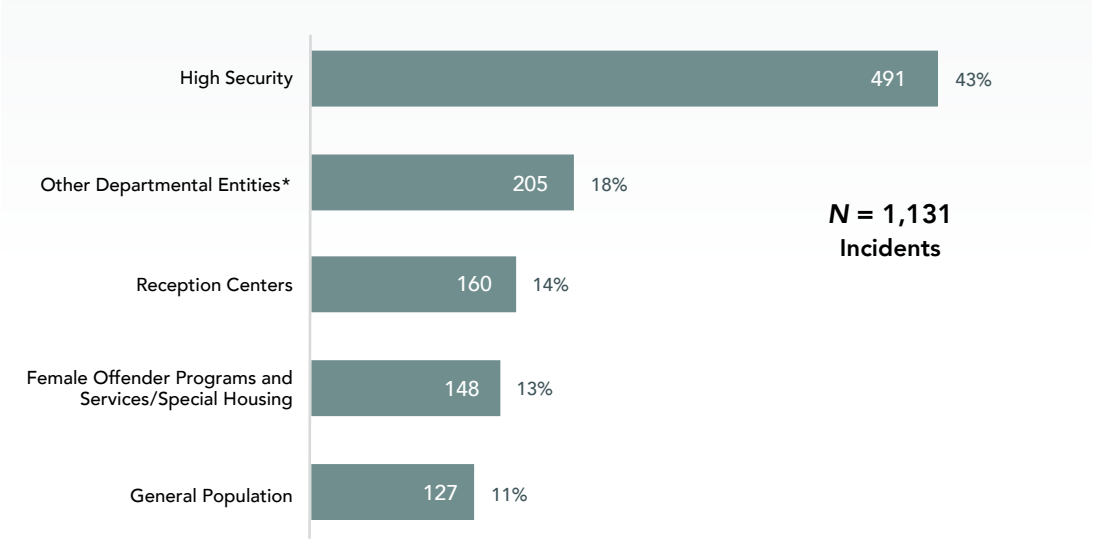
Figure 4. Distribution of the 1,131 Use-of-Force Incidents the OIG Monitored, by Division and Other Entities



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

Among the 926 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 (491), followed by *Reception Center and Camps* (160), *Female Offender Programs and Special Services/Special Housing* (148), and *General Population* (127). The category Other Departmental Entities (205) includes the Division of Juvenile Justice, Division of Adult Parole Operations, and the Office of Correctional Safety (Figure 5, next page).

Figure 5. Use-of-Force Incidents the OIG Monitored, by Mission and Other Entities



* 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

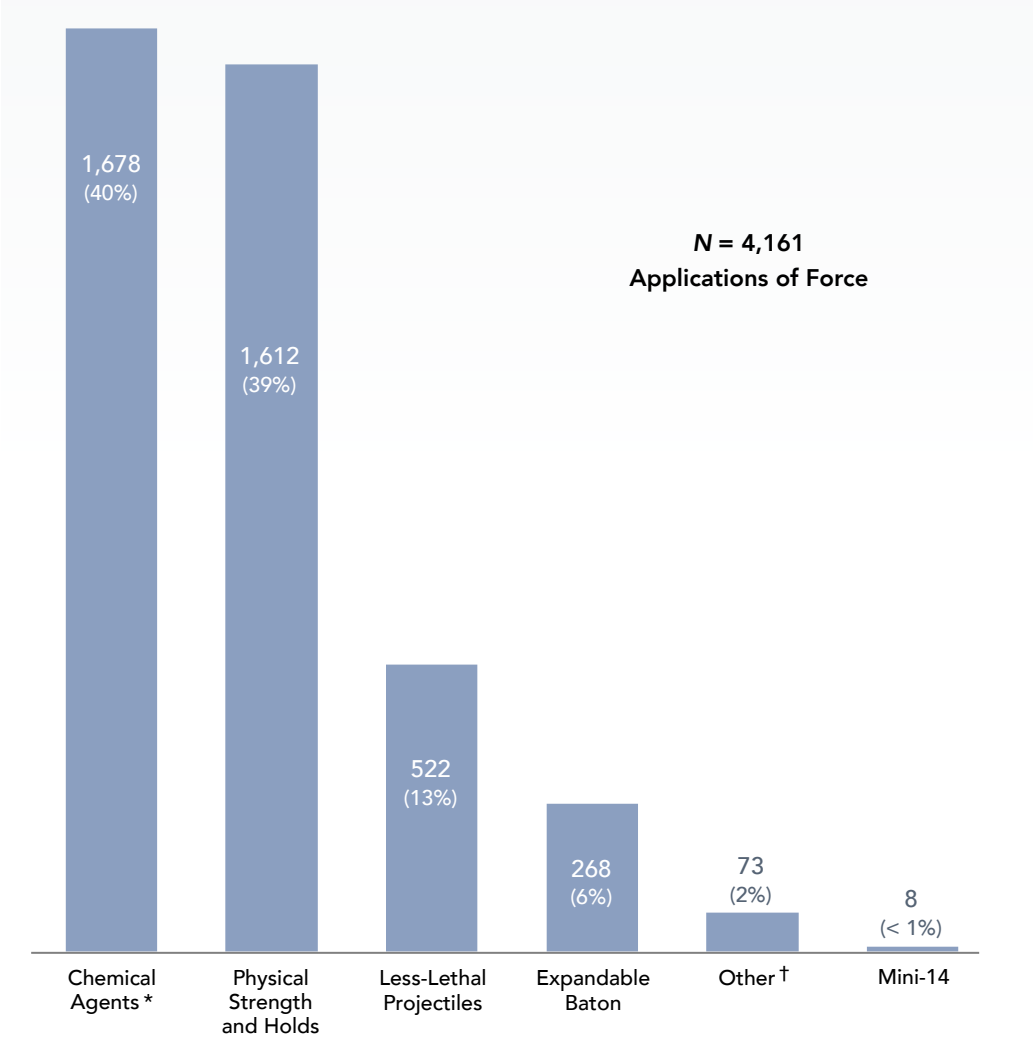
	Number of:			
Departmental Entity	**Use-of-Force Incidents**	**Applications of Force**	**Staff Who Applied Force***	**Incarcerated Persons, Youth, or Parolees to Whom Force Was Applied***
Adult Institutions	901	3,341	2,308	1,795
Contract Beds Unit	25	53	37	39
Juvenile Facilities	177	674	419	497
Parole Regions	18	56	40	18
Office of Correctional Safety	10	37	24	10
Totals	**1,131**	**4,161**	**2,828**	**2,359**

* The OIG counted the name of each staff member and incarcerated person 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 1,131 use-of-force incidents that we monitored, staff members used 4,161 applications of force. The most common force option staff members used was chemical agents (1,678), which accounted for 40 percent of the total applications of force, followed by physical strengths and holds (1,612), at 39 percent. Staff members used other force options less frequently, such as less-lethal projectiles (522), batons (268), other forms of force, such as a shield, nonconventional force, tasers, sting ball grenade, and pepper ball launcher (73), and the Mini-14 rifle (8) (Figure 6, below).

Figure 6. Distribution of the Applications of Force in 1,131 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, 2020, and December 31, 2020. 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 1,131 of the 6,823 use-of-force incidents (17 percent) that occurred within the department between January 1, 2020, and December 31, 2020.[17] To reach this number, we randomly selected 769 incidents and used our discretion to select another 362 incidents. We selected incidents based on the nature of the incident (e.g., serious bodily injury to an incarcerated person caused by force, a riot, a reported force incident involving an allegation of unnecessary or excessive force) and the workload of our inspectors. Incarcerated persons alleged unnecessary or excessive force in 167 of the 1,131 incidents (15 percent) that we monitored. Our review of the allegations in these incidents focused on the video-recorded interview requirements following the allegation. We did not assess the adequacy of the department's inquiry into the allegations at the local level or, if applicable, through its new unit, the Allegation Inquiry Management System (AIMS).[18]

Our inspectors visited every adult prison and juvenile facility,[19] as well as the northern and southern parole regions, and attended 657 of the 1,640 institutions' review committee meetings (40 percent) to monitor

17. During 2020, the department provided a total of 6,818 use-of-force incidents for our review. We randomly or judgmentally selected incidents to monitor. However, we judgmentally selected five use-of-force incidents that were not included among the 6,818 prior to our staff attending the respective institution executive review committee meeting.

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

19. 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.

incidents that occurred in 2020.[20] 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 all 70 meetings (100 percent), during which the committees[21] reviewed incidents that occurred in 2020.

Methodology

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

- **Indicator 1** addresses how well staff followed policies and procedures prior to the use of force, including whether staff contributed to the need to use force and used proper de-escalation techniques.

- **Indicator 2** addresses how well staff followed policies and procedures during the use of force, including whether force was reasonable and whether staff followed training 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 incarcerated person and area were properly decontaminated.

- **Indicator 4** addresses how well medical staff evaluated incarcerated persons following the use of force, including the timeliness of the medical evaluation and the adequacy of the documentation.

20. Since departmental policy requires that institution executive review committees review each incident within 30 days from the date of the incident, some of the meetings we attended occurred in January 2021. In addition, we attended department executive committee meetings through March 2021, since policy requires a review to occur at the departmental level within 60 days after the institution executive review committee completes its review.

21. The executive committees include the department executive review committee (DERC) for the Division of Adult Institutions; the division force review committee (DFRC) for the Division of Juvenile Justice; the field executive review committee (FERC) for the Division of Adult Parole Operations; and the Office of Correctional Safety (OCS).

- **Indicator 5** addresses how well staff followed policies and procedures when supervising incarcerated persons following uses of force, including incarcerated persons who required constant or direct supervision while in restraints or in a spit hood.

- **Indicator 6** addresses how well staff who used force documented their actions following the use of force, including circumstances leading up to the force, articulation of the perceived threat, and the force used.

- **Indicator 7** addresses how well staff who did not use force documented their actions following the use of force, including circumstances leading 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 incarcerated persons alleging unnecessary or excessive force, but does not address the adequacy of the allegation inquiry.

- **Indicator 9** addresses how well staff followed policies and procedures when conducting inquiries into serious or great bodily injury that could have been caused by staff's use of force, including timeliness of the notification to the OIG and video-recording requirements.

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

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

Our monitoring of the department's compliance with its use-of-force policies and procedures is limited to the documentation and other evidence the department maintains and makes available to us. Often, use-of-force incidents are not captured on video. In addition, we are not authorized to conduct our own investigations into these incidents. Therefore, our assessments rely on departmental staff's written accounts of the use-of-force incidents and other evidence we are able to obtain from the department after the incident.

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*.[22] 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 incarcerated persons. On the other hand, we may assign a *superior* rating when, in our opinion, the department performed exceptionally well in multiple or critical areas.

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.

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 on the next page.

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

Equation. Scoring Methodology

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

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

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

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Monitoring Results

Although the Department Performed Satisfactorily Overall in Reviewing Use-of-Force Incidents, Staff Continued to Comply With the Department's Use-of-Force Policy at a Low Rate

The Office of the Inspector General (the OIG) reviewed and analyzed 1,131 staff-reported use-of-force incidents that occurred between January 1, 2020, and December 31, 2020.

Overall, the department determined that its staff completely followed policy in only 843 of the 1,131 incidents (75 percent) that we monitored during this period, as depicted in Figure 7 on the following page. In the OIG's opinion, however, staff committed some type of policy violation in 453 incidents in which the department found no violation.

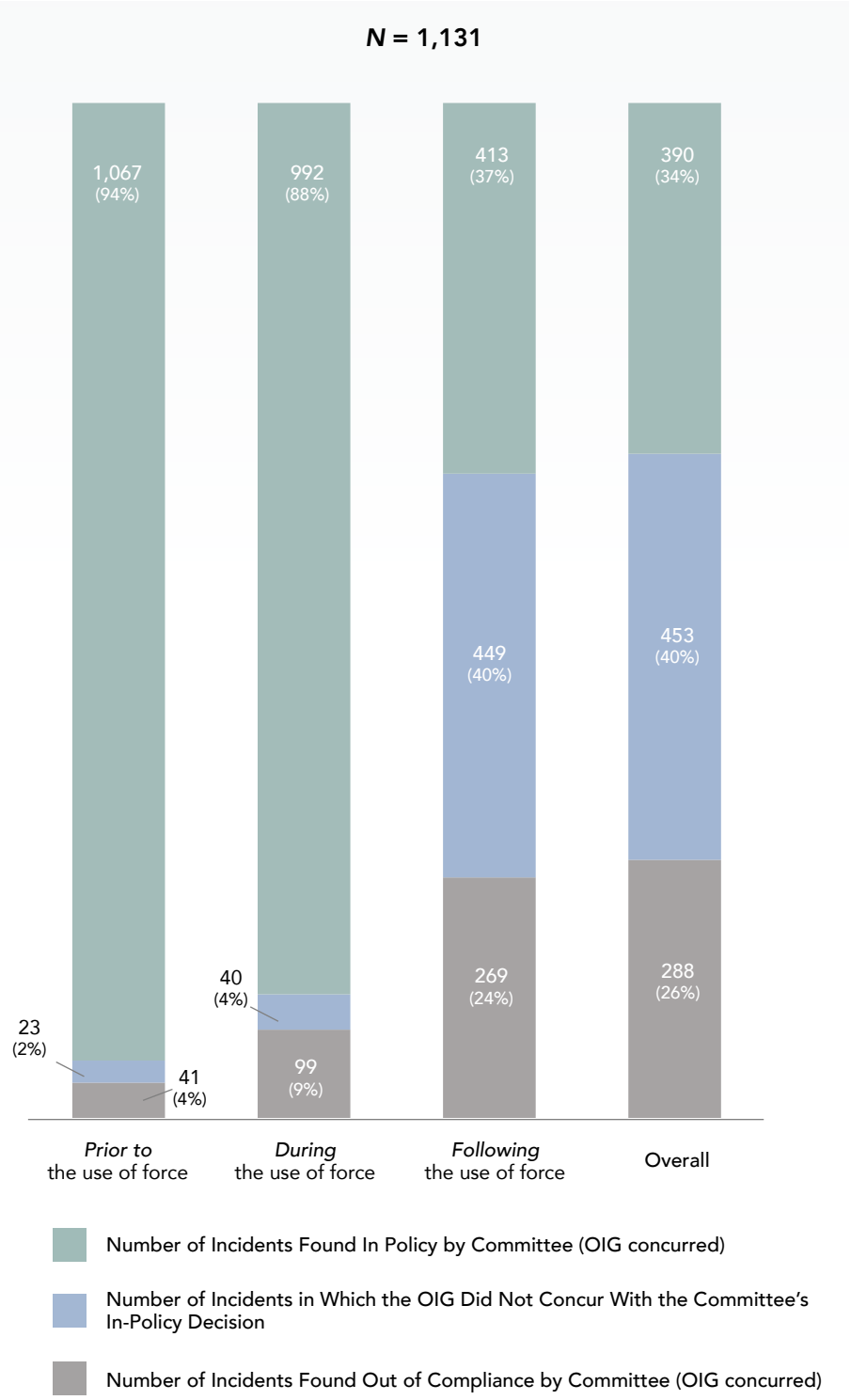
When evaluating force in relation to departmental policy, we evaluate the department's three primary categories: (1) *prior to*, referring to the events leading up to the force; (2) *during*, referring to the actual force; and (3) *following*, referring to the events immediately following the incident 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 1,090 incidents (96 percent). We mostly agreed with the decisions of the department's review committees, but we determined that staff committed some type of policy violation in 23 of the 1,090 incidents for which the department found no violation.

Regarding the policy requirements during the use of force, the department determined that staff followed policy in 1,032 of the incidents (91 percent). Again, the OIG agreed with most of these determinations, but we determined that staff committed some type of policy violation in 40 of the 1,032 incidents for which the department found no violation.

Finally, the department determined that staff complied with policy requirements following the use of force in 862 of the incidents (76 percent). We determined that staff committed some type of policy violation in 449 of the 862 incidents for which the department found no violation.

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

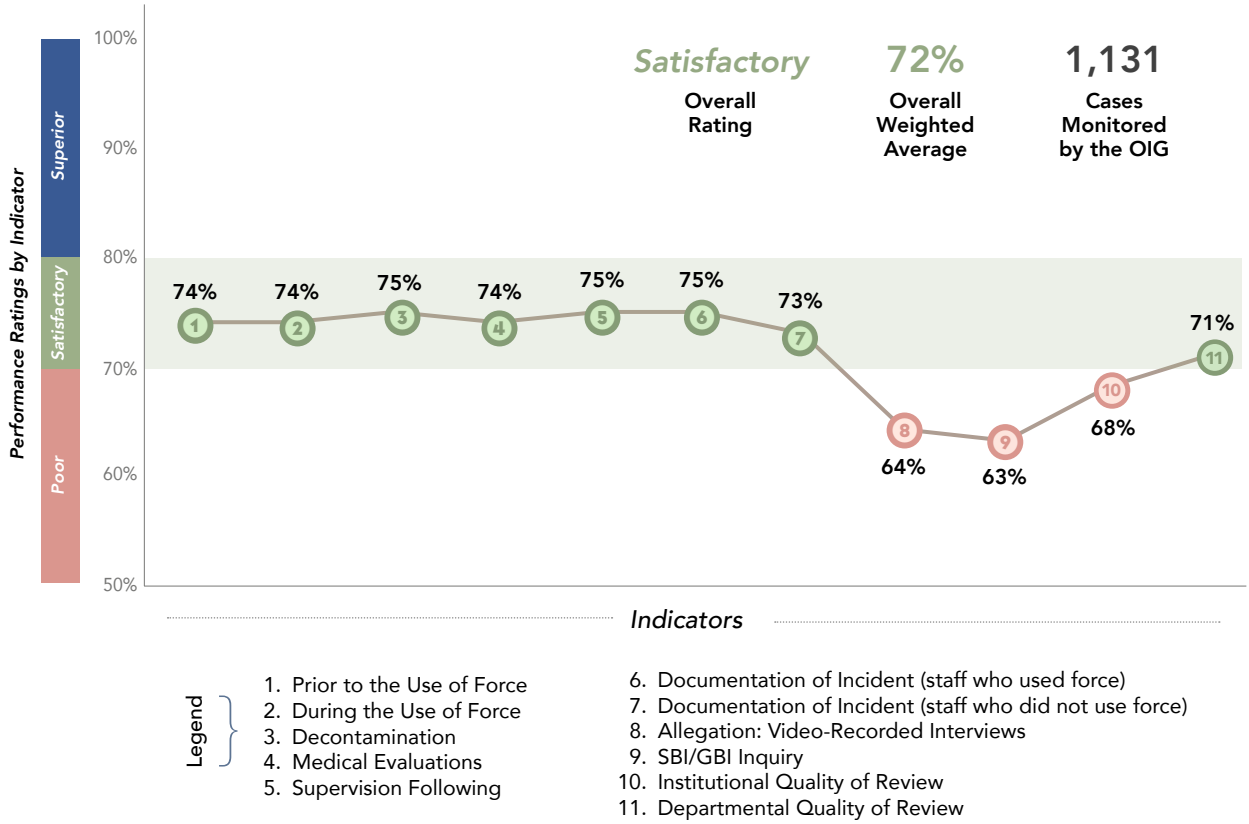


Note: Percentages may not sum to 100 percent due to rounding.
Source: The Office of the Inspector General Tracking and Reporting System.

The Department's Overall Performance in Reviewing 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 eight incidents, *satisfactory* in 960 incidents, and *poor* in 163 incidents. Although we rated the vast majority of the incidents *satisfactory*, 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 conducting use-of-force reviews at the institutions' executive level (Indicator 10).

Figure 8. The OIG's Overall Rating of the Department's Reviewing of Its Use-of-Force Incidents



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

The OIG's overall assessment of how well the department performed *prior to*, *during*, and *following* an incident is based on a cumulative assessment of 11 indicators.[23] 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 in other established procedures,[24] such as the department's training manuals regarding the different force options.

During this reporting period, we assigned an overall rating of ***superior*** to eight incidents. In all eight incidents, we rated three or more individual indicators ***superior***, which produced an overall ***superior*** rating. The following case is an example of staff performing exceptionally well:

- An officer escorted an incarcerated person to his assigned cell. When the cell door opened, the cellmate attacked the incarcerated person under escort. To stop the attack, one officer deployed two less-lethal direct impact rounds, and another officer deployed chemical agents. While the incident itself is a common occurrence, the department performed exceptionally well, in our opinion, in three of the eight applicable indicators: officers and supervisors who provided decontamination thoroughly documented the efforts to decontaminate the incarcerated persons and the affected areas, and the officers who used and observed force provided detailed, well-written reports describing the threat and the force used and observed.

In contrast, we assigned an overall rating of ***poor*** to 163 incidents in which staff performed inadequately in multiple areas, or in which staff performed inadequately in a single critical area, such as the use of unreasonable force. The following cases offer examples of staff performing poorly:

- In one incident, two officers forced an incarcerated person to the ground after the incarcerated person resisted the officers by pulling away during an escort and turning towards the officers. We agreed with the department's determination that the officers' actions prior to and during the incident were in compliance with policy; however, we noted several areas of noncompliance following the incident: officers placed a spit mask on the incarcerated person, but did not articulate the required criteria for placing the mask; one of the officers who used force did not submit a report prior to being relieved from duty; during the video-recorded interview required by the incarcerated person's allegation of unreasonable force, the supervisors conducting the interview did not record all of the incarcerated person's

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

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

alleged injuries and did not request a medical evaluation for newly alleged injuries; staff did not conduct a video-recorded interview pertaining to the incarcerated person's serious bodily injury within the required 48 hours; and finally, the institution's executive review committee did not review the incident until about four months following the incident and did not identify all of the policy concerns. The department's executive review committee identified the deviations and took appropriate action. While the department eventually arrived at the same conclusion we did, we rated the incident *poor* due to multiple violations and the failure by supervisors and managers at the institution to identify and address the deviations.

- In another incident, officers observed an incarcerated person housed alone in a cell engaged in an inappropriate sexual act. The officers ordered the incarcerated person to stop his actions. The incarcerated person refused and replied with multiple expletives towards the officers. The officers opened the cell door and gave further orders for the incarcerated person to stop his actions. The incarcerated person jumped up and attacked the officers by punching them in the head and face with his fists. To subdue the attack, one of the officers sprayed the incarcerated person with pepper spray and struck the incarcerated person on the head with the pepper spray cannister. The other officer reported punching the incarcerated person on the face and head "5–10 times." One of the officers sustained a concussion, and the other officer sustained minor injuries to his face and head. The incarcerated person sustained multiple injuries to his face and head. While we recognize that the incarcerated person's behavior was unacceptable and that the officers were presented with a dangerous threat when the incarcerated person attacked them, it is our opinion that the officers unnecessarily contributed to the need to use force, and to the resulting injuries, by opening the cell door. We asserted that a safer option for the officers and the incarcerated person would have been to contact a supervisor or a mental health representative, but the warden disagreed with our position and took no action.

Indicator Rating
Satisfactory
74% weighted average score

Superior
8 incidents
Less than one percent

Satisfactory
1,054 incidents
93 percent

Poor
69 incidents
6 percent

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 during this period, 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 eight incidents, ***satisfactory*** in 1,054 incidents, and ***poor*** in 69 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 43 of the 1,131 incidents (4 percent) unnecessarily contributed to the need to use force. Due to the seriousness of the conduct, we rated Indicator 1 *poor* in the 43 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 incarcerated persons in danger. While this percentage remains low, it represents an increase from our prior reporting period, in which we identified staff contribution in 3 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 the potentially dangerous situations that result.

The review committees took actions ranging from training to disciplinary action in 31 of the 43 instances, but the committees disagreed with our opinion that staff may have contributed to the need to use force in the remaining 12 incidents, and the committees declined to take action.

The following incident illustrates the seriousness of staff's contribution to the need to use force:

- An officer opened a holding cell door to allow health care staff to conduct an examination of an unrestrained incarcerated person, in violation of the institution's local procedure for maximum custody housing, which requires officers to handcuff an incarcerated person prior to opening the cell door. When the

officer opened the door, the incarcerated person punched the officer in the face and attacked a second officer by punching him several times. Three officers used physical force and expandable batons to gain control of the incarcerated person. Two officers and the incarcerated person sustained minor injuries during the incident. The warden determined that the officer violated the institution's procedure when he opened the cell door without ensuring that the incarcerated person was restrained; the warden referred the matter to the Office of Internal Affairs, which approved the case for direct action. While we agreed with the outcome, the seriousness of the conduct 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 incarcerated person'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."[25]

Of the 1,131 incidents we monitored, we identified 146 in which the involved officers had the opportunity to de-escalate the situation prior to using force. In 14 of those 146 (10 percent), officers did not adequately articulate their attempts.[26] 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.

In the 132 instances in which officers articulated their attempts to de-escalate a situation, we identified eight incidents in which the involved officers performed exceptionally well in the efforts to resolve the situation, resulting in a ***superior*** rating for Indicator 1 for those incidents. The following example illustrates exemplary performance:

- An officer described his interaction with an incarcerated person in a housing unit who was a participant in the department's mental health delivery system. The officer reported that the incarcerated person exited his assigned cell, carrying his mattress, and announced that he was moving into a nearby

25. DOM, Section 51020.5.

26. In the remaining 985 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 such cases, involving, for example, incarcerated persons fighting or an incarcerated person's attack on staff, immediate force is appropriate.

vacant cell. The officer articulated continuous efforts to talk to the incarcerated person by asking him if he was in distress and if he needed to speak to a clinician, explaining the convenience bed-move process, and saying that they "would come to a safe conclusion together, and that everything would be alright." The officer described the incarcerated person's continuous agitated demeanor and defiance and his own efforts to calmly de-escalate the situation. Ultimately, officers needed to use physical force to restrain the incarcerated person, but we recognize the officer's efforts to resolve the situation prior to the need to use force.

Despite the high compliance rate, there was room for improvement. The following is one example from the 14 incidents in which officers were initially presented with a potential threat, but did not adequately attempt to resolve the situation:

- An officer reported that as he approached an incarcerated person under escort by another officer to a housing unit, the incarcerated person turned and stated, "Why the [expletive] are you all so [expletive] close to me?!" The officer reported that he gave the incarcerated person a direct order to face forward during the escort, but the person continued to turn and shout at the officer. After the incarcerated person tried to stop the escort and attempted to turn around, officers used physical force to put the incarcerated person on the ground. During the review process of this incident, the second-level manager noted that a review of the surveillance video showed that "[i]t is clear there is a volatile disagreement going on between [the officer] and [the incarcerated person]. In the video, you can see [the officer] pointing his finger in [the incarcerated person's] face. At this time [the officer] should have let the other two officers finish the escort and he could have trailed." The committee agreed with the second-level manager's assessment, and the warden provided formal counseling to the officer for failing to de-escalate the situation.

In 2017, the department provided training to all custodial and noncustodial staff to improve their communication skills and learn when to apply de-escalation techniques. This training was included in the department's required annual use-of-force training, but due to the novel coronavirus (COVID-19) pandemic restrictions, the department removed the training from the schedule through December 31, 2021. We encourage and look forward to the department's resumption of the de-escalation training to further its objective of accomplishing custodial and correctional functions with minimal reliance on force.[27]

27. DOM, Section 51020.1.

During controlled use-of-force incidents, the department performed well in planning and coordinating with medical and mental health care staff, but deviations from policy related to video-recording requirements remained frequent.

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 advance 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 incarcerated person 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 incarcerated person 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 occurred infrequently (98 percent versus 2 percent, respectively, in the incidents we reviewed this period).

During this reporting period, we monitored 18 controlled use-of-force incidents. We commend the department for complying with policy requirements in nearly all incidents by providing the following: an appropriate "cool-down" period for the incarcerated person; 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 manager's presence on-site during the controlled use of force.

Nevertheless, we identified at least one deviation from policy requirements in 17 of the 18 incidents. The most common deviations were related to video-recording requirements, as follows:

- The video-recording did not display the accurate date and time (five incidents).
- Staff members failed to introduce themselves on camera (five incidents).
- Staff did not follow general video-recording requirements (10 incidents).
- Staff did not display the type of chemical agents on the video-recording and state the times of their applications (four incidents).

Indicator Rating
Satisfactory
74% weighted average score

Superior
No incidents
Zero

Satisfactory
1,067 incidents
94 percent

Poor
64 incidents
6 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 1,067 incidents and *poor* in 64 incidents. No *superior* ratings were assigned to any incidents for this indicator because we only assessed whether the force was reasonable and whether officers complied with specific objective requirements.

In 42 of the 1,131 incidents we monitored during this reporting period (4 percent), officers used unreasonable force. The review committees took action in 19 of the 42 instances, ordering interventions ranging from training to adverse action and referred another five incidents to the Office of Internal Affairs for investigation. We identified an additional 18 incidents in which we believed the officers may have used unreasonable force, but the review committees declined to take any action.

When questioning whether staff used unreasonable force, we looked at whether the force was necessary (whether there was an imminent threat to justify the force) and whether the force was excessive (whether the officers used more force than necessary to control the situation). Each element is presented in more detail below.[28]

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 37 of the 1,131 incidents (3 percent), officers did not adequately articulate an imminent threat, leading us to question whether the force was necessary. This represents an increase since our last report, in which we determined that officers did not justify the force in 2 percent of the incidents. 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

28. In one incident, an officer used force when there was no imminent threat, and then once a threat did exist, an officer used more force than necessary.

increase tension among staff and incarcerated persons, create a culture of mistrust, and expose the department to legal liability. Unnecessary force increases the risk of injury to both staff and the incarcerated person.

Due to the seriousness of the violation in all 37 of these incidents, we rated Indicator 2 *poor.*

- In one incident, officers escorted an incarcerated person in handcuffs and leg restraints to his assigned cell. An officer twice ordered the incarcerated person to kneel down so the leg restraints could be removed, but the person refused. The officer reported that he "utilized immediate physical force to get [the incarcerated person] to gain compliance with a direct order and to overcome [the incarcerated person's] resistive behavior. Specifically, I grabbed the chain in-between the leg restraints and pulling in an upward back motion, making [the incarcerated person] fall to his knees." Neither the lieutenant nor the captain addressed the officer's actions. The associate warden found the officer's actions in compliance with policy, stating that officers were supporting the incarcerated person on either side when the officer pulled the chain, and the incarcerated person went to the ground. During the review committee meeting, the OIG asserted that the officer's actions were inappropriate, given the lack of an imminent threat to justify the force used and the potential for injury. The warden agreed and issued the officer a letter of instruction. Although we agreed with the warden's decision, we determined the officer's unnecessary or excessive force justified the *poor* rating.
- In another incident, officers were searching a dormitory for possible contraband. An officer ordered an incarcerated person to get off his bunk. The incarcerated person complied, then pulled out a cellular telephone and began to hit it on the metal edge of his bed in an attempt to break it. The officer ordered the incarcerated person to submit to handcuffs, but the incarcerated person ignored the order and continued to smash the phone on the metal bed. The officer grabbed the incarcerated person's arm, and the incarcerated person pulled away, reaching for an unknown item on his bunk. The initial officer and four additional officers then used physical force to bring the incarcerated person to the ground and place him in handcuffs. While the officers articulated an imminent threat to justify the force used in the incarcerated person's pulling away and reaching in his bunk for an unknown item, the initial officer's grabbing the incarcerated person's arm appeared to be for the sole purpose of preventing the incarcerated person from destroying the contraband, which was not an authorized reason for the immediate use of force. The levels of review did not identify the initial officer's actions as a policy violation, but we raised the issue during the institution's

review committee meeting. The hiring authority agreed with our opinion and provided training to the officer.

Institutions did not consistently interpret the department's definition of physical force.

Departmental policy states, "Any deliberate physical contact, using any part of the body to overcome conscious resistance, is considered physical force."[29] As noted above, immediate force is authorized when an imminent threat jeopardizes the safety of persons or compromises the security of the institution. The inconsistencies typically arise in incidents in which an incarcerated person refuses an officer's order to submit to handcuffs, but does not necessarily present an imminent threat: when the officer grabs the incarcerated person's arm to apply handcuffs, the incarcerated person actively resists the officer's efforts by pulling away, and the officer uses physical force to gain control of the incarcerated person. There are conflicting opinions as to whether the officer's physical force begins when he initially grabs the incarcerated person's arm or when he uses physical force to gain control after the incarcerated person pulls away.

Considering both the department's requirement of an imminent threat to justify the use of immediate force and the department's definition of physical force, we believe that in the above scenario, the force begins when the officer grabs the incarcerated person's arm (deliberate physical contact) after the incarcerated person's refusal to submit to handcuffs (conscious resistance). The two examples below illustrate the conflicting viewpoints offered by different institutions:

- In one incident, a correctional counselor ordered a disruptive incarcerated person to leave his office. When the incarcerated person refused, the correctional counselor ordered the incarcerated person to submit to handcuffs. The incarcerated person refused the order and walked away, stating that he was going to talk to a supervisor. The correctional counselor reported that the incarcerated person "walked down the hallway stopping at [the correctional counselor supervisor's] office. I stepped behind [the incarcerated person] and gave [him] another order to submit to handcuffs which he refused. At which time I attempted to place [the incarcerated person] in handcuffs grabbing his right wrist with my left hand." The incarcerated person pulled away and advanced toward the counselor with clenched fists. Another correctional counselor used physical force to restrain the incarcerated person. The OIG disagreed with the levels of review, all of which determined that the correctional counselor's actions were within policy. We contended, based on the department's policy and definition, that the correctional

29. DOM, Section 51020.5.

counselor's initial grabbing of the incarcerated person's wrist constituted physical force, for which the counselor did not articulate an imminent threat.

- In another incident,[30] an incarcerated person refused an officer's orders to continue to be escorted in a dayroom and then refused orders to submit to handcuffs. The officer stated, "As I approached her, [she] attempted to walk away from me. [Officers] stopped [the incarcerated person] by blocking her path. [The incarcerated person] stopped and faced me, I then grabbed [the incarcerated person's] right wrist with my left hand in attempt to place her in handcuffs." The incarcerated person pulled away from the officer and struck the officer in the chest, causing the officer and two others to use physical force to restrain the incarcerated person. The first two levels of review found the officer's actions in compliance with policy, but the associate warden disagreed, stating, "Once [the incarcerated person] stated she would not allow [the officer] to place her in handcuffs and demonstrated her unwillingness to comply by walking away and pulling her arm away, there did not appear to be an imminent threat requiring the use of immediate force at that time." The warden initially disagreed with the associate warden, finding that the officer's actions complied with policy. However, we discussed the matter with the warden and asserted that there was no imminent threat to justify the officer's grabbing the incarcerated person. The warden changed his initial position and referred the matter to the Office of Internal Affairs, which opened an investigation.

We recognize that the department has proposed a change to the regulations,[31] which, among other things, would modify the definition of physical force to read, "**Any deliberate physical contact, using any part of the body to overcome active physical resistance, is considered physical force**" [*emphasis added*].[32] Seemingly, the language in the modified regulations would make the actions of the officers justifiable in both examples above because the physical force did not occur until the incarcerated persons actively resisted by pulling away.

While the modified language may provide a clearer definition of physical force, we encourage the department to consider that in incidents such as the examples above, there may be an opportunity for the officers to de-escalate the situation prior to placing hands on the incarcerated person

30. This incident occurred in 2021, so it is not counted for statistical purposes in this report. It is presented as an example here because it illustrates how similar instances were handled differently by the department.

31. From the State of California Office of Administrative Law's **website**: "The California Code of Regulations is the official compilation and publication of the regulations adopted, amended, or repealed by State agencies pursuant to the Administrative Procedure Act. Properly adopted regulations that have been filed with the Secretary of State have the force of law."

32. Notice of Change to Regulations, Number 21-03, published February 26, 2021.

to apply handcuffs, thereby making a safer environment for incarcerated persons and staff.

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

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.

Due to the seriousness of the conduct, we rated all six of these incidents *poor*. One example follows:

- Two officers used physical force and a third officer struck the incarcerated person with a baton to get the incarcerated person to the ground after he punched an officer in the face. A sergeant arrived and reported that the incarcerated person attempted to stand up, and "fearing [he] was going to stand up and continue his attack towards staff and to prevent him from causing any serious bodily injury to staff, I kicked [the incarcerated person's] upper left torso area with my right boot, causing [him] to fall back down to a prone position." The sergeant reported that the incarcerated person continued to resist by attempting to stand up, so he stepped on the incarcerated person's forearm. The warden imposed formal discipline on the sergeant for using unreasonable force. Although we agreed with the warden's decision, we found the sergeant's excessive force justified the *poor* rating.

In a small number of incidents, staff deployed less-lethal weapons beyond the maximum range.

As described in the "Force Options" section of this report, there are specific 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 training specifies minimum limitations set by the manufacturer to lessen the possibility of serious injury or death. If an officer deploys a round beyond the maximum allowed distance, the effectiveness and accuracy is compromised.

In their reports, officers are required to specify the distance from which they fired a less-lethal round. Typically, the reported distance is based only on that officer's best estimate. We identified four incidents in which officers estimated firing the less-lethal weapon at a distance less than the maximum allowed, but the department determined that the

officers fired from a distance well beyond the maximum range.[33] In one case, an officer reported firing the less-lethal weapon from 105 feet, which is the maximum distance, but the department determined that the officer actually fired the round from 210 feet. In that case, the round inadvertently struck an incarcerated person in the head. These discrepancies lead us to wonder whether the officers were not proficient at estimating distances or whether they automatically wrote the maximum distance in their report, knowing that the distance may have been greater. Presuming the former, we recommend that the department place schematics or photographs of the exercise yard in each control booth and observation tower. The schematic or photograph should include premeasured points to indicate to the officers working in those posts the maximum range for each type of round.

33. There is no requirement for the department to confirm the estimate reported by the officer firing the weapon, but it is sometimes done as part of a crime scene schematic. The number of incidents in which the actual distance is greater than the reported distance is likely much higher than the four we identified.

Indicator Rating
Satisfactory
75% weighted average score

Superior
21 incidents
3 percent

Satisfactory
614 incidents
94 percent

Poor
15 incidents
2 percent

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 incarcerated persons the opportunity and means to decontaminate themselves, removed any spit masks during incarcerated persons' decontamination, and ensured that incarcerated persons 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 incarcerated persons and examines how thoroughly staff decontaminated the physical area affected by chemical agents.

Officers used chemical agents in 650 of the 1,131 incidents that we monitored (57 percent). Among the incidents we monitored during this review period, we found the department's compliance with its decontamination policies following the use of chemical agents *satisfactory*. The OIG assessed the department's performance as *superior* in 21 incidents, *satisfactory* in 614 incidents, and *poor* in 15 incidents.

Based solely on our review of staff reports, we determined that if staff met the policy requirements or committed only minor deviations, typically the rating was *satisfactory*. If, in our opinion, staff did an exceptional job of describing in detail their efforts to offer decontamination to the affected incarcerated persons and decontaminate the affected area, we assigned a *superior* rating. Conversely, when the reports lacked information regarding the decontamination efforts, making it impossible to determine whether the requirements had been met, we assigned a *poor* rating.

The following example illustrates staff's inadequate performance in this area:

- Two incarcerated persons fought in the dayroom of a housing unit during the evening medication release. To stop the fight, an officer applied pepper spray to the faces of both incarcerated persons. Officers documented removing the involved incarcerated persons and offering water to relieve the effects of the pepper spray. However, none of the reports documented questioning incarcerated persons in the surrounding area regarding possible exposure, cleaning the affected area, ventilating the housing unit, or offering the involved incarcerated persons fresh clothing, all of which are required by policy.

On the other hand, we identified 21 instances in which staff did an exceptional job in describing the required decontamination steps, earning a ***superior*** rating in this indicator. The following example illustrates exemplary performance:

- Two officers pepper-sprayed an incarcerated person who forced his way into the dormitory's office and advanced toward the officers with his fists clenched. A responding officer articulated that he removed the incarcerated person from the affected area and walked him into fresh air to begin the decontamination process. The officer further articulated that he instructed the incarcerated person to "breathe normally and blow his nose as [he] escorted him to the [facility's] decontamination shower for further decontamination," where he provided "copious amounts of fresh water" in the shower until the incarcerated person said he was done. The sergeant who responded to the dormitory articulated that he questioned the incarcerated persons around the incident regarding possible exposure to the pepper spray, and none had been exposed. He further articulated that all of the incarcerated persons in the dormitory were escorted outside while staff cleaned the area with soapy water and decontaminated the building with running fans.

The department showed improvement from its performance in our prior report in describing the decontamination of the indoor area.

Departmental 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. In our prior report, we noted that the policy does not address other indoor spaces used by incarcerated persons and staff, such as classrooms or medical clinics, and that consequently, those areas were sometimes not decontaminated following the use of chemical agents. The department accepted our recommendation and issued a memorandum to all institutions, advising that the decontamination requirement following the use of chemical agents extends to all indoor areas.

In our prior report, we noted that officers did not properly decontaminate the area in 63 of the 591 applicable incidents (11 percent). In the incidents we monitored for this report, that number decreased to 17 of 298 applicable incidents (6 percent).

Indicator Rating
Satisfactory
74% weighted average score

Superior
31 incidents
3 percent

Satisfactory
1,034 incidents
91 percent

Poor
66 incidents
6 percent

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

Indicator 4 measures how well licensed nursing staff evaluated incarcerated persons following the use of force; this includes assessing how promptly nurses conducted medical evaluations after the use of force and how thoroughly nurses documented 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 incarcerated persons who were involved in a use-of-force incident was *satisfactory*. The OIG assessed the department's performance as *superior* in 31 incidents, *satisfactory* in 1,034 incidents, and *poor* in 66 incidents.

The licensed nursing staff who conduct medical assessments of incarcerated persons involved in use-of-force incidents must document the evaluation using the Medical Report of Injury or Unusual Occurrence form (CDCR Form 7219, Figure 9, next page). Staff's failure to identify and assess incarcerated persons' injuries in a timely manner can delay necessary medical care. In rating 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."[34] Nursing staff is required to complete the medical report form and submit it to the response supervisor prior to leaving the institution.

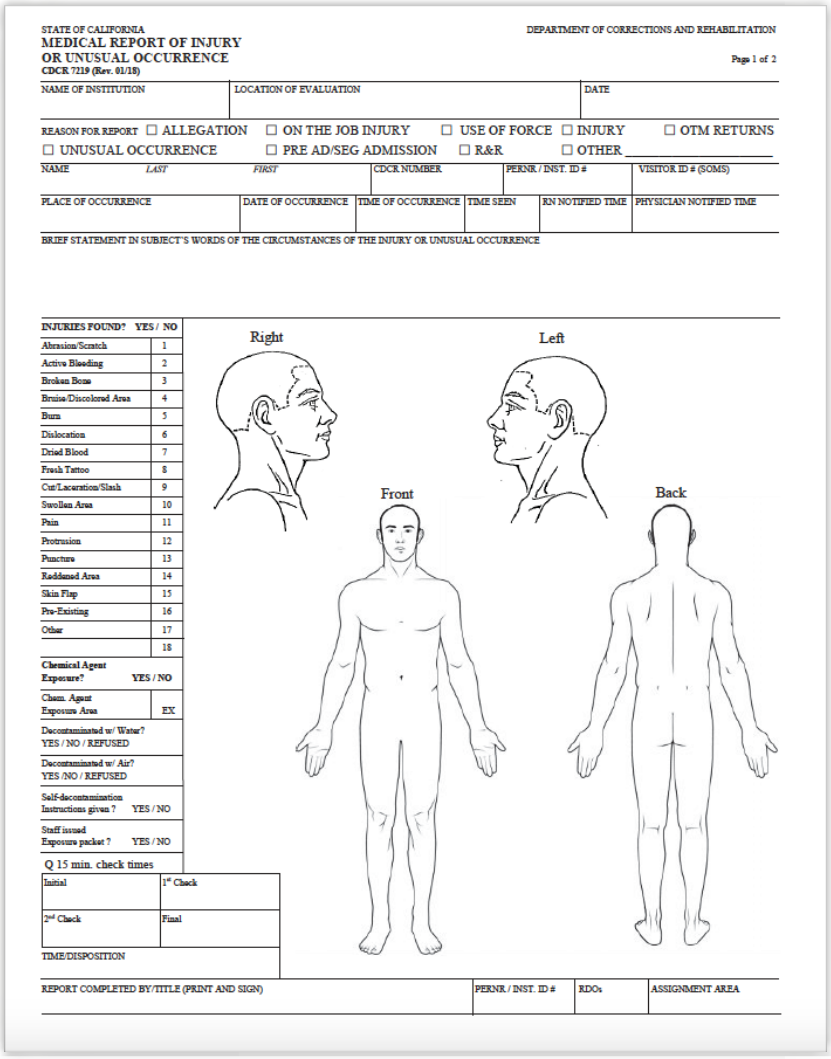
The form must include the following:

- The incarcerated person'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
- A description of injuries sustained and the medical treatment rendered
- Any refusal by the incarcerated person of medical evaluation and/or treatment
- Any alternative assistive devices provided
- Any medical recommendation or accommodation
- In-cell decontamination instructions
- Times of 15-minute checks, if applicable[35]

34. DOM, Section 51020.9.

35. DOM, Section 51020.17.6.

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



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MEDICAL REPORT OF INJURY OR UNUSUAL OCCURRENCE
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NAME OF INSTITUTION | LOCATION OF EVALUATION | DATE

REASON FOR REPORT ☐ ALLEGATION ☐ ON THE JOB INJURY ☐ USE OF FORCE ☐ INJURY ☐ OTM RETURNS
☐ UNUSUAL OCCURRENCE ☐ PRE AD/SEG ADMISSION ☐ R&R ☐ OTHER _____

NAME LAST FIRST | CDCR NUMBER | PERNR / INST. ID # | VISITOR ID # (SOMS)

PLACE OF OCCURRENCE | DATE OF OCCURRENCE | TIME OF OCCURRENCE | TIME SEEN | RN NOTIFIED TIME | PHYSICIAN NOTIFIED TIME

BRIEF STATEMENT IN SUBJECT'S WORDS OF THE CIRCUMSTANCES OF THE INJURY OR UNUSUAL OCCURRENCE

INJURIES FOUND? YES / NO	
Abrasion/Scratch	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
Reddened Area	14
Skin Flap	15
Pre-Existing	16
Other	17
	18
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	

Right Left Front Back

Initial	1st Check
2nd Check	Final
TIME/DISPOSITION	

REPORT COMPLETED BY/TITLE (PRINT AND SIGN) | PERNR / INST. ID # | RDOs | ASSIGNMENT AREA

Source: The California Department of Corrections and Rehabilitation.

Some staff performed exceptionally well in ensuring that incarcerated persons received a timely medical evaluation following a use-of-force incident.

Staff complied with policy and training and ensured incarcerated persons received a timely medical evaluation in 1,073 of the 1,131 incidents (95 percent). The following is an example of staff performing exceptionally well in their efforts to conduct timely medical evaluations of incarcerated persons, resulting in a *superior* rating in Indicator 4.

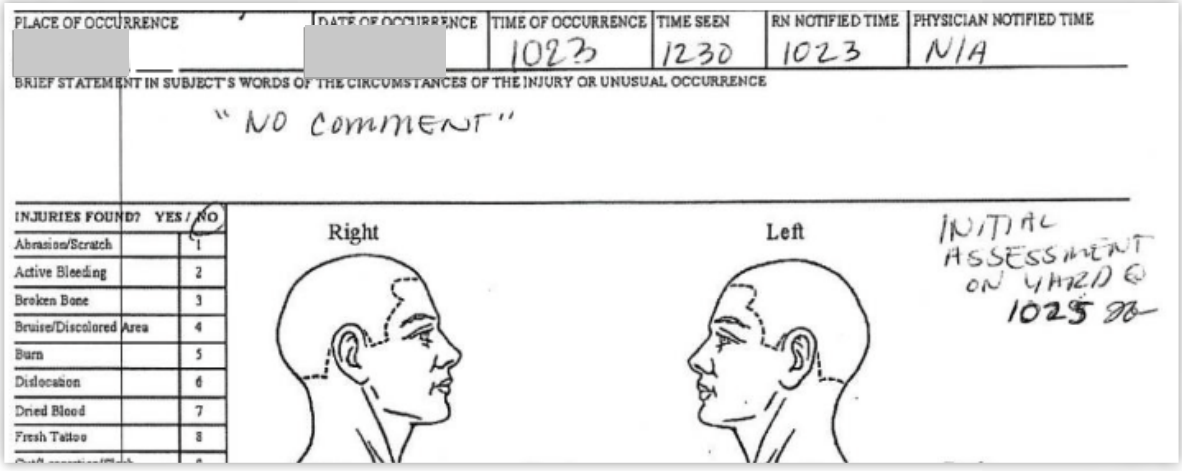
- An incarcerated person battered another incarcerated person in the dayroom within a housing unit. As the incarcerated persons continued to fight, officers yelled orders and instructions to stop

and get down, with negative results. To prevent serious injury, two officers deployed chemical agents to stop the incident. The department provided both incarcerated persons with adequate medical care within four minutes of the incident.

The percentage of incidents in which the department did not timely medically evaluate the incarcerated person following a use-of-force incident remained unchanged since our prior report.

Of the 1,131 incidents we monitored, staff failed to ensure incarcerated persons received a timely medical evaluation following a use of force in 58 incidents (5 percent). We acknowledge that many circumstances can reasonably delay a medical evaluation, including large-scale riots, multiple incarcerated persons with serious injuries, and staff safety considerations; however, circumstances such as administering medication (pill-line), health care staff assigned to other areas, and crime scene preservation, among other common occurrences, are not acceptable reasons for a delay. In some instances, an incarcerated person may have received an initial medical evaluation to assess whether he or she should be seen and treated immediately (triage), but there is no field on the medical report form to document triage. The medical report of injury form contains only one field to document medical evaluation: the "Time Seen" field, which staff use only to document a detailed medical evaluation, not an initial medical assessment of triage. For example, health care staff informally documented the time of the initial assessment, or triage, on the medical evaluation form shown in Figure 10, below, by writing in the margin around a diagram. Without this informal documentation of the initial assessment, however, it would appear the incarcerated person was not seen until nearly two hours after the incident.

Figure 10. Initial Medical Evaluation Documented, No. 1 (CDCR Form 7219)



Source: The California Department of Corrections and Rehabilitation.

Because the medical report of injury form does not offer an option for recording the time triage occurs, we identified that the "time seen" on many of these forms was not "as soon as practical," but instead occurred well over an hour after the use-of-force incident. On those forms, then, it appears that the care of an incarcerated person who may have needed medical care was unreasonably delayed. However, this delay may have reasonably occurred because triage determined the person's injuries were minor or because triage prioritized other persons' injuries for treatment.

In addition, deliberate failure on the part of custody staff to timely alert health care 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 incarcerated persons.

The following example illustrates staff's inadequate performance in this area:

- Officers observed nine incarcerated persons attack another incarcerated person on a prison yard, resulting in a violent riot. To stop the attack, officers deployed chemical agent grenades and fired several 40mm impact munitions. The department's use of force ultimately stopped the violence, and officers were able to restrain and escort the involved incarcerated persons off the yard for medical evaluations. While the department completed most of the medical evaluations in a timely and efficient manner, the primary victim of the attack did not receive medical care until over four hours after the incident. The OIG raised the issue at the institution's executive review committee meeting; however, the hiring authority declined to take any action.

Following medical evaluations, some staff failed to satisfactorily document incarcerated persons' injuries.

Of the 1,103 incidents[36] in which we evaluated the documentation of injuries, we identified 35 incidents in which staff failed to satisfactorily document the incarcerated person's injuries (3 percent). Following medical evaluations, staff generally release incarcerated persons back to their assigned housing or to a more restrictive program, depending on the circumstances surrounding the use-of-force incidents. Incarcerated persons' injuries are time-sensitive and best captured on camera and documented immediately following the incident. Injuries that go unidentified are rendered, effectively, as if they did not happen, since the lack of documentation eliminates possible evidence to corroborate statements. The following example illustrates staff's inadequate

36. This number is less than the 1,131 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.

performance in documenting incarcerated persons' injuries, resulting in a *poor* rating for Indicator 4 in this incident:

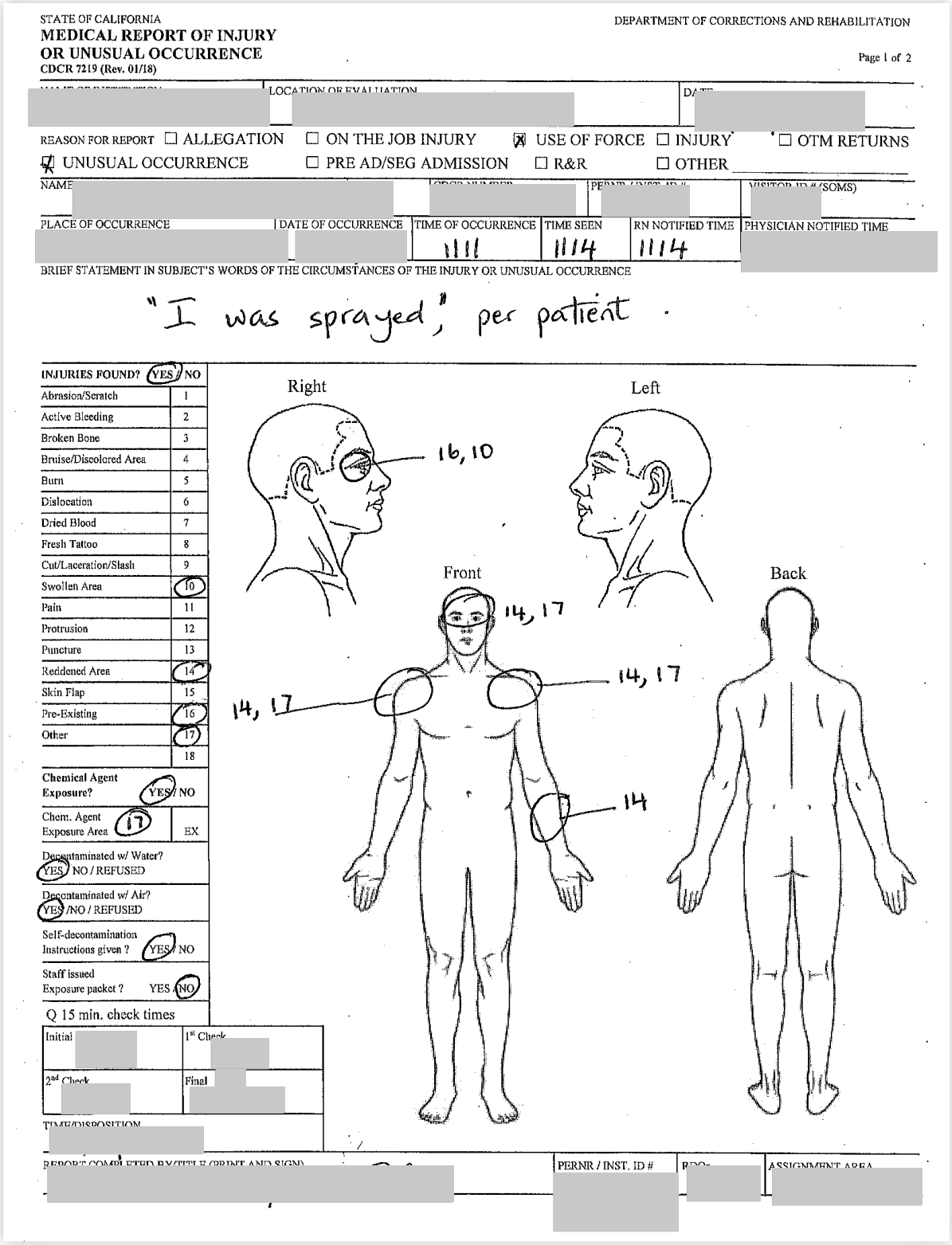
- Officers observed two incarcerated persons striking each other in the face with their fists while standing on the stairs. One incarcerated person pushed the other down the steps. Officers yelled orders to the incarcerated persons to stop fighting and get down onto the ground, with negative results. An officer assigned to the prison's investigative services unit struck one of the incarcerated persons with his State-issued baton. After the incident concluded, the officer who used his baton during the incident interviewed the incarcerated person regarding potential injuries he received from use of force. The officer determined the incarcerated person's injuries were not caused by the force the officer applied; he then chose to process the evidence at the incident scene instead of requesting assistance from his supervisor or from other noninvolved investigative services personnel. During the medical assessments of the incarcerated persons following the incident, the department's medical provider failed to document on a medical evaluation form injuries that were clearly identified in photographs and reports from involved staff. The hiring authority provided training to the medical provider for failing to document the incarcerated person's injuries. However, the hiring authority declined to take any action regarding staff who used force also participating in an interview to determine the cause of the injury following a use of force.

Some staff performed exceptionally well in their efforts to satisfactorily document all incarcerated person injuries. Staff complied with policy and training and satisfactorily documented the incarcerated persons' injuries in 1,068 of the 1,103 incidents (97 percent).

The following is an example of staff's performance contributing to a *superior* rating for Indicator 4:

- Officers overheard banging coming from a cell within the psychiatric inpatient program. An officer approached the cell and observed that the incarcerated person had barricaded his cell with a mattress and used wet toilet paper to cover the cell windows. Officers opened the cell door to remove items blocking their view and obstructing entry into the cell. Without provocation, the incarcerated person began banging his head against the cell wall. Officers gave orders to stop, with negative results; an officer used chemical agents to prevent further serious injury. The incarcerated person immediately ceased his self-injurious behavior. The officers ensured the incarcerated person received a medical evaluation within three minutes of the incident conclusion, and a medical provider adequately documented all injuries (Figure 11, next page).

Figure 11. Initial Medical Evaluation Documented, No. 2 (CDCR Form 7219)



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LOCATION OF EVALUATION | DATE

REASON FOR REPORT ☐ ALLEGATION ☐ ON THE JOB INJURY ☒ USE OF FORCE ☐ INJURY ☐ OTM RETURNS
☒ UNUSUAL OCCURRENCE ☐ PRE AD/SEG ADMISSION ☐ R&R ☐ OTHER

NAME | CDCR NUMBER | PERNR / INST. ID # | VISITOR ID # /SOMS)

PLACE OF OCCURRENCE	DATE OF OCCURRENCE	TIME OF OCCURRENCE	TIME SEEN	RN NOTIFIED TIME	PHYSICIAN NOTIFIED TIME
		1111	1114	1114	

BRIEF STATEMENT IN SUBJECT'S WORDS OF THE CIRCUMSTANCES OF THE INJURY OR UNUSUAL OCCURRENCE

"I was sprayed," per patient.

INJURIES FOUND? (YES) / NO	
Abrasion/Scratch	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
Reddened Area	(14)
Skin Flap	15
Pre-Existing	(16)
Other	(17)
	18
Chemical Agent Exposure? (YES) / NO	
Chem. Agent Exposure Area (17)	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	1st Check
2nd Check	Final

TIME/DISPOSITION

Right
Left
16, 10
Front
Back
14, 17
14, 17
14, 17
14

REPORT COMPLETED BY (TITLE) (PRINT AND SIGN) | PERNR / INST. ID # | RDO | ASSIGNMENT AREA

Source: The California Department of Corrections and Rehabilitation.

Indicator Rating
Satisfactory
75% weighted average score

Superior
No incidents
Zero

Satisfactory
1,118 incidents
99 percent

Poor
13 incidents
One percent

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

Indicator 5 assesses how well staff followed policies and procedures when supervising incarcerated persons following uses of force; among other considerations, this indicator measures whether staff maintained constant supervision of incarcerated persons 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 incarcerated persons following a use of force *satisfactory*. The OIG assessed the department's performance as *satisfactory* in 1,118 incidents and *poor* in 13 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."[37] The policy further requires that "restrained inmates shall never be left unsupervised."[38]

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

The number of incidents in which staff failed to maintain constant supervision of incarcerated persons after applying a spit hood or mask almost doubled from our last reporting period.

Staff applied a spit hood or mask in 70 incidents we monitored. In nine of the 70 incidents, staff failed to maintain constant supervision of incarcerated persons after applying spit hoods or masks (13 percent, up from 6 percent in our prior year's report). The following example illustrates staff's inadequate performance in this area, resulting in a *poor* rating for Indicator 5 in this incident:

- Officers responded to an incarcerated person's cell due to a possible medical emergency. The incarcerated person was in an agitated state and appeared to be under the influence of an unknown substance. Officers ordered the incarcerated person and his cellmate to exit the cell and submit to restraints. Officers placed the incarcerated person's cellmate in restraints and escorted him out of the area. The incarcerated person exited

37. DOM, Section 51020.16.
38. DOM, Section 51020.6.

the cell, but refused to be placed in restraints. Officers used physical force to place the incarcerated person in restraints while he continued to resist and kicked an officer. Officers used additional physical force to bring the incarcerated person to the ground, at which time fluids began to emit from his mouth. An officer placed a spit hood on the incarcerated person, escorted him to a temporary holding cell, and left the incarcerated person unsupervised. The OIG found that the officer's report did not mention constant supervision of the incarcerated person from the time of placing the spit hood and until the spit hood was removed. 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 agree.

Some staff failed to maintain supervision of incarcerated persons placed or held in restraints.

When incarcerated persons are restrained, but unsupervised, they may use the restraints to cause injuries to themselves, other incarcerated persons, or staff, or they may create security concerns. Of the 1,131 incidents we monitored, we identified 939 incidents in which staff applied restraints to an incarcerated person.

In eight of these incidents, staff failed to maintain constant supervision of incarcerated persons 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:

- Officers observed three incarcerated persons striking a fourth with their fists; they struck him on the head and upper torso area while he was lying down in a fetal position, not defending himself. Officers gave the incarcerated persons multiple orders to stop the attack and get down on the ground, with negative results. One officer used his oleoresin capsicum (OC) pepper spray to stop the attack. The use of force had its desired effect: the incarcerated persons stopped fighting and got down on the ground. One officer, who escorted two of the incarcerated persons to a temporary holding cell, failed to maintain constant supervision of the two persons while they were left in restraints for approximately five minutes. When asked to clarify his report's description of his actions, the officer explained that he did not need to maintain constant supervision because both incarcerated persons were behind a locked door. The hiring authority identified that the officer's statement was in direct conflict with the use-of-force policy; the hiring authority provided training to the officer for failing to provide constant supervision of incarcerated persons left in restraints. The OIG concurred.

The review committees took action in five of the 14 incidents in which we identified a policy deviation related to supervision of incarcerated persons while held in a spit hood or restraints, and they ordered training to address the deviations. We identified the remaining nine incidents in which we believed staff violated one or more policies, but the review committees declined to take any action.

Indicator 6. The Department's Compliance With Policies and Procedures Specific to Reporting Requirements for Staff Who Used Force Was *Satisfactory*

Indicator Rating
Satisfactory
75% weighted average score

Superior
101 incidents
9 percent

Satisfactory
929 incidents
82 percent

Poor
101 incidents
9 percent

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 101 incidents, *satisfactory* in 929, and *poor* in 101 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, incarcerated persons' 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*].[39] The policy further requires staff to identify any witnesses, describe the circumstances precipitating the force, the 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, incarcerated persons' actions, force 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.

39. DOM, Section 51020.17.

Figure 12. CDCR 837 Crime/Incident Report Form

Double Click Here to Print Preview

STATE OF CALIFORNIA
CRIME / INCIDENT REPORT
PART C - STAFF REPORT
CDCR 837-C (Rev. 10/15)

DEPARTMENT OF CORRECTIONS AND REHABILITATION

PAGE 1 Of _____ | INCIDENT LOG NUMBER

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 ☐ N/A

YOUR ROLE	WITNESSES (PREFACE S-STAFF, V-VISITOR, O-OTHER)		INMATES (PREFACE S-SUSPECT, V-VICTIM, W-WITNESS)	
☐ Primary				
☐ Responder				
☐ Witness				
☐ Camera				
☐ Victim				
☐ Other:				

☐ N/A — FORCE USED BY YOU – TYPE OF WEAPON / SHOTS FIRED / NON-CONVENTIONAL FORCE

☐ Physical:	Lethal Weapons:	Warning:	Effect:	Less Lethal Weapons:	# Effect:	Chemical Agent:	Projector:	#Deployed:
☐ Hand-Held Baton	☐ Mini 14			☐ 37 mm				
☐ X-10 BRD w/o OC	☐ .38 Cal			☐ 40 mm		☐ OC		
	☐ .40 Cal			☐ L8		☐ CN		
☐ X-10 BRD w/ OC	☐ 9 mm			☐ 40 mm Multi		☐ CS		
	☐ Shotgun			☐ HFWRS				

☐ Non-Conventional or Force Not Listed Above:

FORCE OBSERVED BY YOU: ☐ N/A ☐ Physical ☐ Hand-Held Baton ☐ Chemical Agent ☐ X-10 ☐ Less Lethal ☐ Lethal ☐ Non-Conventional

EVIDENCE COLLECTED BY YOU	EVIDENCE DESCRIPTION	EVIDENCE DISPOSITION	BIO HAZARD	PPE
☐ YES			☐ YES	☒ YES
☐ NO	☐ N/A	☐ N/A	☐ NO	☐ NO

REPORTING STAFF INJURED	DESCRIPTION OF INJURY	LOCATION TREATED (HOSPITAL/CLINIC)	FLUID EXPOSURE	SCIF 3301/3067 COMPLETED
☐ YES			☐ BODILY ☐ N/A	☐ YES
☐ NO	☐ N/A	☐ N/A	☐ UNKOWN	☐ NO
			☐ Other:	

NARRATIVE:

☐ 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 ☐ YES ☐ NO	APPROVED ☐ YES ☐ NO	DATE

DISTRIBUTION: Original: Incident Package Copy: Reporting Employee Copy: Reviewing Supervisor

Source: The California Department of Corrections and Rehabilitation.

We noted an increase since our last reporting period in the number of incidents in which staff who used force did not articulate the imminent threat justifying the use of immediate force.

The department defines the 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."[40] 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."[41] Some examples include escape attempts, ongoing physical harm to oneself or others, and active physical resistance.

Of the 1,114 incidents[42] we monitored in which staff used immediate force, we identified 54 incidents (5 percent) in which staff failed to *articulate* in their reports an imminent threat necessitating the need for immediate force. This percentage more than doubles the 2 percent failure rate from our prior year's report. 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 example below, the reports following immediate uses of force lacked the required articulation of imminent threat, resulting in a *poor* rating for Indicator 6:

- When incarcerated persons were being called in from the yard, officers observed three incarcerated persons striking one another in the face and upper torso with their fists. Officers yelled orders to cease fighting and assume a prone position. After the officer's verbal attempts to stop the fighting were ignored, several officers used chemical agent grenades and less-lethal rounds. The force had the desired effect, and the incarcerated persons lay prone on the ground. An uninvolved incarcerated person changed positions in order to avoid being exposed to the chemical agents. An officer observed this movement, and without articulating an imminent threat, fired a less-lethal round at this incarcerated person, striking him in the leg. The officer's force caused an injury to this otherwise uninvolved incarcerated person. The hiring authority provided training to the officer to address this deficiency.

Staff complied with policy and training when articulating the imminent threat in 1,060 of the 1,114 incidents (95 percent, a decrease from the 97 percent compliance rating in our prior year's report). The following is an example of a staff member performing exceptionally well in his efforts to articulate the imminent threat, resulting in a *superior* rating for Indicator 6:

40. DOM, Section 51020.4.

41. Ibid.

42. Controlled uses of force were not included in this assessment.

- While monitoring the morning meal, officers observed two incarcerated persons striking each other in the face and upper torso area with their fists. Staff gave multiple orders to stop and get down on the ground with negative results, as the fight continued. An officer used chemical agents, striking both incarcerated persons in the face, stopping the fight. After the incident, the officer wrote a very detailed account that documented his observations of the incarcerated persons' actions and the immediate threat that required the use of immediate force.

Exhibit 1.

NARRATIVE

On , at approximately hours while performing my duties as , I was monitoring the beginning morning meal for the top tier from the front of podium, I observed inmate approach inmate who was handing out morning trays at the , when began striking in the facial area and upper torso with his fists. Inmate reacted by striking back at inmate striking him in the facial area and upper torso with his fists. I activated my Personal Alarm Device (PAD) and announced to Central Control via institutional radio code 1, 1 on 1 in . I gave verbal orders for all inmates to get down. All inmates complied except inmate and inmate , who continued to strike each other with their fists to the facial and upper torso areas between benches. I maintained positon at the podium gave another verbal order to "stop fighting and prone out." Sensing the threat of serious bodily injury occurring due to the numerous strikes to the facial area and upper torso of both inmates, I unholstered my MK. 9 O.C. Pepper Spray and dispersed a 1 second burst of O.C. pepper spray from approximately 6 feet away, aiming at inmate facial area striking my intended target to quell the incident. Due to the close proximity of the both inmates, inmate was also contaminated with O.C. pepper spray in the facial area. This use of force had its desired effect as both inmates and ceased their fight and assumed a prone position. Responding staff arrived to the , placed both inmates in handcuffs and escorted them to without further incident. No other inmates were near the area were contaminated from the O.C. pepper spray therefore, no other inmates were offered decontamination. I cleaned up the contaminated area with soap, water and a dry mop. This concludes my involvement with this incident.

The number of incidents in which staff who used force failed to satisfactorily document their actions or observations following use-of-force incidents increased from our last reporting period.

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

- Incarcerated persons' actions
- Any force used or observed
- Projector type and distance if chemical agents were used
- The level of resistance by the incarcerated person or incarcerated persons
- The threat perceived
- Any identified incarcerated person disabilities
- Observations of decontamination

Among the 1,131 incidents the OIG monitored this period, we identified 86 incidents (8 percent, up from 2 percent in our prior year's report) in

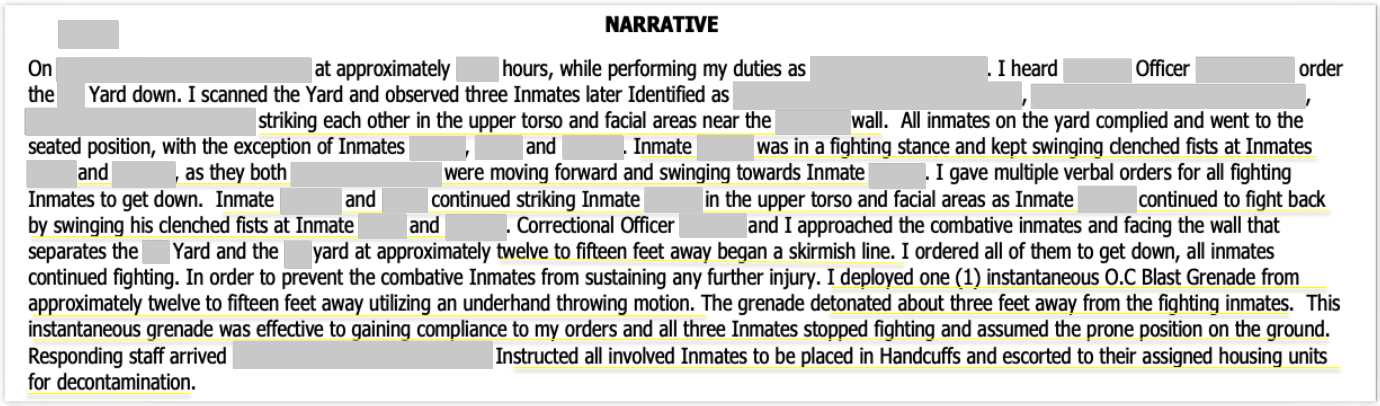
which users of force failed to satisfactorily document their observations or actions. The following is an example of an incident to which we assigned a *poor* rating because staff failed to satisfactorily describe their own actions or observations:

- Staff responded to a cell and observed an incarcerated person banging his head against the cell, causing injury to himself. Staff ordered the incarcerated person to stop and placed him in restraints. Health care staff arrived, conducted a medical assessment, and ordered the incarcerated person to be placed in a safety cell to prevent further harm. As staff began to escort the incarcerated person, he began to break away and turn toward the officers, which resulted in multiple officers having to use physical force to take him to the ground into a prone position. On two subsequent occasions—while waiting for the doctor and during medication administration—staff used additional physical force to maintain control of the incarcerated person. At one point, the incarcerated person attempted to bite the psychiatric technician. Three officers and one sergeant failed to adequately describe the force used and observed, the incarcerated person's actions, or other details from the incident. A lieutenant who reviewed the incident identified most of the issues referenced above; the lieutenant requested and received approximately 40 clarifications from among the three officers and one sergeant, to ensure the reports contained the required elements. The hiring authority provided report-writing training to the involved staff to address the deficiencies.

On a positive note, we found that staff complied with policy and training in 1,045 of the 1,131 incidents (92 percent) when describing their involvement throughout the incident and describing the force used. Among those 1,045 incidents, 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. Two examples follow:

- While monitoring recreational activities, officers observed two incarcerated persons striking a third in the facial and upper torso areas with their fists. The victim attempted to defend himself by using his arms to block the punches. Staff ordered the incarcerated persons to stop and get down into a prone position, with negative results: the attack continued. One officer used chemical agent grenades to stop the attack. The force was effective: the incarcerated persons stopped the attack and got down on the ground. The officer who used force described in detail the actions of the aggressors as well as the victim's actions, the force used, the deployment type, the distance from the officer's location and the force used, the outcome of the use of force, and the actions of the supervisor who responded to the scene.

Exhibit 2.



NARRATIVE

On [redacted] at approximately [redacted] hours, while performing my duties as [redacted]. I heard [redacted] Officer [redacted] order the [redacted] Yard down. I scanned the Yard and observed three Inmates later Identified as [redacted], [redacted], [redacted] striking each other in the upper torso and facial areas near the [redacted] wall. All inmates on the yard complied and went to the seated position, with the exception of Inmates [redacted], [redacted] and [redacted]. Inmate [redacted] was in a fighting stance and kept swinging clenched fists at Inmates [redacted] and [redacted], as they both [redacted] were moving forward and swinging towards Inmate [redacted]. I gave multiple verbal orders for all fighting Inmates to get down. Inmate [redacted] and [redacted] continued striking Inmate [redacted] in the upper torso and facial areas as Inmate [redacted] continued to fight back by swinging his clenched fists at Inmate [redacted] and [redacted]. Correctional Officer [redacted] and I approached the combative inmates and facing the wall that separates the [redacted] Yard and the [redacted] yard at approximately twelve to fifteen feet away began a skirmish line. I ordered all of them to get down, all inmates continued fighting. In order to prevent the combative Inmates from sustaining any further injury. I deployed one (1) instantaneous O.C Blast Grenade from approximately twelve to fifteen feet away utilizing an underhand throwing motion. The grenade detonated about three feet away from the fighting inmates. This instantaneous grenade was effective to gaining compliance to my orders and all three Inmates stopped fighting and assumed the prone position on the ground. Responding staff arrived [redacted] Instructed all involved Inmates to be placed in Handcuffs and escorted to their assigned housing units for decontamination.

- Officers were monitoring medication distribution when an agitated incarcerated person approached, asking to speak with a supervisor regarding laundry. Staff attempted to de-escalate the situation by explaining to the incarcerated person that his laundry day was on a different day. Staff tried to calm the incarcerated person for approximately five minutes, with negative results. Officers attempted to place the incarcerated person in restraints when he started to bounce back and forth with clenched fists and swung at the officer's face. Officers used physical force to take the incarcerated person to the ground and place him in restraints. Following the use of force, the officers who used force included detailed accounts of the force they used, their attempts to de-escalate, the incarcerated person's demeanor and actions, and other details.

Exhibit 3.

NARRATIVE

On , while performing my duties as , I was monitoring the inmates on the yard. Officer called over the institutional radio and instructed me to stop an inmate that was walking towards my direction. I stopped Inmate , and asked him where he was going. Inmate stated that he wanted to speak to a sergeant about his laundry. I told Inmate that he did not need a sergeant to talk about laundry and that there is a laundry schedule for the buildings. Inmate appeared to be very agitated and stated that he did not care and wanted his laundry at the very instant. I told Inmate to relax and he stated," Fuck that I want my laundry now!" At this time Officer arrived at my location and advised Inmate to return to his assigned housing unit and that he would get his laundry the following day according to the laundry schedule. Inmate was becoming more agitated and would clench his hands, keep them to his side and move side to side. I advised Inmate that it would not be wise to fight over laundry and needed to be patient. Inmate stated," Fuck that I already got a battery on staff, I don't give a fuck". Officer advised him to calm down to which he complied. Inmate , in a sobbing voice stated, "I just want to get out of this prison". Suddenly, Inmate became agitated and stated, "Fuck that I can do time anywhere, I don't give a fuck". After about five minutes dialoging with Inmate , I could see that Inmate was not receptive to counseling and was becoming even more agitated by clenching his hands and get in a fighting stance. For officer safety and Inmate , I ordered Inmate to turn around and be placed in handcuffs. I approached Inmate and he raised his fist and started to bounce around like a boxer. Inmate then threw a right punch at my facial area, I ducked and he struck me on the right side of my forehead. I attempted to wrap my arms around Inmate but he was swinging his fists wildly and struck me on my right forearm. I continued to attempt to wrap my arms around Inmate but he continued to fight by throwing punches towards Officer . I could not determine if he struck Officer . I wrapped my arms around Inmate torso and used my physical strength to force him down to the ground. Inmate landed on his back and I grabbed his right arm utilizing both of my hands. Inmate continued to struggle by twisting his body from side to side and pulling his arm to attempt to loosen my grip. I told Inmate that it's over and to relax to which he complied. I turned Inmate over onto his stomach and handcuffed him. I placed my knee on Inmate back to prevent him from getting up, while responding staff placed leg irons on Inmate . Subsequently, Inmate was escorted to the Clinic for medical evaluation.
I reported to the Triage treatment Area for medical evaluation .

Exhibit 4.

NARRATIVE

On , while performing my duties as , I was monitoring Noon Medication in , when I noticed Inmate walk out of the Housing Unit towards Office in an agitated state. I notified Officer , who was by Clinic, via the Institutional Radio to stop Inmate . I approached and location to see what was wrong with . seemed to be in an agitated state and was demanding that he get his laundry. I advised that laundry day for Housing Unit was tomorrow and to return to Housing Unit . became argumentative and he was taking a bladed stance while clinching his fists at his side and bouncing from side to side. Officer advised that it would not be wise to fight over laundry. stated "Fuck that, I already got a battery on staff, I don't give a fuck". In an attempt to de-escalate the situation and to prevent harm to the inmate and staff, I instructed to calm down, to which he complied. began to state in a sobbing voice, "I just want to get out of this prison". Then without provocation stated "FUCK THAT I can do my time anywhere, I don't give a fuck". For about five minutes and I were trying to de-escalate the situation, with negative results. was not receptive to counseling and was becoming even more agitated by clenching his fists and raising his fists as if he wanted to fight us. ordered to submit to mechanical restraints. As approached to place him in Mechanical Restraints, without provocation raised his clinched fists and started to bounce back and forth from side to side. stepped towards while swinging his closed right fist towards facial area. I immediately ordered to get down in a loud, clear voice, with negative results. Utilizing my Institutional Radio, I called for a "Code 1 Staff Assault, in front of Clinic". I observed duck down in an attempt to avoid being battered by and get struck on his head by with a closed right fist. bounced around towards me in an aggressive manner. Fearing for the safety of myself and my partner and in order to gain compliance with a lawful order, overcome resistance, effect custody and to subdue the attacker, I grabbed left bicep utilizing my right hand. immediately broke my grasp and continued his attack. was swinging both fists towards me, in a wild manner, striking me in my upper left cheek bone below my left eye. After being battered by , I regained my ground and wrapped my left and right hands around waist and utilizing my physical body weight along with , we pulled to the ground. landed on his back, and was violently thrusting his legs and upper torso area in an attempt to further batter staff. I maintained control of legs by applying downward pressure on his left and right legs with my left and right hands. was able to gain control of arms along with responding staff and told him to relax with positive results. ceased his combative behavior and stopped resisting. I assisted in turning over on his stomach in a prone position to place him in mechanical restraints. I observed Officer place in leg irons. Responding staff took control of and proceeded to escort to the Building . I reported to the Triage Treatment Area (TTA) where a CDCR 7219 Medical Form was conducted, noting a bruise, pain, swelling and redness to my upper left cheek area, as well as pain and redness to my right knee. I was offered EAP and Peer Support.

The department showed some improvement from our last reporting period in staff's articulation of approved criteria when applying a spit hood or mask.

We identified 47 incidents in which staff who used force applied a spit hood or mask. In six of those incidents (13 percent, down from 16 percent in our prior year's report), staff who used force failed to articulate policy-specific 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 incarcerated persons 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 to apply when considering the use of a spit hood. It states, in part, that a spit hood or mask shall not be placed upon an incarcerated person who

- Is in a state of altered consciousness; or
- Displays visible signs of seizure; or
- Is vomiting or exhibiting signs of beginning to vomit.[43]

Departmental policy allows staff to apply a spit hood or mask if there is verbal or physical intent by the incarcerated person to contaminate others with spit or other bodily fluids from the nose or mouth; if the incarcerated person is not able to control expelling fluid from the nose or mouth; or if the incarcerated person is on authorized security precautions.[44] The following example demonstrates staff's unauthorized use of a spit hood or mask, contributing to a *poor* rating for this indicator in this incident:

- An incarcerated person summoned an officer to his cell and requested to speak with a sergeant regarding his medication. The officer called for the sergeant using his handheld radio. Officers escorted the incarcerated person to the office to speak with the sergeant. During the interview, the sergeant observed the incarcerated person agitated, withdrawn, pacing back and forth, and sweating profusely. The sergeant requested the officers to conduct a clothed body search for possible contraband. Without provocation, the incarcerated person lunged at and attempted to strike the sergeant. His attempted strike was unsuccessful, and multiple officers intervened and forced the incarcerated person to the ground. Once the incarcerated person was on the ground, officers used additional force to place him in restraints. The sergeant ordered an officer to place a spit hood

43. DOM, Section 51020.16.

44. Ibid.

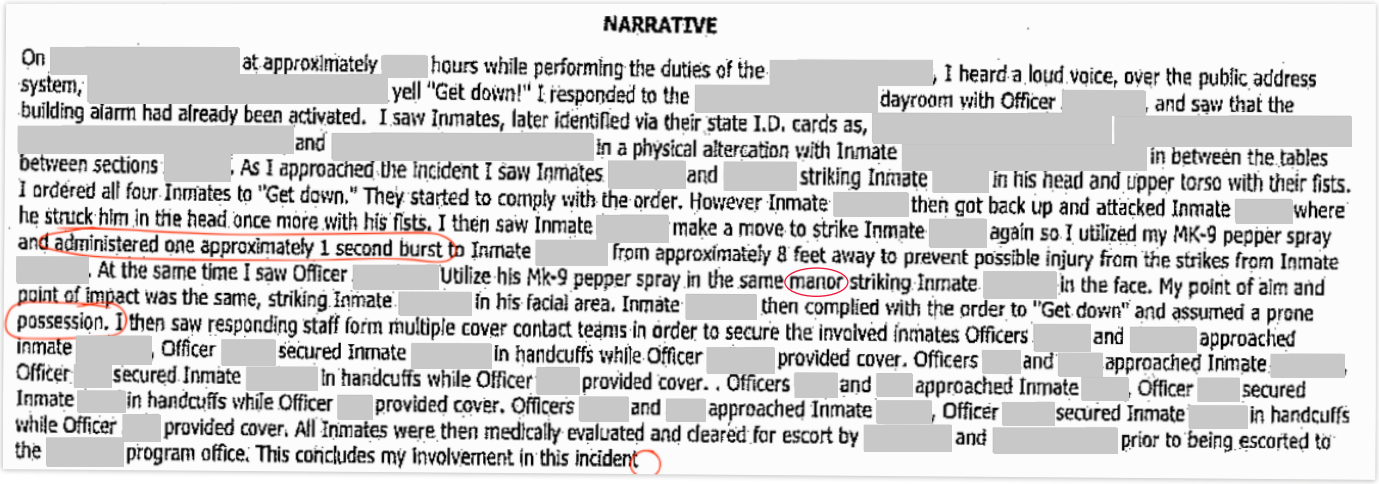
over the incarcerated person's head as a "safety measure" due to his face covering falling off, the current COVID-19 directive, and his assaultive behavior. The OIG identified and raised the consideration that the use of the spit hood did not meet the criteria for placement. The hiring authority disagreed and declined to take any action.

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

Of the 1,131 incidents we monitored, we identified six 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 the standpoint of their own individual recollections, not those of others. We acknowledge that similar descriptions of actions or events will occur when several people are completing reports of the same incident. However, although these descriptions can be similar in nature, they would never be almost identical to those of their counterparts. The following is an example demonstrating staff's deficient performance and intent to collaborate, resulting in a *poor* rating for Indicator 6 in this incident:

- An officer observed three incarcerated persons striking a third in the head and upper torso with their fists and feet. Officers gave orders to stop fighting and get down, with negative results; two officers used chemical agents to stop the incident. The two officers' reports were very similar, containing the same grammatical error and awkwardly worded sentence.

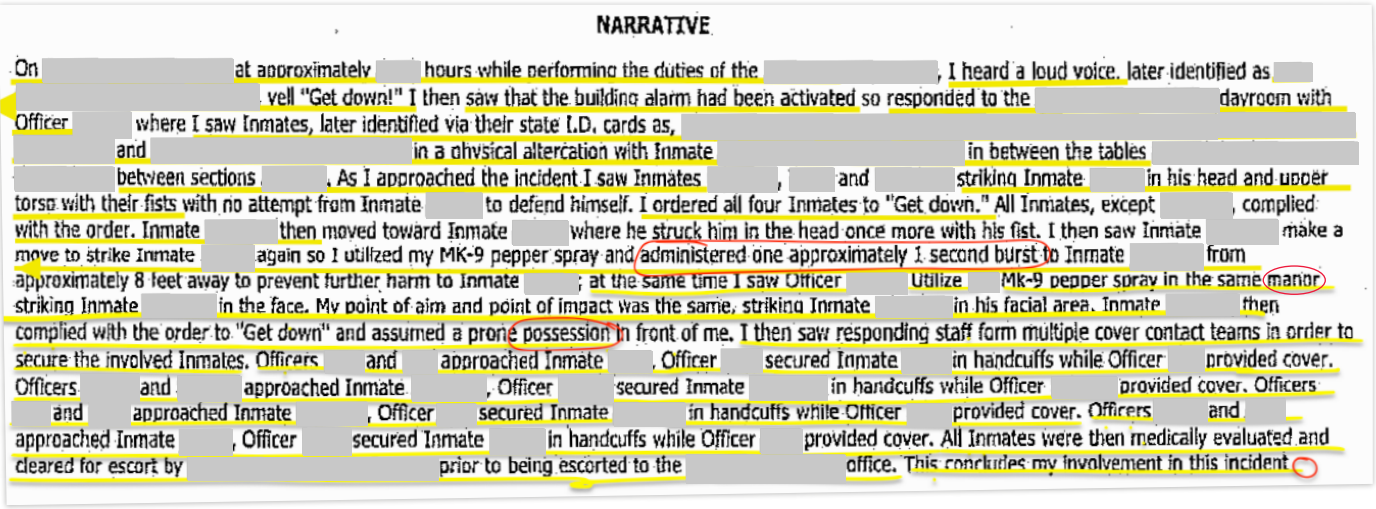
Exhibit 5.



NARRATIVE

On at approximately hours while performing the duties of the , I heard a loud voice, over the public address system, yell "Get down!" I responded to the dayroom with Officer , and saw that the building alarm had already been activated. I saw Inmates, later identified via their state I.D. cards as, and in a physical altercation with Inmate in between the tables between sections . As I approached the incident I saw Inmates and striking Inmate in his head and upper torso with their fists. I ordered all four Inmates to "Get down." They started to comply with the order. However Inmate then got back up and attacked Inmate where he struck him in the head once more with his fists. I then saw Inmate make a move to strike Inmate again so I utilized my MK-9 pepper spray and administered one approximately 1 second burst to Inmate from approximately 8 feet away to prevent possible injury from the strikes from Inmate . At the same time I saw Officer Utilize his Mk-9 pepper spray in the same manor striking Inmate in the face. My point of aim and point of impact was the same, striking Inmate in his facial area. Inmate then complied with the order to "Get down" and assumed a prone possession. I then saw responding staff form multiple cover contact teams in order to secure the involved inmates Officers and approached inmate , Officer secured Inmate in handcuffs while Officer provided cover. Officers and approached Inmate , Officer secured Inmate in handcuffs while Officer provided cover. . Officers and approached Inmate , Officer secured Inmate in handcuffs while Officer provided cover. Officers and approached Inmate , Officer secured Inmate in handcuffs while Officer provided cover. All Inmates were then medically evaluated and cleared for escort by and prior to being escorted to the program office. This concludes my involvement in this incident

Exhibit 6.



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Indicator 7. The Department's Compliance With Policies and Procedures Specific to Reporting Requirements for Staff Who Did Not Use Force Was *Satisfactory*

Indicator Rating
Satisfactory
73% weighted average score

Superior
31 incidents
3 percent

Satisfactory
975 incidents
86 percent

Poor
125 incidents
11 percent

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 incarcerated persons' 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 health care 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 reporting requirements for staff who did not use force was *satisfactory*. The OIG assessed the department's performance as *superior* in 31 incidents, *satisfactory* in 975 incidents, and *poor* in 125 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 such strategies.[45]

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 1,019 incidents the OIG monitored this period, we identified 64 in which observers of force failed to satisfactorily document their observations or actions (6 percent, up from 5 percent in our prior year's report); 112 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:

- A counselor who observed force failed to articulate how staff used force to gain and maintain control of the incarcerated person. Officers approached an incarcerated person who was attempting to use the phone when it was not his allotted phone time. The incarcerated person became irate and yelled obscenities at the officers while walking out of the housing unit to speak with a supervisor. Staff ordered all incarcerated persons to get down on the ground, with negative results; the incarcerated person refused orders to be placed in restraints. Two officers used physical

45. DOM, Section 51020.17.

force to grab his wrists and attempted to place them behind his back. The incarcerated person pulled away from the officers, requiring them to use additional force to gain compliance and place him in restraints. The incarcerated person was escorted to a temporary holding cell. The counselor who observed force completed and submitted his report a day late because he said he did not believe he observed force. After the counselor was asked multiple questions seeking clarifications, he wrote a vague description of the force he had observed. During the institution's review committee meeting, the OIG noted the lack of detail in the counselor's description and recommended further action. The hiring authority reviewed the issues further and provided corrective action to the counselor to address the deficiency.

Staff complied with policy and training in 955 of the 1,019 incidents (94 percent, down from 95 percent in our prior year's report) when articulating their involvement throughout the incident and describing the force observed. The following is an example of staff performing exceptionally well in articulating the force they observed, contributing to a ***superior*** rating for Indicator 7 in these incidents:

- An officer observed an incarcerated person inserting an unknown object into an electrical outlet, causing it to spark and smoke. Officers responded to the cell and gave multiple orders for the incarcerated person to exit his cell and submit to restraints. Officers attempted to apply restraints when the incarcerated person began to aggressively pull away, resulting in officers having to use physical force to take him down to the ground. Officers escorted the incarcerated person to a temporary holding cell. A sergeant conducted a cell inspection and contacted the institutional fire department to clear the cell as a precaution, due to the smoke. The fire captain conducted a thorough investigation into the cause of the fire and took multiple pictures for evidence. All staff who did not use force wrote detailed and accurate reports of the events.

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 1,081 applicable incidents we monitored, we identified 14 instances in which staff who did not use 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, which resulted in a ***poor*** rating for Indicator 7 in this incident:

- Officers observed two incarcerated persons striking each other in the face and upper torso area with their fists. Multiple orders were given to stop fighting and get down on the ground. The incarcerated persons ignored the orders, requiring an officer to deploy one less-lethal round. The force had the desired effect, as both incarcerated persons separated and got down on the ground into a prone position. The reports completed by two officers contained descriptions of the incident that were nearly identical in many areas [Exhibits 7 and 8, below]. The two officers had the same poorly worded sentences: "Officer ____ then *point* out the two inmates," "I *secure* the inmate ____," and "I conducted an unclothed body search of inmate ____ with negative *result* for contraband." Supervisors and managers missed the collaboration, but it was identified by the use-of-force coordinator. The OIG also raised the issue during the institution's review committee meeting, and the hiring authority provided training to both officers to address the collaboration.

Exhibit 7.

NARRATIVE

On while working , a code 1 was announced over institutional radio, Housing Unit on the yard. I responded from the office to Housing Unit . After there was enough responding staff, signaled the officer to open the yard door. Officer then point out the two inmates that were fighting, inmates and . We then enter the yard and formed a skirmish line in front of the door. I ordered inmate to get up and walk backwards to the skirmish line where I placed him in handcuffs, I conducted a cursory search of with negative results for contraband. I escorted inmate to clinic holding cell . During the escort Inmate was evaluated by medical staff and cleared. Once at the clinic holding cell I conducted a search of cell with negative results for contraband. I secure the inmate in cell and signaled for clinic control to secure door. I removed the handcuffs from inmate through the open food/cuff port and conducted an unclothed body search of inmate with negative result for contraband. I initiated a holding cell log.

Exhibit 8.

NARRATIVE

On while working , a code 1 was announced over institutional radio, Housing Unit on the yard. I responded from the office to Housing Unit . After there was enough responding staff, signaled the officer to open the yard door. Officer then point out the two inmates that were fighting, inmates and . We then enter the yard and formed a skirmish line in front of the door. I ordered inmate to get up and walk backwards to the skirmish line where I placed him in handcuffs, I conducted a cursory search of with negative results for contraband. I escorted inmate to clinic holding cell . During the escort Inmate was evaluated by medical staff and cleared. Once at the clinic holding cell I conducted a search of cell with negative results for contraband. I secure the inmate in cell and signaled for clinic control to secure door. I removed the handcuffs from inmate through the open food/cuff port and conducted an unclothed body search of inmate with negative result for contraband. I initiated a holding cell log.

The number of incidents in which staff did not articulate approved criteria when applying a spit hood or mask almost doubled from our last reporting period.

We identified 32 incidents in which staff who did not use force applied a spit hood or mask to an incarcerated person. In seven of those 32 incidents (22 percent, up from 10 percent in our prior year's report), staff failed to describe the required criteria, leading us to question whether the placement of the spit hood was justified.

The department showed improvement in health care staff documenting their involvement during controlled uses of force.

Our assessment of health care staff's *actions* during a controlled use of force was discussed earlier in Indicator 1. We identified 18 incidents in which health care staff had the opportunity to document their involvement during a controlled use of force. Of the 18 incidents, we identified five incidents in which staff failed to satisfactorily document required elements (27 percent, down from 31 percent in our prior year's report). For the purposes of this indicator, we used three requirements to assess the quality of health care staff's written articulation of their involvement during controlled uses of force: we assessed their descriptions of their attempts to provide intervention prior to the use of force, their review of the incarcerated person's health record to screen for potential adverse outcomes, and their assessment of the incarcerated person's ability to effectively communicate. We found the following lapses in health care staff's documentation:

- Health care staff who provided intervention failed to articulate their interventions (three incidents).
- Licensed nursing staff failed to articulate on the incident report their review of the incarcerated person's health record regarding increased risk for adverse outcomes (three incidents).
- A licensed mental health care practitioner failed to articulate on the incident report whether the incarcerated person 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 (three incidents).

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

Indicator Rating
Poor
64% weighted average score

Superior
No incidents
Zero

Satisfactory
92 incidents
55 percent

Poor
75 incidents
45 percent

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

Among the 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 167 incidents applicable to this indicator, the OIG rated 92 *satisfactory* and 75 *poor*; we assigned no *superior* ratings.

In 2020, the department formed the Allegation Inquiry Management System (AIMS), a designated entity that functions as a statewide independent unit responsible for reviewing and investigating staff misconduct grievance allegations raised by persons under the department's jurisdiction.[46] Our monitoring assessment in this indicator involved local-level inquiries through the prisons' chain of command.

Departmental policy requires staff to video-record an interview with an incarcerated person who alleges unnecessary or excessive force;[47] and staff must interview the incarcerated person as soon as possible, but no later than 48 hours[48] from the discovery of the allegation. The policy further requires staff to record any visible or alleged injuries, and it 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 incarcerated person from providing relevant information.

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 incarcerated person within 48 hours ensures that potential visual evidence of the incarcerated person's alleged injuries is captured. Promptly and properly documenting evidence may support an incarcerated person's claim of unnecessary or excessive force, but a lack of visible injuries may

46. The OIG's Staff Complaints Monitoring Team monitors AIMS's investigative activities. See our most recent report issued in February 2021, ***The California Department of Corrections and Rehabilitation: Its Recent Steps Meant to Improve the Handling of Incarcerated Persons' Allegations of Staff Misconduct Failed. . . .***

47. DOM, Section 51020.17.3.

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

refute an incarcerated person's allegation against staff. For example, an incarcerated person'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 incarcerated person within the required time frames and complete proper documentation, the department is vulnerable to allegations 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 incarcerated person to speak openly about the allegation.

The department achieved high compliance rates in the areas that may have led to potential bias if policies were not followed, including uninvolved supervisors conducting the interviews (96 percent) and not inhibiting the incarcerated person from providing relevant information (92 percent). However, considering the requirements to ensure prompt and adequate documentation of the allegation and injuries, improvement was 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 77 percent of the incidents. Finally, staff stopped the video for a new medical evaluation following the identification of new injuries in only 38 percent of the applicable incidents.

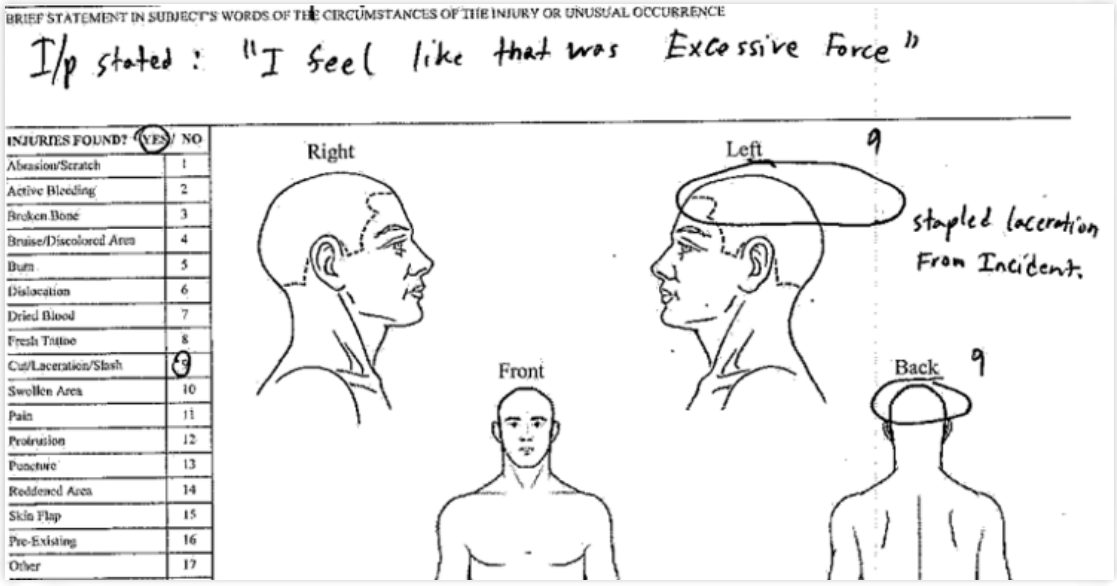
Not all incidents in which we identified a deviation from policy resulted in a *poor* rating. However, in incidents involving multiple violations or egregious violations of the video-recorded interview policy, we assigned a *poor* rating, as illustrated in the following examples:

- In one incident, officers reported that an incarcerated person refused to exit his cell, and a controlled use of force was initiated after an approximate three-hour cooling-off period. Three applications of pepper spray vapor and two bursts of a pepper spray fogger were deployed through the food port over a period of approximately 11 minutes. Since the person refused to comply, an extraction team entered the cell and used physical force, a safety shield, and a baton strike against the resistive incarcerated person. The incarcerated person received a serious bodily injury: a head wound requiring extensive suturing (11 staples).

  On the day of the incident, the medical evaluation form, as shown in Figure 13 on the next page, included the incarcerated person's statement: "I feel like that was excessive force." Despite the incarcerated person's clear allegation of excessive force, staff failed to video-record an interview with the incarcerated person until 14 days after the incident. Although at the beginning of the interview, departmental staff stated the video-recording was "for an allegation of excessive use of force," the written report of the interview stated, "[I]t should be corrected that the video

was conducted due to possible SBI (serious bodily injury) on inmate." During the interview, the incarcerated person alleged, "They came into my cell, hit me with a billy club, I went down to the ground." Departmental staff concluded no further action was warranted since the baton strike to the incarcerated person's head was inadvertent, due to the person's erratic movement.

Figure 13. Incarcerated Person's Statement Concerning Excessive Force (CDCR Form 7219)



- In another example, an incarcerated person was attacked by another incarcerated individual. The incarcerated person who was attacked alleged a "control booth officer did not skip his rounds (indirect fire) but shot directly at him (direct fire) and the round hit him in his hand." Furthermore, the person stated the control booth officer had shot him "with the 40mm four times . . . one in the thigh, one in the back, one behind my arm, and one that hit my hand and broke it." During the video-recorded allegation interview, the correctional supervisor, who served as the interviewer and the camera operator, did not state the purpose of the interview or identify himself on camera. After the incarcerated person alleged additional injuries to his left eye, cheek, and nose, injuries that were not completely documented on the prior medical evaluation, the department failed to arrange for another medical evaluation to be completed.

The correctional supervisor also asked the person a few leading questions that only required a yes or no response, including, "Do you feel you shouldn't have been shot?" as well as the unrelated and inappropriate question, "Do you have any questions about him (the other incarcerated person)?" The institution's executive review committee addressed the above deviations by providing training to the correctional supervisor, but the committee did not seek clarification regarding the continued imminent threat that necessitated the need for each of the four applications of force with the 40mm launcher.

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 Rating
Poor
63% weighted average score

Superior
No incidents
Zero

Satisfactory
28 incidents
50 percent

Poor
28 incidents
50 percent

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 notified the OIG and evaluating how well staff followed video-recording requirements, such as interviewing the incarcerated person on video within 24 hours of the incident and making a reasonable attempt to capture injuries on the video-recording.

Among the 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 56 incidents applicable to this indicator, the OIG rated 28 *satisfactory* and 28 *poor*. We assigned no *superior* ratings.

After an incident during which an incarcerated person sustains serious or great bodily injury[49] 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.[50] Second, policy requires that a supervisor who did not use or observe force during the incident conduct a video-recorded interview with the incarcerated person 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 recording on video any visible or alleged injuries and not inhibiting the incarcerated person from providing relevant information.

As was the case in Indicator 8, the department's deficiencies in this indicator occurred primarily in the areas intended to ensure prompt and adequate documentation of the incarcerated person's injuries. Staff met the time requirements for the video-recorded interview in 72 percent of the incidents and captured the incarcerated person's injuries on video in only 67 percent of the incidents. Finally, staff stopped the video-recording to obtain a new medical evaluation following the identification of additional injuries in only 45 percent of the applicable incidents.

49. DOM, Section 51020.4, defines a serious bodily injury as a serious impairment of physical condition, including, but not limited to the following: loss of consciousness; concussion; bone fracture; protracted loss or impairment of function of any bodily member or organ; a wound requiring extensive suturing; and serious disfigurements. A great bodily injury is any bodily injury that creates a substantial risk of death.

50. DOM, Section 51020.18.2.

For the 15 incidents in which a video-recorded interview with an incarcerated person was either not conducted at all or not conducted within 48 hours of discovery of the serious bodily injury, we identified a concerning trend. The department's process to determine whether a serious bodily injury may have been caused by staff's use of force was inconsistent: at times, health care staff was requested to assess the injury; at other times, custody supervisors made their own determinations about whether an incarcerated person's injury should be considered serious.

In the cases we monitored, we found serious deviations from policy, including failure to timely notify the OIG; inadequate inquiry into the cause and appropriateness of the serious bodily injury; and inconsistent processes to determine whether a serious bodily injury occurred due to staff's use of force. The examples below highlight the lack of compliance that produced a *poor* rating in this indicator:

- Two officers were escorting an incarcerated person out of his cell when the person kicked backwards with his left foot, striking one of the escort officers on the right knee and shin. The escort officers reported using physical force by pushing the person forward and to the ground. Health care staff determined the incarcerated person required a higher level of care, but the person refused any further medical treatment on the day of the incident. The next day, the incarcerated person was treated at an outside hospital. Subsequently, prison health care staff reviewed the person's health records and reported that the injuries sustained were serious bodily injury (protracted loss or impairment of function of any bodily member or organ) since an X-ray of the left shoulder showed an "anterior inferior dislocation of the humeral head" (see Figure 14, next page). However, following prison health care staff's evaluation of serious bodily injury, the incident commander, three days after the incident, independently "determined that the injury sustained would not lead to a protracted loss or impairment of function of any bodily member or organ." Thus, the incident commander did not initially provide notification of serious bodily injury to our office or conduct a video-recorded interview within 48 hours of identification of serious bodily injury to the incarcerated person.

Figure 14. CDCR Medical Evaluation Serious Bodily Injury Determination Chrono

DOM Supplement 51030, Incident Reporting Attachment C

STATE OF CALIFORNIA **DEPARTMENT OF CORRECTIONS AND REHABILITATION**

On [redacted], I reviewed the Unit Health Record on inmate [redacted], CDCR # [redacted].
Inmate [redacted] was involved in an incident dated [redacted], Incident Report Log # [redacted].
During this incident, inmate [redacted] received the following injuries:

☐ Loss of Consciousness (claimed by inmate)

☐ Loss of Consciousness (witnessed by staff)

☐ Concussion

☐ Bone Fracture (Identify specific location)

☐ A wound requiring extensive suturing (Identify specific location, length, and number of sutures)

☐ Serious disfigurement (Identify specific location)

☒ Protracted loss or impairment of function of any bodily member or organ (Identify specific location)
X-RAY OF THE LEFT SHOULDER SHOWED ANTERIOR INFERIOR DISLOCATION OF THE HUMERAL HEAD. No fractures noted

☐ No injuries noted

This information is being provided at the request of custody staff for inclusion in the Incident Report and/or the Rules Violation Report(s) associated with it.

[redacted]
Medical Personnel (Print Name)

[redacted]
Medical Personnel (Signature)

DATE: [redacted] **MEDICAL EVALUATION** **CDCR-128C**

A subsequent administrative review of the incident by institution staff affirmed the prior identification of serious bodily injury by prison health care staff. Accordingly, a video-recorded interview was conducted 17 days after the incident, and the OIG received notification of the serious bodily injury 21 days after the initial serious bodily injury determination by health care staff. During the video interview, the incarcerated person identified a new injury not previously documented, yet the interviewer did not stop the video or obtain a new medical evaluation form to document the new injury.

- In another incident, a transgender incarcerated person refused to return to her assigned cell and struck the faces of both escort officers with her fists. The officers each used their physical strength and struck the resistive offender three times on the right side of her face. The officers then pulled the person to the floor, and she landed face down on her stomach. The person continued to be resistive by keeping her left arm under her body, and officers used physical force to apply mechanical restraints. After she stopped resisting, the person appeared to have a seizure and was placed in a recovery position (placing the body so as not to restrict breathing) by an escort officer. The incarcerated person and both officers were subsequently treated at outside hospitals for further evaluation.

  During the medical evaluation by institutional staff, the incarcerated person stated she "was hit on the head," but the only injuries identified were reddened areas on the backs of both hands. When the incarcerated person was further assessed at an outside hospital, it was noted she had a head injury with a loss of consciousness, and the incarcerated person stated she had "pain on left side of [her] head and [her] left lateral ribs." A chest X-ray identified a "nondisplaced fracture of the left seventh rib laterally." The incarcerated person's serious bodily injuries—bone fracture and loss of consciousness—were never documented as part of the incident package. At the institution's executive review committee meeting, health care staff informed the committee about the incarcerated person's rib fracture that may have been caused by staff's use of force. However, the incident commander and committee never notified the OIG of the serious bodily injury; no inquiry into the cause and appropriateness of the serious bodily injury was ever conducted; and the incident was not reviewed by the department's executive review committee, as required by departmental policy.

- In another incident, two incarcerated persons were attacking another incarcerated person. The incarcerated persons did not comply with orders to get down, and custody staff deployed 11 40mm exact-impact sponge rounds, two oleoresin capsicum (OC) instantaneous blast grenades, and two pocket tactical

grenades. One of the 40mm rounds was observed by the officer who shot the round and was observed by another officer as it struck a person in the right upper thigh and buttock area. No other witnesses were able to identify where the other rounds struck. The initial medical evaluation by institutional staff identified several injuries, including a "cut/laceration/slash" to the person's right ear and a "bruise/discolored area" to the right lower-back area.

Approximately three hours after the incident, the incident commander noted that the person struck in the right thigh received eight stitches to his right ear (at an outside hospital). Institutional health care staff, approximately two hours after the incident, noted a laceration to the right ear and complaints of "decreased vision and hearing on right side." The day after the incident, the incident commander noted that "medical staff determined that there was no serious bodily injury [no medical assessment form or documentation was provided]; however, due to [incarcerated person] stating that he was struck in the head with a 40mm round a video tape interview was conducted." Institutional staff did not determine the person's injuries (a wound requiring extensive suturing) to be a serious bodily injury. Thus, departmental staff did not notify the OIG of the serious bodily injury, and the incident was not reviewed by the department's executive review committee. Although a video-recorded interview was conducted, it was conducted as part of the incarcerated person's allegation inquiry into alleged misconduct by departmental staff. It was not conducted as part of an inquiry into the cause and appropriateness of the serious bodily injury.

- A different serious bodily injury assessment was reached in an incident similar to the one discussed above. Two incarcerated persons were attacking another incarcerated person, striking with their fists. The incarcerated persons did not comply with orders to get down, and a control booth officer fired three 40mm exact-impact rounds. One incarcerated person alleged he was struck by a 40mm round on his back. He said, "I was in an altercation and I felt the first shot in my back and while still continuing the altercation I felt the second shot hit me in the back of the head like a baseball bat and I started seeing stars, went black. . . . I almost did lose consciousness." The person was transported to an outside hospital for further medical treatment. Prison medical staff noted a laceration, a bruised area, and staples behind the person's right ear, as well as a bruised and swollen area in the lower back. The incident commander and health care staff did not identify the injuries as a serious bodily injury, but timely notification was made to the OIG of an unintentional or ricochet head-strike with an impact-weapon munition.

During a meeting of the institution executive review committee approximately four weeks after the incident, the hiring authority considered the extensive suturing of three staples to the head and the serious disfigurement of the person as meeting the requirements of a serious bodily injury. Training was recommended to the incident commander regarding serious bodily injury requirements. Although the hiring authority considered this incident to meet the requirements of serious bodily injury, the OIG was never notified of the serious bodily injury; no inquiry into the cause and appropriateness of the serious bodily injury was ever conducted; and the incident was not reviewed by the department's executive review committee, as required by departmental policy.

Outside hospital records showed that on the day of the incident, the person received three skin staples over the head wound without a loss of consciousness. Institutional medical records, eight days after the incident, noted that three staples were removed with no signs of infection. Thus, a review of medical records did not support the hiring authority's decision that extensive suturing or serious disfigurement resulted from staff's use of force.

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

Indicator Rating
Poor
68% weighted average score

Superior
No incidents
Zero

Satisfactory
823 incidents
73 percent

Poor
308 incidents
27 percent

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 *poor*. The OIG found the department's performance *satisfactory* in 823 incidents (73 percent) and *poor* in 308 incidents (27 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."[51] At the culmination of the five levels of review, the executive review committee makes a final determination of 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. Deviations that are not uncovered until review reaches the departmental 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. Our prior report identified similar issues: in 35 percent of incidents monitored during that reporting period, one or more reviewers did not identify a deficiency. In our prior report, we recommended the department develop a method to ensure that reviewers at all levels adequately review and identify deviations from use-of-force policy, procedure, and training. The department reiterated its expectations in a departmental memo, provided to all levels of review, that was implemented in September 2020. Despite the department's corrective action plan, monitored incidents in which one or more reviewers did not identify a deficiency increased from 35 percent to 44 percent.

51. DOM, Section 51020.19.

In Table 4 below, we identify the number of deficiencies that reviewers at each level did not identify. Of the 1,131 incidents we monitored, we found 500 incidents (44 percent) in which one or more reviewers 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 2,072 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 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.[52]

Table 4. Policy Violations Not Identified at a Level of Review

Level of Review	DAI	DJJ	DAPO	OCS	Total
Incident Commander	438	73	10	1	522
First-Level Manager's Review	390	47	9	1	447
Second-Level Manager's Review	362	45	9	1	417
Use-of-Force Coordinator's Review	322	N/A	N/A	N/A	322
Institution Executive Committee Review	314	41	8	1	364
Total Policy Violations	**1,826**	**206**	**36**	**4**	**2,072**
	Total Use-of-Force Incidents Assessed by the OIG				
	926	**177**	**18**	**10**	**1,131**

Note: **DAI** stands for the Division of Adult Institutions; **DJJ**, the Division of Juvenile Justice; **DAPO**, the Division of Adult Parole Operations; and **OCS**, the 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:

- Officers escorted a maximum-custody incarcerated person from a mental health treatment class toward his assigned cell. While passing through a rotunda area of a housing unit, the incarcerated person ceased walking and demanded to speak with a sergeant. An officer agreed to contact a sergeant and instructed

52. 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 executive review committee.

the incarcerated person to continue walking. After taking a few steps, the incarcerated person refused to walk any farther, and the officers carried him into a holding cell. As the officers placed the incarcerated person into the holding cell, he attempted to kick an officer, and the officers used physical strength to force the incarcerated person to the ground.

During the altercation, the incarcerated person grabbed an officer's right arm, and the officer struck the incarcerated person nine times on the head with his left hand. The officer submitted his report five days after the incident, rather than before the end of his shift on the day of the incident, as required by policy. The officer was evaluated and treated at an outside hospital for a hand injury. In his belated report, the officer only articulated striking the person three times and later reported he could not remember how many times he struck the person. Several officers who used physical force to strike the same person simultaneously failed to identify the other officers present by name, only referring to the officers as "unidentified officers." Another officer, who also reported he struck the same incarcerated person simultaneously with other officers, reported he could not remember where he struck the person. The officers who reported they were unable to identify their colleagues all worked in the same housing unit and shift. All the officers' reports describe the incarcerated person being struck on the left side of his face, yet departmental staff only photographed the right side of the person's face.

The reviewing sergeant, the lieutenant, and the captain did not identify any concerns with the force used during the incident. The second-level manager, an associate warden, identified that the officer's nine strikes appeared to be an excessive use of force, but only recommended "further discussion on this [issue] with the IERC [institution executive review committee] to determine appropriate action," in lieu of requesting an investigation into the matter. During the institution's executive review meeting, we recommended the committee refer the matter to the Office of Internal Affairs for investigation. We also questioned why the person was removed from the holding cell so that photographs of injuries could be taken, yet departmental staff did not arrange for the person to be seen by health care staff for a medical evaluation and treatment until an hour and a half after the incident. The hiring authority stated the incarcerated person needed "to cool down" prior to being seen by health care staff and disagreed with our suggestion to refer the incident for an investigation. The hiring authority only recommended that the officer who struck the person nine times in the head and a response supervisor (sergeant) receive training: for submitting an untimely report and for failing to ensure submission of a timely report, respectively.

- In another incident, as officers searched and processed incarcerated persons in a housing unit prior to releasing them for recreational activities on a prison yard, one incarcerated person became confrontational with the officers and complained about being searched. The department conducts searches of incarcerated persons prior to and upon returning from yard recreation in order to identify and confiscate any possible contraband, which may include narcotics and weapons. Two officers then escorted the incarcerated person to a rotunda area within a housing unit to conduct an unclothed body search of the person in a private setting. The incarcerated person refused to permit officers to search him, and officers determined a low-dose body-scan X-ray was necessary to determine whether the person had concealed contraband on his person. During the escort to the scan, the incarcerated person attacked an officer. Both escort officers used their physical strength to force the person to the ground.

  After the incarcerated person was secured in restraints and no longer presented a threat to the officers, four additional officers used physical force to restrain the person on the ground. These officers reported the incarcerated person did not resist, and they did not articulate an imminent threat prior to using force. For example, one officer stated, "Once [incarcerated person] was on the ground, I assisted with my body weight with downward pressure with my right hand on the middle of the back of (the incarcerated person) to ensure the safety of (a correctional officer) who was placing leg restraints" on the person. None of the institution's levels of review identified concern with physical force being used by four officers without any imminent threat. We presented our concerns to the institution's review committee that officers were using unnecessary force, but the hiring authority disagreed and took no corrective action.

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

Indicator Rating
Poor
71% weighted average score

Superior
No incidents
Zero

Satisfactory
130 incidents
86 percent

Poor
22 incidents
14 percent

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 *satisfactory*. Of the 152 incidents applicable to this indicator,[53] the OIG assessed the department's performance as *satisfactory* in 130 incidents and *poor* in 22 incidents; we assigned no *superior* ratings. Each of the 22 incidents rated *poor* was specific to the Division of Adult Institutions.

The department executive review committees are required to review significant incidents that could have been caused by staff members' use of force, such as those involving warning shots, serious bodily injury, great bodily injury, or death.[54] 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 they may directly request to review incidents. Policy requires that at the departmental level, a review occur within 60 days after the institution's review committee completes its review,[55] 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 152 incidents we monitored that the department executive committees reviewed, we found they identified use-of-force deviations not previously discovered by the institutions' reviews in 32 incidents (23 percent).

The department executive review committee failed to review all incidents required by policy, and those reviews it did perform were often untimely.

Specific to the Division of Adult Institutions, the department executive review committee reviewed only 57 of the 72 incidents (79 percent) that we determined met the criteria for review. To clarify the significance of this inadequate performance: Approximately a quarter of the OIG-monitored use-of-force incidents requiring the highest level of review were not addressed at the departmental executive level. These figures are

53. The 152 incidents applicable to this indicator includes 72 incidents within the Division of Adult Institutions that we determined met the criteria for review and 80 incidents within the Division of Juvenile Justice.

54. DOM, Section 51020.19.6.

55. Ibid.

similar to the findings of our last report, which identified only 55 of the 73 incidents (75 percent) that met the criteria were reviewed.[56]

Table 5 on the next page shows that of the 22 incidents from the Division of Adult Institutions incidents rated as *poor*, the department executive review committee failed entirely to review 13 incidents and reviewed the remaining two incidents late, over six months and one year after the institution's review, respectively. Failure to promptly review incidents may leave significant policy violations unchecked and cause delays in imposing necessary corrective action. Table 5 on the next page presents each of the 15 incidents resulting in serious bodily injuries that could have been caused by staff members' use of force. The list, which includes incidents from each of the department's missions, specifies the type of force used, the initial reported injury, the injury type, and whether the department executive review committee reviewed the incident. In eight of the 15 incidents (53 percent), the serious bodily injury was identified by the incident commander in the incident reports prepared for the institution executive review committee. In the remaining incidents, serious bodily injury was identified by departmental health care staff, by outside health care staff, or in one incident, by the hiring authority.

The following examples from Table 5 illustrate incidents involving serious bodily injury that could have been caused by staff members' use of force at the institution level, but were never reviewed by the department executive review committee to address possible use-of-force policy violations:

- Incident 1 (Table 5) involved two incarcerated persons who, while returning from the evening meal, began striking each other on the head and body. Officers observed the persons fighting in the recreational yard and ordered them to stop fighting and get down on the ground, with negative results. Two officers used oleoresin capsicum (OC) spray, and two other officers each used an expandable baton.

  One officer used a total of eight baton strikes on two incarcerated persons. That officer used his baton on the first incarcerated person four times, striking twice on her buttocks and thigh area. However, the officer missed his target with his other two baton strikes, when he aimed for her shoulder and buttocks, and instead struck her right forearm and shoulder blade. The officer explained that due to the erratic movement of the persons fighting, his intended target was missed. That same officer used an additional four baton strikes on the second incarcerated person, aiming at and striking her buttocks (two strikes), her right thigh (one strike), and her shoulder area (one strike).

56. The OIG, ***Monitoring the Use-of-Force Review Process of the California Department of Corrections and Rehabilitation***, 81.

Table 5. Identification of Serious Bodily Injury

Incident Number	Department Mission	Injury Reported Per Incident Package	Type of Force Used	Injury Type	Subsequent Serious Bodily Injury Identification	Subsequent Serious Bodily Injury Conducted	DERC Review
1	Female Offender Programs and Services	Serious Bodily Injury	MEB	Bone Fracture (right elbow)	N/A	Yes	No
2	Female Offender Programs and Services	Serious Bodily Injury	Physical Strength	Bone Fracture (mandible fracture)	N/A	Yes	No
3	General Population	Serious Bodily Injury	40mm	Bone Fracture (right wrist)	N/A	Yes	Yes (more than 6 months after IERC review)
4	General Population	Serious Bodily Injury	40mm	Bone Fracture (right 4th finger)	N/A	Yes	No
5	General Population	Minor	40mm	Extensive Suturing (8 sutures to right ear)	Outside Hospital (day of incident)	No	No
6	General Population	Serious Bodily Injury	40mm	Extensive Suturing (12 sutures to forehead)	N/A	Yes	No
7	General Population	Minor	40mm	Bone Fracture (right 5th proximal phalanx)	Outside Hospital (day of incident)	No	No
8	General Population	Serious Bodily Injury	40mm	Bone fracture (mandible fracture)	N/A	Yes	Yes (more than 12 months after IERC review)
9	High Security	Minor	40mm	Extensive Suturing (3 sutures behind right ear) Serious Disfigurement	Hiring Authority (during IERC)	No	No
10	High Security	Minor	Physical Strength	Bone Fracture (missing tooth and chipped teeth)	CDCR RN (approximately 4 months after incident)	Yes	No
11	High Security	Minor	40mm	Extensive Suturing (7 sutures to head)	CDCR RN (day of incident)	Yes	No
12	Reception Center	Serious Bodily Injury	40mm	Extensive Suturing (12 sutures to top of head)	N/A	Yes	No
13	Reception Center	Minor	Physical Strength	Bone Fracture (right 5th finger)	CDCR Physician (3 days after incident at new institution)	Yes	No
14	Reception Center	Minor	Physical Strength	Bone Fracture (left rib)	CDCR Medical (during IERC)	No	No
15	Reception Center	Serious Bodily Injury	MEB	Bone Fracture (left rib)	N/A	Yes	No

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

The second officer struck the second incarcerated person twice, aiming at and striking her left buttock area and right leg.

The baton strike of the first officer on the first incarcerated person's right forearm (elbow) was believed to have caused serious bodily injury. Departmental staff conducted a serious bodily injury inquiry and recommended no further action since staff's actions were not considered unnecessary or excessive. A lieutenant received training for failing to appropriately record all injuries during the videotaped serious bodily injury interview. An allegation inquiry was performed by the Allegation Inquiry Management Section, which referred the completed inquiry to the hiring authority for final determination. The department's executive committee did not conduct a review of the incident.

- Incident 5 (Table 5, page 83) involved two incarcerated persons who attacked a third on a prison recreation yard. During the fight, officers used chemical grenades and a 40mm launcher, unintentionally striking an incarcerated person on the head with a 40mm round. We were timely notified of the injury, which was reported as a head strike allegedly caused by a 40mm round. The incarcerated person sustained a laceration on his right ear that required eight sutures. Although the person sustained serious bodily injury (a wound requiring extensive suturing), the institution failed to conduct an inquiry and reported the injury as minor. At the institution review, we recommended the department conduct an inquiry into the serious bodily injury and refer the incident to the department executive review committee, as required by departmental policy. The hiring authority disagreed with our assertion that the person sustained a serious bodily injury and failed to conduct an inquiry into the injury. The department's executive committee did not conduct a review of the incident.

The division force review committee reviewed all required incidents from juvenile justice institutions and improved its average time in reviewing incidents after a facility's review.

The division force review committee reviewed 100 percent of the 81 incidents the OIG monitored that met the criteria for review. The Division of Juvenile Justice requires the division force review committee to review a minimum of 10 percent of serious use-of-force incidents that meet specified criteria, including those involving self-injurious behaviors, serious injuries sustained by a youth or staff, incidents involving only one youth, use of pepper spray on a youth with a mental health designation, and incidents in which a youth alleges unreasonable force.[57]

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

During this reporting period, the Division 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 80 incidents an average of 74 days after the facility's review, which is a 67-day improvement from their average of reviewing incidents 141 days after their occurrence, as we noted in our prior report. In that report, we recommended the Department of Juvenile Justice adopt a policy to ensure eligible incidents are reviewed by the executive review committee within 60 days following the facility's review. The Division of Juvenile Justice reported in June 2021 that the division force review committee had reviewed 93 percent of all use-of-force incidents within 60 days. The department reported that it was able to fully implement this recommendation in September 2021.

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Recommendations

For the January to December 2020 reporting period, we offer four recommendations to the department:

Nº 1. The department should require a diagram or schematic in each elevated post with markings that delineate the maximum range for each type of less-lethal round.

We identified a few instances in which the department determined, after taking actual measurements, that officers fired less-lethal rounds well beyond the maximum allowed distance, yet reported firing at the maximum range. To eliminate the problems inherent in officers' attempting to estimate the maximum distance from their elevated post, we recommend posting a simple diagram of the exercise yard in each control booth and observation tower that would indicate to the officer the points beyond which he or she could not deploy the rounds.

Nº 2. The department should revise its current medical report of injury form to include the time of medical triage, if applicable, in providing documentation of medical evaluations conducted on incarcerated persons involved in use-of-force incidents.

The medical report of injury form available to health care staff does not support accuracy in documenting the time an incarcerated person is first medically assessed. Policy requires that an incarcerated person involved in a use-of-force incident be medically evaluated as soon as practical; the medical report of injury form contains a field labeled "Time Seen," which staff use to document a detailed medical evaluation. In some instances, however, an incarcerated person may receive an initial assessment (triage) to determine whether he or she should receive that detailed medical evaluation immediately, yet no field for documenting triage exists. When triage occurs, then, it likely passes undocumented. In such cases, incarcerated persons who may have been medical assessed in a timely manner appear to have experienced unreasonable delays in receiving medical attention. The OIG recommends the department revise its medical report of injury form to document when health care staff conduct a medical triage.

Nº 3. The department should coordinate with California Correctional Health Care Services to implement a statewide process that would

a. promptly determine whether an incarcerated person received a serious or great bodily injury that could have been caused by staff's use of force, and

b. ensure that a custody supervisor completes a fact-finding investigation prior to an institution executive committee review.

We recommend the department create and follow a consistent statewide process to ensure that possible serious or great bodily injuries that may have been caused by staff's use of force are assessed promptly by medical providers and documented on a medical evaluation form. If serious or great bodily injury is found that could have been caused by a staff use of force, all required procedures should include, in part, a custody supervisor completing a fact-finding review, a video-recorded interview with the incarcerated person no later than 48 hours from discovery of the injury or allegation, and a report that concludes with a recommendation to a custody manager regarding further actions to be taken. This recommendation should be made by custody staff for inclusion in the incident report to be reviewed by the institution executive review committee. This process change will help ensure that each use-of-force incident with serious or great bodily injuries will be properly evaluated and reviewed by the institution executive review committee.

Nº 4. The department should update its current notification policy to ensure accurate and timely notification to the appropriate mission associate director or designee whenever an incarcerated person has suffered serious or great bodily injury that could have been caused by a staff use of force.

Current departmental policy requires a correctional supervisor to notify the Office of Internal Affairs and our office as soon as possible, but no later than one hour, from the time an incident is discovered in which a serious or great bodily injury could have been caused by a staff use of force. Since the policy does not require notification to the mission associate directors, they must rely on other mechanisms[58] to ensure these incidents are reviewed by the department executive review committee within 60 days of completion by the institution's executive review committee. This has resulted in a high failure rate (23 percent) during the past two calendar years in reviewing all incidents involving serious bodily injuries. We recommend the department require that the appropriate mission associate director or designee also be notified when serious or great bodily injury occurs. In addition, we further recommend that whenever serious bodily injury is identified, whether immediately or subsequent to an incident, the department should also ensure accurate and timely notification to all required parties.

58. The department currently directs respective mission-based staff to review a "Daily Briefing Report" or case management system that includes reports of incidents when an incarcerated person has suffered serious or great bodily injury that could have been caused by a staff use of force.

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

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