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1
2 **I.**

3 **INTRODUCTION**

4 A. Background.

5 Pelican Bay State Prison (“PBSP”) Sergeant E.M. Powers (“Powers”) and Correctional
6 Officer J. R. Garcia (“Garcia”) were charged in the United States District Court for the Northern
7 District of California (case CR-00-0105-MJJ) with a conspiracy to violate civil rights (18 U.S.C.
8 § 241) and a substantive count of violations of civil rights (18 U.S.C. § 242). After a trial by
9 jury, Powers and Garcia were each convicted of one count of conspiracy to violate civil rights
10 and sentenced to prison. The cases are presently on appeal.

11 In October 2001, while the Powers/Garcia criminal case was pending, officials from the
12 California Department of Corrections (“CDC”), including attorneys from the CDC Employment
13 Law Unit (“ELU”), prepared a detailed written plan entitled “Follow-up Investigative Plan and
14 Disciplinary Review Process” (“Post Powers Plan”) that called for investigations and discipline
15 of those employees who had violated the PBSP use of force policy because of their involvement
16 with the misconduct of Powers and/or Garcia. The Post Powers Plan was submitted to the
17 Special Master. After several meetings and numerous revisions, it was approved by the Special
18 Master.

19 In June 2002, after the jury verdict in the Powers/Garcia criminal trial, various CDC
20 officials, including the Department’s highest ranking investigators and an ELU attorney, met
21 with Assistant United States Attorney Melinda Haag, one of the U.S. Attorneys who had
22 prosecuted Powers and Garcia. Ms. Haag summarized the evidence presented at the criminal
23 trial. The CDC officials at the meeting concluded that seven incidents of potential staff
24 misconduct warranted further administrative review. During a follow-up meeting on June 8,
25 2002, the decision was reached to pursue three of the seven cases further.

26 The three cases will be referenced by the name of the inmate victim. The Perez case
27
28

1 involved Sergeant Powers allegedly assaulting inmate Perez in the prison chapel hallway; the
2 Black case involved Powers and other correctional officers allegedly assaulting inmate Black in a
3 PBSP gymnasium; and the Chester case involved correctional staff allegedly planning and
4 facilitating the stabbing of inmate Chester in a PBSP recreation yard. The underlying incidents,
5 however, were not the focus of the CDC's investigation. Pursuant to the Post Powers Plan
6 submitted to the Special Master, the CDC intended to investigate whether the subject
7 Correctional Officers: Jones, Matlock, and Tuttle, had committed perjury during their testimony
8 regarding the Perez, Black, and Chester incidents at the Powers/Garcia criminal trial.

9 The Special Master was informed of the CDC's decision to pursue the three cases via a
10 telephone conference with CDC officials in late June 2002. At that time, the cases were
11 described as "solid." The Special Master was provided an update concerning the investigations
12 at a "60-day" meeting in Sacramento in January 2003, and was told that internal affairs
13 investigations had commenced concerning the three cases. In late March 2003, however, the
14 Special Master received a telephone call stating that the investigations had been completed and
15 the decision had been made not to proceed with discipline.

16 In his status report filed July 23, 2003, the Special Master informed the Court that the
17 CDC had failed to comply with the use of force remedial plan and the Post Powers Plan. Rather
18 than completing the investigations in six months, the investigations had not been assigned for
19 four months. Instead of assigning a team of investigators, only one investigator was instructed to
20 complete three complicated and serious investigations. No reports were prepared, no notes were
21 retained, and only a fraction of the key witnesses on one of the three cases were interviewed. The
22 remaining two cases were essentially ignored.

23 The case that was investigated involved Correctional Officer Jones, who allegedly
24 directed Correctional Officer Schembri to look away when Chester was to be stabbed. This case
25 had been discussed with Robert Gaultney ("Gaultney"), Assistant Chief Counsel of the ELU on
26 March 20, 2003. Gaultney instructed the investigator and lawyer assigned to the case to refer it to
27

1 the San Francisco District Attorney. Thereafter, on March 24, 2003, the investigator informed
2 the California Correctional Peace Officers Association (“CCPOA”) that the CDC had made the
3 decision to “go criminal.” A few days later the investigator was ordered to appear at a meeting
4 with the then Director of Corrections, Edward Alameida (“Alameida”). On March 27, 2003, one
5 week after Gaultney made the decision to “go criminal,” all three investigations were shut down
6 by Alameida.

7 The Special Master subsequently received a “fact finding” letter prepared by the CDC’s
8 Central Office to support the decision to close the investigations. Several statements within that
9 letter were false. For example, concerning the incident where Officers Jones and Matlock are
10 alleged to have covered up Sergeant Powers’ alleged assault of inmate Perez, the letter stated:
11 “Perez’s credibility is questionable due to a history of mental illness.” As verified by Court
12 expert Dr. Jeffrey L. Metzner, Mr. Perez does not have a mental illness or a history of mental
13 illness. Concerning the allegation that Officer Jones allegedly told Officer Schembri to look
14 away when inmate Chester was to be stabbed, the letter stated : “Officer Manzano was in the
15 control booth during the alleged conversation between Schembri and Jones and stated he did not
16 hear the alleged conversation.” CDC documents and the trial transcript, however, prove this
17 statement to be inaccurate. Officer Manzano testified under a grant of immunity that he was in
18 the control booth when Officer Jones spoke to Officer Schembri and he did hear a conversation
19 about inmate Chester being in trouble, but heard nothing about Chester being stabbed. The
20 Special Master also informed the Court in his status report that the CDC had missed the one year
21 statute of limitations to file administrative charges against Officers Jones, Matlock, and Tuttle, if
22 any administrative action was warranted.

23 Based on these initial findings, the Special Master recommended a series of hearings
24 concerning the Post Powers/Garcia investigations and the decision to shut down the three cases.
25 At the Status Conference of July 28, 2003, the Court instructed the Special Master to proceed
26 with those hearings and develop a full record and report.

1 3. Any involvement in a coordinated effort with other staff to prohibit factual
2 information from being reported as required in the Use of Force Policy.

3 See, Use of Force Disciplinary Procedure Section V.C. 2-3 (9/30/02)

4 At the conclusion of the investigation, the investigator shall provide a detailed
5 report of the investigation on a CDC Form 989A and B, Internal Affairs
6 Investigation Report. The CDC Form 989A and B shall be filled out completely
7 and contain the facts and evidence discovered by the investigator.

8 See, Use of Force Investigation Policy and Procedure Section VIII.B.3 (9/20/00)

9 The findings of each allegation shall be noted as to whether the inquiry
10 supports or refutes the allegation(s). The investigator shall arrive at one of the
11 following findings identified in Section VII, Subsection B, (5), (b), of this
12 procedure.

13 See, Use of Force Investigation Policy and Procedure Section VIII.B.4 (9/20/00)

14 A Court approved use of force policy and investigation policy has been in place at PBSP
15 since 1996. Not surprisingly, these policies have been modified over time; however, essential
16 provisions have remained consistent. The provisions above were in place at the time of the
17 CDC's Post Powers administrative investigations.

18 The CDC officials who attended the meeting in the Director's Office on March 27, 2003
19 were well aware of the existence of these orders. For example, the Special Master met with
20 Alameida in his office at CDC Headquarters shortly after Alameida's appointment as Director.
21 At that time, the Special Master provided Alameida with a verbal and written summary of the
22 status of remedial plan efforts, emphasizing that monitoring was still necessary concerning
23 adverse action discipline cases. Alameida also attended several "60-day" meetings in
24 Sacramento with the Special Master and counsel for the parties where investigation and
25 employee discipline cases were discussed.

26 Thomas Moore ("Moore"), the Deputy Director of the Office of Investigative Services
27 ("OIS"), the highest level investigator in the Department of Corrections, had been assigned to
28 investigate PBSP employee misconduct cases prior to his appointment as Deputy Director. He

1 acquired, during those investigations, specific knowledge of the PBSP use of force remedial plan.
2 Moore also attended various 60-day meetings in Sacramento. Kathy Kinser (“Kinser”), Chief
3 Deputy Director, had worked with the Special Master on remedial plan revisions, including
4 revisions pertaining to use of force policy modifications concerning “Skelly” hearing procedures.
5 Likewise Dennis Beaty (“Beaty”), Staff Counsel and retired annuitant Brian Parry (“Parry”)
6 (former acting Deputy Director of OIS) had knowledge of, and prior involvement with,
7 investigations and discipline of PBSP inmates based on the Court approved use of force remedial
8 plan.

9 III.

10 THE SPECIAL MASTER’S HEARINGS AND DOCUMENT REQUESTS

11 The Special Master conducted five days of hearings concerning the Post Powers/Garcia
12 administrative investigations prior to issuing his draft report. The dates of the hearings,
13 witnesses, and references to the transcript are set forth in Appendix 1. The transcripts for all
14 hearings have been lodged with the Court, as were the exhibits placed in evidence during those
15 hearings. The page numbers for the transcripts are sequential; therefore, citations to testimony
16 from the hearings will reference the name of the witness, followed by “Tr.” and the page of the
17 transcript where that testimony is found.

18 Exhibits placed into evidence during the hearings are listed in Appendix 2. The Special
19 Master also refers to additional exhibits in this report, documents provided by the Department of
20 Corrections and reports from Court expert Dr. Patrick Maher. These exhibits are listed in
21 Appendix 3. Finally, the Special Master also reviewed and considered a number of documents
22 provided by the Department of Corrections which are not referenced in this report. Those
23 documents are listed in Appendix 4. Appendix 5 is a glossary of Department of Corrections
24 acronyms used in the report.

25 The exhibits listed in Appendices 2-3 are filed with the Court concurrently with the filing
26 of this report. Exhibit 29, an Office of the Inspector General (“OIG”) report concerning
27

1 problems with the OIS, was to be filed under seal. Its contents, however, have been the subject
2 of public hearings and other proceedings to a degree that the report is no longer confidential.
3 Therefore, Exhibit 29 is not filed under seal.

4 The Special Master held numerous discussions with counsel during the hearing process.
5 He allowed counsel for the parties to examine and cross-examine witnesses. The Special Master
6 also allowed the parties the opportunity to call their own witnesses during the hearings. For
7 example, defendants presented the testimony of Michael Miller and David Tristan (“Tristan”).
8 In addition, the parties were provided the opportunity to submit documentary evidence in
9 addition to documents placed in evidence by the Special Master. For example, defendants
10 submitted into evidence exhibits 25 and 32. The parties were also offered the opportunity to
11 argue at the final hearing; however, both plaintiffs and defendants declined the offer.

12 In addition to the hearings described above, the Special Master issued a draft report in
13 January 2004 and thereafter held three additional hearings to allow for objections and comments
14 to that report. He met and conferred with the Youth and Adult Correctional Agency (“YACA”)
15 and CDC representatives on numerous occasions concerning proposed remedial plans, and also
16 attended three days of California State Senate hearings that addressed correctional officer
17 misconduct, the code of silence, and problems with the Memorandum of Understanding
18 (“MOU”) between the CDC and the CCPOA.

19 IV.

20 THE SPECIAL MASTER’S COMPLIANCE WITH THE ORDER OF 21 REFERENCE FILED JANUARY 23, 1995

22 A. Introduction.

23 The Special Master served a draft version of this report on the parties on January 15,
24 2004. A formal hearing concerning the findings of fact and the Special Master’s first, second,
25 and fourth recommendations was held at 9:00 a.m. Friday, February 27, 2004. A second hearing
26 was conducted to discuss the parties’ objections to the Special Master’s third recommendation at
27

1 1:00 p.m. the same day.

2 Plaintiffs filed a letter with the Court on February 20, 2004 that raised no objections
3 concerning the Special Master's factual findings (CR 1720). Defendants raised two limited fact
4 finding objections and three objections relating to systemic recommendations in the responsive
5 pleading they filed on February 20, 2004 (CR 1721). Defendants' objections are discussed in
6 subsection B. below.

7 Former Director of Corrections Edward Alameida, represented by Mildred O'Linn and
8 David Bancroft, raised extensive factual and legal objections to the draft report's findings of fact
9 and the Special Master's first and second recommendations in an Objection filed with the Court
10 on March 3, 2004 (CR 1726). According to defendants, after the Special Master filed his draft
11 report the Office of the Attorney General determined that a conflict precluded their representing
12 Alameida concerning the Special Master's draft recommendations. The CDC determined,
13 however, that it should pay for conflict counsel for the former Director. Alameida's attorneys
14 requested and were granted a continuance to prepare their objections. They argued their
15 objections at a hearing on February 27, 2004 (the transcript for this hearing has been lodged with
16 the Court). Alameida's objections are discussed in subsection C. below.

17 Former Deputy Director of OIS Thomas Moore failed to file timely objections to the draft
18 report. Similar to Alameida, the Attorney General declared a conflict concerning Moore's legal
19 representation. Unlike Alameida, however, Moore was not provided with a conflict attorney by
20 the Department of Corrections. On March 3, 2004 the Special Master was contacted by Paul
21 Goyette, who had been retained by Moore. Mr. Goyette requested a continuance, which was
22 granted. In total, the Special Master allowed Mr. Goyette four additional weeks to file written
23 objections for Thomas Moore.

24 Moore's objections to the draft report were filed on April 12, 2004 (CR 1734). A third
25 hearing was held on May 7, 2004 concerning Moore's objections (the transcript for this hearing
26 has been lodged with the Court). *See* subsection D., below.

1 The Special Master was also contacted by Katie S. Hagen, Assistant Deputy Director of
2 the CDC's Office of Selection and Standards. Ms. Hagen expressed concern about the
3 completeness and accuracy of the Special Master's draft findings re the "11 hour rule" limitation
4 concerning background checks for correctional officer applicants. Ms. Hagen's concerns are
5 addressed in subsection E. below

6 The CCPOA filed the Declaration of Ronald Yank (with attachments), and a pleading
7 entitled the California Correctional Peace Officer Association Points and Authorities (with
8 attachments) on February 20, 2004. Mr. Yank filed a second Declaration Correcting Inadvertent
9 Errors on February 23, 2004 (*see* CR 1719, 1722). In addition, the CCPOA provided the Special
10 Master with a February 20, 2004 letter from Mr. Yank (Exhibit 61). After an initial evaluation of
11 the filings, the Special Master informed the CCPOA that he would treat the filings as an amicus
12 brief and denied the CCPOA's request to argue at the hearing of February 27, 2004 (Exhibit 62).
13 The issues raised by the CCPOA are discussed in subsection F. below.

14 B. Defendants' Objections to the Draft Report.

15 Defendants raise two types of objections: (1) objections to findings of fact and (2)
16 objections to recommendations to the Court.

17 1. *Objections to Findings of Fact:* Defendants object to the Special Master's
18 finding at paragraph "O" of page 46 of his draft report, that: *the OIS failure to conduct adequate*
19 *Post Powers/Garcia investigations is indicative of serious systemic problems the Department of*
20 *Corrections has failed to correct for more than two years.* Defendants propose that the Special
21 Master replace the word "is" with "may be," pointing out that the OIS conducts thousands of
22 investigations.

23 The Special Master disagrees with defendants' objection. As explained below, the
24 problems with the Post Powers investigations are identical to the systemic shortfalls of OIS
25 operations that have been identified by the OIG, problems that the CDC did not begin to correct
26 until *after* the Special Master begin his formal hearings. All of the testimony, including that of
27

1 Moore and the Agent in Charge of the Northern Region of OIS, Sandi Grout, indicate that the
2 problems that arose concerning these investigations are indicative of problems that have arisen in
3 many other cases. The fact that many other investigations are processed by OIS does not change
4 this fact. Furthermore, defendants' objection is not entirely accurate. OIS does not process
5 "thousands" of investigations that involve the abuse of prisoners or ethical misconduct by
6 correctional officers.

7 Defendants also object to the Special Master's finding that Robert Gaultney was not
8 entirely truthful in his testimony, as demonstrated by an e-mail issued by him (draft report at
9 page 22 and Exhibit 54). Defendants' contention that Mr. Gaultney was not shown the damaging
10 exhibit during his testimony is correct. Therefore, the Special Master has modified this section
11 of his final report.

12 2. *Objections to Recommendations.*

13 a. Defendants object to the Special Master's draft recommendation re civil contempt.

14 The draft report recommended the following:

15 *The Court should issue an Order to Show Cause re Civil Contempt for defendant*
16 *Director of the Department of Corrections for violations of the Court approved*
17 *Use of Force Discipline Remedial Policy, Use of Force Disciplinary Procedure,*
18 *and the Use of Force Investigation Policy and Procedure. To purge this*
contempt, defendants should be ordered to develop and implement in a timely
manner a comprehensive remedial plan . . .

19 Defendants raise two objections. First, defendants contend that the Special Master cannot
20 recommend civil contempt and that the evidence needed to prove disobedience to a specific and
21 definite court order is not shown in the report. The Special Master disagrees.

22 To begin, the Special Master is not "bringing" a contempt motion, he is recommending
23 that the Court consider civil contempt as a remedy to purge the prior violations of its order. As
24 explained in the finding below, undisputed evidence exists concerning violations of the Court's
25 orders (although CDC officials attempted to characterize their misconduct as gross incompetence
26 and negligence rather than deliberate actions). These violations are affirmed in reports issued by
27

1 the OIG. Thus, there is no reason to reconsider the civil contempt recommendation based on
2 defendants' first argument.

3 Defendants, however, emphasize that the Department of Corrections and other State
4 agencies are now actively engaged in the development of a remedial plan that addresses the
5 concerns of this report. Defendants stress in their objections that "an Order to Show Cause re:
6 Civil Contempt is not required to compel Defendants to produce a remedial plan or implement
7 one." The Special Master agrees. As explained in Section VI, Discussion of Recommendations,
8 has a new Governor, a new Secretary of the Youth and Adult Correctional Agency, and a new
9 Director of Corrections. Given these changes, given the renewed effort by the CDC's Central
10 Office to deal with problems of outside influence, bad investigations, and inadequate correctional
11 officer discipline, the Special Master has withdrawn his recommendation re civil contempt.

12 b. Defendants also express concern about the generalized language used in the Special
13 Master's draft recommendation re Court monitoring. Specifically, defendants seek assurance
14 that monitoring by the Special Master will be limited to use of force cases and will not extend to
15 all internal affairs investigations (for example, investigations of correctional officer misconduct
16 outside the prison such as spouse abuse, theft, driving under the influence, etc.). The Special
17 Master agrees with this objection. The monitoring recommendations are limited to the abuse of
18 force and ethical misconduct (including the code of silence).

19 c. Defendants also contend that monitoring should be limited to "Pelican Bay and CDC
20 Headquarters" and not extend to other prisons. In response, the Special Master notes that
21 evidence is already before the Court, for example a report prepared by the OIG concerning
22 adverse action discipline, which proves that the employee discipline problems identified at PBSP
23 exist at other CDC prisons. The evidence gathered in the Post Powers investigation demonstrates
24 that the investigation shortfalls of OIS adversely impact on all CDC institutions. Concerning
25 almost every aspect of the problems described in this report, the shortfalls emanate from the
26 CDC's Central Office in Sacramento, which serves all prisons. Likewise, the OIS and the ELU

1 serve all prisons. In similar fashion, the policies at issue in the Post Powers investigation pertain
2 to all prisons. Finally, the Senate hearings attended by the Special Master and referenced in this
3 report produced testimony about problems with investigations, discipline, and the code of silence
4 at numerous other CDC prisons.

5 The Special Master believes, therefore, that an appropriate and balanced monitoring
6 program must be developed that considers the limitations of this litigation and the need to correct
7 and monitor the correction of the very serious *systemic* problems that presently exist. As
8 mentioned above, the problems discovered during the Post Powers investigation involve the
9 officials, policies, and practices of the CDC's Central Office headquarters in Sacramento. Thus,
10 minimally adequate monitoring must include Central Office processes, including OIS reviews of
11 use of force cases and correctional officer integrity cases at other prisons.

12 On February 25, 2004 the Special Master submitted a five page letter to counsel that
13 addressed the scope of monitoring and set forth proposed monitoring provisions for his final
14 report. A meeting was held on February 27, 2004 to discuss the issue. Neither party has raised
15 objections to the monitoring provisions recommended by the Special Master. The Special
16 Master incorporates those provisions in the monitoring recommendations in this report. Given
17 the cooperation between the parties concerning the Post Powers remedial efforts, the Special
18 Master is confident that the issue of monitoring can be handled in a manner that takes into
19 account jurisdictional limitations as well as the desire by all parties to solve the problems of
20 ineffective investigations and ensure employee discipline in an adequate, timely, and cost
21 effective manner.

22 C. Alameida's Objections to the Draft Report.

23 Edward Alameida's Amended Notice of Lodging of Amended Objections of Edward
24 Alameida to Special Master's Draft Report with Amended Appendices A Through C Filed
25 Concurrently and Attached Thereto can be divided into two distinct sets of objections (*see* CR
26 1726). Pages 1 through 152 consists of specific objections to the draft report itself, including
27

1 proposed alternative language to many portions of the Special Master’s report. The amended
2 appendices, 36 pages in length, set forth Alameida’s legal contentions concerning the draft
3 report.

4 *1. Alameida Objections to the Format and Factual Content of the Draft Report.*

5 The Special Master has reviewed Alameida’s objection concerning the content and format
6 of the draft report. He also requested that Dr. Patrick Maher perform an independent evaluation
7 of each factual objection.

8 In essence, Alameida proposes to substitute his credibility determinations for those of the
9 Special Master, and to ignore a considerable amount of relevant information, including, for
10 example, Officer Lewis’ shooting of an unarmed Pelican Bay inmate. For the most part, the
11 Special Master disagrees with Alameida’s proposed modifications to the draft report. Many
12 objections misinterpret the testimony and the documents presented at the hearings; for example,
13 several objections rely only upon a specific sentence or one small part of a transcript and ignore
14 the rest of the evidence accumulated by the Special Master. Other objections are based on a
15 fundamental misunderstanding of the role of the Special Master, assuming inaccurately that the
16 Special Master must ignore personal observations, his discussions with the parties, and the long
17 history of this case. Alameida’s proposed revisions to the report also seek to discount or ignore
18 the testimony of Assistant United States Attorney Melinda Haag, and to substitute Ms. Haag’s
19 description of what was proven at the trial with selected portions of the transcripts of Officer
20 Jones, Matlock, and Tuttle, the very officers who were under investigation by the Department of
21 Corrections until Alameida closed the cases. Finally, Alameida attempts to interpret the evidence
22 concerning what took place in his office on March 27, 2003, the day that the Post Powers
23 investigations were shut down, as nothing more than a simple error, caused in part by his
24 subordinates. This interpretation of the facts is not supported by the evidence. Therefore, the
25 Special Master rejects the great majority of the modifications and findings proposed by Alameida
26 and his attorneys.

1 Each objection to the draft report was, however, carefully considered. Working with Dr.
2 Maher, the Special Master made forty-three changes to the text of this final report based on
3 modifications proposed by Alameida.

4 *2. Alameida's Legal Objections to the Draft Report.*

5 a. Jurisdictional/Due Process Objections (Appendix pgs. 21-27)

6 Alameida raises two objections which question the Special Master's authority to conduct
7 an investigation into why the Post Powers investigations were shut down by the Director of
8 Corrections.

9 First, Alameida argues that the Special Master exceeded his authority by taking testimony
10 at the hearings to determine why the defendants violated the Court's use of force investigation
11 orders, who was responsible for the violation, and whether the violation was a deliberate effort.
12 Essentially, Alameida contends that the evidence gathered by the Special Master should be
13 limited to determining whether an act of non-compliance with a Court order has taken place
14 (Appendix pg. 22, lines 16-20). Once non-compliance has been demonstrated, Alameida argues,
15 the Special Master should cease any investigation into the causes of the non-compliance. The
16 Special Master disagrees. A full record and report about the closure of the Post Powers
17 investigations required a determination into why the investigations were closed, the
18 circumstances under which they were closed, and who was responsible for the closures. Indeed,
19 a report that informed the Court of nothing more than a finding of a violation of Federal orders,
20 without explaining the scope of the violation and identifying the CDC officials responsible,
21 would be useless. Alameida's proposed limitations on the Special Master's authority serves only
22 to encourage future instances of official misconduct.

23 Second, Alameida disputes the Special Master's draft findings and recommendations by
24 attempting to characterize the Special Master's hearings as a "critical stage" of a Federal Court
25 criminal proceeding (Appendix pgs. 23-26). The characterization is inaccurate. Alameida also
26 misstates the record.

1 The Special Master’s requests for documents and the hearings under oath were conducted
2 for to assemble a full record and report concerning what had transpired concerning the closure of
3 the Post Powers investigations. The defendants in this case, including Alameida, did not provide
4 this information voluntarily. The hearings were not conducted to determine whether the Director
5 of Corrections should be charged with criminal contempt; indeed, at the time the Post Powers
6 hearing began, the Special Master did not know the true facts concerning why the investigations
7 had been shut down. In fact, the full scope of the violations of Court orders was uncovered only
8 because of the hearings. As soon as an adequate record was obtained, however, the Special
9 Master ceased his evidence gathering and issued a draft report, as required by the Order of
10 Reference. Contrary to Alameida’s assertions, no critical phase of a criminal proceeding has
11 been conducted by the Special Master.

12 The claim that “[t]he Special Master’s hearings were conducted without notice to Mr.
13 Alameda that he was a criminal target” (Appendix pg. 25, line 6-7) is entirely false. Early in the
14 Post Powers investigative process, defendants proposed, as an alternative to formal hearings, an
15 “informal” meeting between CDC officials, the Special Master, and counsel. The Special Master
16 informed both Scott Mather, the Deputy Attorney General representing Alameida, and Kathy
17 Keeshen, Deputy Director of the CDC’s Legal Affairs Division, that he did not know what the
18 evidence might reveal, and therefore was not inclined to obtain “informal” information. Both
19 attorneys understood that evidence of willful misconduct might be uncovered, and both discussed
20 the issue of a conflict of interest with the Special Master. Based on this discussion, the one
21 informal meeting that was held did not include Alameida.

22 Furthermore, defendants, including Alameida, did not raise objections during the hearings
23 complaining that the Special Master was intruding upon criminal due process rights. No one
24 asserted at any time, including Alameida on the day he testified, that the Special Master was
25 embarking on a critical phase of a criminal prosecution. It should also be noted that Alameida
26 was accompanied by conflict counsel Mildred O’Linn, the same conflict attorney who represents
27

1 him now, when he appeared to testify under oath on November 21, 2003. Alameida and his
2 attorneys made the conscious decision to participate in the Post Powers hearing process. His
3 objections arose only after the Special Master issued his draft report.

4 b. Objections Relating to the Manner by Which the Special Master has Provided
5 Information to the Court.

6 Alameida also raises two objections to the manner in which the Special Master has
7 provided information to the Court.

8 First, Alameida objects to the Special Master's reference to an unrecorded conversation
9 between he and the Special Master (Appendix pg. 28). To some degree, this and related
10 objections by Alameida are based on a misunderstanding of the role of the Special Master.

11 The Special Master functions as the eyes and ears of the Court when performing his
12 monitoring duties. As reported below, the Special Master had a conversation with Alameida
13 wherein the Director made statements that are inconsistent with his testimony under oath. The
14 Special Master has every obligation to bring this conflict to the Court's attention, as well as his
15 concerns about Alameida's credibility. The great majority of monitoring information gathered by
16 the Special Master is obtained through prison inspections, the review of documents, meetings
17 that are not recorded, and discussions with inmates and PBSP staff that are also not recorded.
18 The Order of Reference specifically provides for the Special Master going on-site at the prison
19 and gathering information through informal discussion. The Special Master's investigation of
20 the Post Powers investigation involved both formal and informal evidence gathering. It is
21 entirely consistent with his past practices. To summarize, there is no "recorded testimony only"
22 limitation on the Special Master's ability to inform the Court of compliance problems.

23 Second, Alameida objects to the Special Master attaching Exhibits 45 - 48 prepared by
24 the Court's use of force expert, Dr. Patrick Maher to this report concerning credibility
25 assessments. (*see* Appendix at pgs. 29-31). The Special Master rejects this credibility related
26 objection. Alameida and his appointed "Directorate" (Alameida, Kinser and Tristan) made
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1 credibility assessments that should be brought to the Court's attention. In fact, Alameida and the
2 Directorate shut down the Post Powers investigations following a thirty to forty minute meeting
3 on March 27, 2003, based in part, according to his testimony, on credibility assessments of the
4 victims and witnesses to the alleged staff assaults on inmates. The Directorate's credibility
5 determinations are set forth in the letter subsequently sent to the Special Master (Exhibit 19).

6 Given these facts, the Court should be provided with expert reports that explain the nature
7 and scope of each incident under investigation, and include an assessment of witness testimony.
8 Dr. Maher is not offering an opinion about the credibility of a witness in a criminal case that is
9 being heard by a jury. He is providing the Court with compliance related information relative to
10 the credibility of officer statements. The opinions are intended to assist the Court to determine
11 whether the Post Powers cases were closed for a legitimate reason, or were closed because of
12 outside influences. The Court, of course, has the discretion to assign a weight to Dr. Maher's
13 opinions; however, there is no reason to exclude them entirely, especially given the excuses
14 offered for the closure of the Post Powers investigations by Alameida, Kinser, and Tristan.

15 Likewise, Dr. Maher's detailed explanation of the operation of the code of silence, and
16 the dynamics of the meeting in Alameida's conference room on March 27, 2003 (Exhibit 50) is
17 also relevant. As explained in detail below, Alameida, Kinser, and Tristan characterize, in their
18 testimony, the meeting as being cordial and open, where everyone was provided ample
19 opportunity to give their real opinion. Employment Law Unit attorney Joseph Barbara
20 ("Barbara"), Parry, and OIS investigator Robert Ballard ("Ballard") testify to a different meeting
21 environment. To the degree Exhibit 50 provides relevant information concerning this crucial
22 event, it should be considered by the Court, which can give it whatever weight it deems
23 appropriate.

1 c. Objections Relating to Criminal Contempt.

2 Alameida raises three objections that presume criminal contempt charges will be filed
3 against him. While these objections are premature, the Special Master sets forth a brief response
4 below.

5 i. *Alameida's Argument That the PBSP Use of Force Investigation Policy*
6 *was not adopted by the Court's June 21, 2000 Order (Appendix pg. 2).*

7 Alameida argues that the Court's Order of June 21, 2000 did not adopt the PBSP
8 modified Use of Force Investigation Plan. Therefore, Alameida contends, he has not violated a
9 Court order even if he violated the PBSP Use of Force Investigation Policy. The Special Master
10 notes that this objection is limited to the Recommendations 1. b. & 1.c. The other two contempt
11 recommendations (Recommendation 1.a. & 1.d.) pertain to violations of the Use of Force
12 Discipline Policy. Alameida has not raised this objection relative to the Use of Force
13 Disciplinary Policy.

14 The Special Master disagrees with Alameida's limited objection for two reasons. First,
15 the Special Master believes that the Order of June 21, 2000 did adequately adopt the revised
16 PBSP policy. Second, even if the Order of June 21, 2000 did not adopt the revised Use of Force
17 Investigation Policy, the provisions of the revised policy that were violated had been adopted by
18 the Court in prior orders. For example, the Order Re Use of Force Investigation Policies filed
19 April 24, 1998 (Exhibit 24, placed into evidence by defendants) proves that the Court adopted
20 DOM section 31140 and the Revised Use of Force Disciplinary Policy revised March 11, 1998.
21 The provisions in the DOM and revised policy are almost identical to the provisions set forth in
22 the 2000 revised PBSP Policy. In fact, since the Court adopted the DOM, Alameida's decision
23 not to follow DOM requirements for closing out investigations during the meeting of March 27,
24 2003 provide the basis for another violation of Court orders.

1 For example, DOM section 31140.14 requires:

2 “Upon completion of each Category II internal affairs investigation the special
3 agent shall forward the completed investigation and all supporting documents,
4 including investigative notes and case file documents to the regional special agent
5 in charge via the senior special agent and legal counsel. The completed
6 investigation shall include all relevant information supporting or refuting the
7 allegations. The investigation shall contain the findings of fact. Upon approval of
8 the completed investigation the regional special agent in charge shall forward a
9 complete copy, including all original exhibits, investigative notes, and case file
10 documents to the hiring authority who requested the investigation.”

11 As the facts below demonstrate, Alameida and Moore shut down the investigation, no
12 final report was completed, and the case was never referred to PBSP Warden Joe McGrath.

13 *ii. Alameida’s Argument That There is no Evidence he had Knowledge of*
14 *the Court’s Order (Appendix pg. 3).*

15 As mentioned above, based on prior meetings with Alameida and Moore, the Special
16 Master is convinced that both of these high level CDC officials had specific knowledge of the
17 Court’s orders re investigations and employee discipline. Furthermore, in early 2002, Alameida
18 was personally involved in a problem involving the CDC/CCPOA MOU violating a provision of
19 the use of force discipline policy relative to “Skelly” hearing requirements. The Special Master
20 held three meetings concerning this problem; the first in Federal Court in Sacramento, the second
21 at the Office of the Attorney General in San Francisco, and the third in Federal Court in San
22 Francisco. Alameida attended both of the San Francisco meetings. Use of force investigations,
23 including how the hiring authority manages investigations, and numerous details of the discipline
24 policy were discussed for several hours at each meeting. Alameida was also personally involved
25 in proposing changes to the CDC “Skelly” hearing procedures based on his concern about the
26 impact of the Court orders on the MOU and the CDC’s DOM. There is no question that the
27 former Director had detailed knowledge of both the PBSP’s discipline and investigation policies
28 long before the meeting in his office on March 27, 2003.

Finally, as explained below, Alameida, Moore, Kinser, Beaty, and Parry testified they
were aware of the importance of the Post Powers investigations relative to Madrid compliance;

1 indeed, there is no other explanation for the Director of Corrections to hold a meeting on March
2 27, 2003 about an use of force investigation concerning PBSP staff.

3 *iii. Alameida's Argument that the PBSP Use of Force Investigation Policy*
4 *Did Not Apply to him (Appendix pgs. 4-6).*

5 Alameida also contends that the PBSP remedial plan applies only to PBSP, citing specific
6 provisions of the Use of Force policy. The Special Master disagrees. Alameida was a named
7 defendant in the *Madrid* litigation. As the Director of Corrections he was subject to all remedial
8 orders. Furthermore, Alameida, at the meeting of March 27, 2003, made the decision to close
9 down the Post Powers investigation. He essentially by-passed PBSP and the proper hiring
10 authority, Warden Joe McGrath. Alameida guaranteed that the Court's orders pertaining to
11 Pelican Bay State Prison would not be enforced by preventing the Post Powers cases from ever
12 reaching Pelican Bay. Under these circumstances, the remedial orders, in the opinion of the
13 Special Master, apply to the Director of Corrections.

14 The Special Master notes that there is a common thread running through certain of
15 Alameida's objections that calls for discussion. Alameida argues that not all of the specific facts
16 necessary to prove each and every element of criminal contempt have been proven at the Post
17 Powers hearings. The hearings, however, were for the purpose of developing a record and report
18 of what caused the Post Powers investigations to be closed down. The hearings were not
19 conducted to obtain evidence of every element of a willful violation of the Court's orders by
20 CDC officials. To the contrary, when the Special Master concluded his review and made his
21 initial determination to recommend that the Court consider an Order to Show Cause ("OSC") re
22 contempt, he determined that it would not be appropriate to conduct further hearings into the
23 requirement of criminal contempt. Rather, the consideration of these issues should be left to the
24 Court to make. Furthermore, if the contempt process begins, it should take place before an
25 Article III Judge, and not before the Special Master.

1 d. Evidentiary Objections.

2 Alameida also raises four evidentiary objections.

3 i. *Documents missing from record (Appendix pg. 29).*

4 In an excess of caution, the Special Master provided the parties with a list of the
5 documents that he reviewed during the Post Powers investigation process but did not attach to his
6 report (see Appendix 4). Alameida complains that he “has not been provided with copies of
7 those documents.” The objection is without merit. The documents listed in Appendix 4 were
8 obtained from the Department of Corrections. At the time the documents were gathered,
9 Alameida was the Director of Corrections. Alameida’s attorneys had copies of the documents
10 listed in Appendix 4; after all, CDC counsel provided the documents to the Special Master.
11 There appears to be a failure to communicate between Alameida’s conflict attorney and counsel
12 for the CDC, a problem that was not created by the Special Master.

13 ii. *Non testifying witnesses not excluded during hearing (Appendix pg.*

14 *31).*

15 Alameida complains that non testifying witnesses were not excluded during the Post
16 Powers hearings. Defendants, however, did not seek exclusion. Likewise, Alameida did not
17 request exclusion, including the day he testified accompanied by Ms. O’Linn, his conflict
18 attorney.

19 iii. *Attorney/client privilege (Appendix pgs. 31-33).*

20 On December 8, 2003, several weeks after Alameida had retained conflict counsel, the
21 Special Master requested a number of documents from defendants that related to statements
22 made by Alameida during his testimony on November 21, 2003. Some of the documents were
23 requested to test the veracity of Exhibit 32 (a note from Alameida’s secretary and copies of
24 Alameida’s calendar pertaining to the meeting of March 27, 2003) which Alameida’s attorneys
25 submitted as evidence, without prior notice, at the hearing of November 21, 2003. Other
26 requested documents related to the decision to pay for Correctional Officer David Lewis’

1 criminal defense.

2 On January 2, 2004 defendants produced both a privilege log and the requested
3 documents to the Special Master and plaintiffs' counsel. When the hearings resumed on January
4 9, 2004 the Special Master questioned witness Peter Jensen about the documents that had been
5 produced. The Special Master then placed into evidence exhibits 33 through 38, including a
6 legal opinion from Legal Affairs attorney Mark Mustybrook (Exhibit 38). (Tr. 910-917). No
7 objections were raised. Thereafter, Mr. Specter questioned Mr. Jensen about the exhibits. (Tr.
8 920-926). Again, no objections were raised. Following Mr. Specter's questions, Counsel for
9 defendants requested a brief recess. A five minute recess was granted, which took eight minutes.
10 (Tr. 930). Deputy Attorney Generals and lawyers from the CDC's Legal Affairs Unit were
11 involved in the recess discussion. Following the recess, no objections were raised concerning the
12 documents. Thereafter, the Special Master heard testimony from Joe Reynoso and Frank King.

13 Another recess was granted prior to the conclusion of the day's testimony. After that
14 recess, defendants informed the Special Master that the documents which had been placed into
15 evidence were inadvertently provided, apparently due to a failure to communicate between the
16 Legal Affairs Unit and the Attorney General. According to the statements of defense counsel,
17 defendants were unaware of the delivery of the documents because of the failure by a Legal
18 Affairs attorney to review the pleadings submitted to the Special Master and plaintiffs by the
19 Attorney General. No attorney client objection was raised at that time. Defendants did ask the
20 Special Master to file the documents under seal. (Tr. 951). The Special Master denied this
21 request and instructed defendants to file objections with the Court. (Tr. 956). Defendants did
22 not, and have not, filed such objections.

23 As explained above, the documents were requested by the Special Master based on the
24 testimony of Alameida himself. Both the Attorney General and conflict counsel were aware of
25 this fact. The documents in question were provided to the Special Master and plaintiffs after
26 review by the Attorney General. According to the testimony of the attorneys representing
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1 Alameida, the disclosure was because a Legal Affairs attorney assigned to the *Madrid* case failed
2 to review the Attorney General’s submission. Thereafter, however, defendants made no effort to
3 correct the allegedly erroneous submission. For example, there was no effort to correct the
4 disclosure between the date the documents were provided and the January 9, 2004 hearing. (Tr.
5 952-956). Furthermore, Alameida was represented by counsel at the hearing of January 9, 2004;
6 indeed, there were numerous lawyers from both the Attorney General’s Office and CDC Legal
7 Affairs in the courtroom. Nevertheless, those attorneys failed to raise attorney client privilege
8 objections at that time.

9 The record is not in dispute. Neither Alameida nor his attorneys made reasonable efforts
10 to protect or to preserve the privilege. The documents were made public at the hearing, there was
11 extensive testimony on the record about the documents, and the privilege has been waived.

12 *iv. Lewis Legal Fee Testimony and Contact with CCPOA Leaders*
13 *(Appendix pgs. 35-36).*

14 Finally, Alameida argues, “[a]ll references to the David Lewis case should be struck,”
15 contending that “[t]he Lewis prosecution had nothing to do with the Powers/Garcia case.” This
16 statement is simply wrong. Before he was fired from the CDC for misconduct that included
17 calling inmates “primates,” “monkeys,” “toads,” and “niggers,” and for demeaning actions
18 toward sex offenders, Correctional Officer David Lewis worked for Powers. As shown in
19 Exhibit 26, Lewis was involved in the pattern of mistreatment of inmates organized by Powers
20 and Garcia, including, according to the charging documents that led to his termination, for
21 identifying inmates convicted of child molestation to other inmates. Indeed, the F.B.I. was
22 preparing the prosecution of Powers and Garcia when its agents came across evidence that Lewis
23 had shot an unarmed inmate. (Reynoso Tr. 490 - 491).

24 More importantly, the references to David Lewis are relevant because they demonstrate a
25 pattern of interference by the CCPOA that took place during the Powers and Lewis criminal
26 investigations, including, as described in detail below, an attempt by CCPOA Vice President
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1 Lance Corcoran to pressure the CDC to prevent one of its investigators from assisting the United
2 States Attorney in a criminal trial scheduled to begin before United States District Court Judge
3 Martin Jenkins.

4 The record should also reflect that the Special Master sought approval from the Court
5 prior to conducting the hearings that related to David Lewis (Exhibit 63). In its Order filed
6 September 23, 2003 the Court concluded there was a sufficient basis for the Special Master to
7 inquire into the Lewis matter. (Exhibit 64). Based on all of these factors, the Special Master
8 denies Alameida's request to strike all reference to David Lewis in this report.

9 D. Moore's Objections to the Draft Report.

10 1. *Objections to Contempt Recommendations.*

11 Moore's objections to the Special Master's recommendations essentially adopt the
12 objections of Alameida (see CR 1734 at pgs 1 - 9). Therefore, the Special Master's response to
13 Alameida's objections applies equally to Moore's objections and will not be repeated.

14 2. *Objections to Recommendation Re Referral to United States Attorney for the*
15 *Filing of Perjury Charges.*

16 Moore's objections to the Special Master's recommendation that the Court should
17 consider referring the Post Powers Report and the transcript of Moore's testimony to the United
18 States Attorney for possible perjury charges are found at CR 1734 at pgs. 10 - 19. The Special
19 Master has reviewed each objection concerning the five portions of Moore's testimony
20 referenced in the draft report. He also discussed the objections with Mr. Goyette during the
21 recorded argument that took place on May 7, 2004.

22 To begin, the Special Master disagrees with Moore's claim that none of these statements
23 were material because the Special Master should have stopped his hearings as soon as evidence
24 arose that the remedial plan had been violated (CR 1734 at pgs 11 - 12). As discussed above, the
25 Special Master was instructed to conduct a full investigation about the shut down of the Post
26 Powers investigations and report to the Court. This investigation required an inquiry into why
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1 the investigations were closed down, who closed them down, and under what circumstances.

2 Second, the transcript of Moore's testimony on July 30, 2003 reveals numerous false and
3 misleading statements. The five statements selected for the Special Master's recommendations
4 where chosen because they focus on critical aspects of the Post Powers inquiry; for example,
5 exactly when an investigator really was assigned to the cases; or why Moore called Ballard and
6 instructed him to appear in Alameida's office.

7 The Special Master also does not believe, given the testimony of Thomas Moore, that his
8 statements were "literally true;" nor does the recorded testimony indicate that Moore truly
9 believed what he was saying; indeed in some cases Moore testified, under oath, to different
10 versions of what transpired.

11 Finally, the Special Master finds that several of Moore's objections ignore the relevant
12 facts surrounding the statement at issue. For example, the fifth of Moore's statements that the
13 Special Master recommends the Court consider for referral to the United States Attorney is the
14 following:

15 "He gave myself a briefing as to, meaning Ballard and Barbara gave myself and
16 Brian Parry, Parry was privy to the briefing. And it was then that we realized we
17 had to brief Mr. Alameida now. I believe the day before I contacted Mr.
Alameida to make sure his calendar would be available because I knew this case
had to be reviewed." (Moore Tr. 159: 19 - 25).

18 Moore contends that it is plausible to interpret this statement as simply meaning that one
19 meeting followed another or that Moore realized that California's Peace Officer Bill of Rights
20 ("POBAR") investigation time constraints existed. (CR 1734 at pg. 18). The Special Master
21 disagrees. As explained below, Brian Parry was not at the 3:00 p.m. meeting. Furthermore,
22 Moore had not just "checked" Alameida's calendar, he actually made an appointment for a 4:00
23 p.m. meeting with Alameida on March 26, 2003, twenty-four hours before he met with Ballard
24 and Barbara. *See also*, pages 69 - 70 below.

1 F. The Amicus Filing of the CCPOA and the Union's Objections to the Draft Report.

2 1. *Introduction.*

3 Judge Steve White and former Inspector General testified at the Senate hearing of January
4 21, 2004 that the CCPOA can be a force for both good and bad. The Special Master agrees. In
5 some respects the CDC is a better organization because of the CCPOA. The union has worked
6 diligently to improve wages and working conditions of its members. It has also established
7 reasonable inmate to correctional officer ratios, improved CDC training, and taken steps to
8 protect the rights of victims of crime. As the record in the Post Powers hearings and Senate
9 hearings demonstrate, however, the CCPOA has not been responsive concerning the abuse of
10 inmates and the code of silence.

11 The CCPOA functions as a mirror or twin of its adversary and lifetime partner, the CDC.
12 Like the CDC, the CCPOA has grown dramatically over the past twenty years, and it has a
13 limited and small core of leaders - almost all of whom have not worked in a prison for more than
14 a decade. Like the CDC, the CCPOA functions in an insular manner, it has not established
15 ethical policies and procedures, it has failed to train its representatives on ethical standards, and it
16 refuses to acknowledge the existence of the very code of silence it helps perpetuate. And
17 identical to the CDC prior to Mr. Hickman's recent memorandum, there is a code of silence
18 about the code of silence in the CCPOA. Unlike the recent changes in YACA and the CDC,
19 however, the CCPOA continues to deny a wide range of serious problems, as exemplified by its
20 amicus filing with the Court.

21 2. *The Special Master's Long Standing Policy to Address the CCPOA's Concerns*
22 *About Potential MOU and Remedial Plan Conflicts.*

23 As the Court is aware, the Special Master has repeatedly endeavored to include the
24 CCPOA and other employee labor organization in remedial plan discussions when appropriate.
25 For example, the CCPOA has been involved in remedial plan discussions such as the hiring and
26 retention of Medical Technical Assistants ("MTA's") at PBSP; a conflict between the MOU and
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1 the use of force discipline policy that arose after the MOU was modified in 2000; and most
2 recently concerning modifications to PBSP policies re “Skelly” hearings based on a decision
3 from the California Courts of Appeal. On many occasions, the resolution of these problems
4 involved both the exchange of letters and face-to-face meetings between the Special Master, the
5 remedial team, the CDC, and the CCPOA.

6 The Special Master has also been careful to ensure that his recommendations for Court
7 orders do not conflict with State law or contracts, consistent with the Court initial remedial
8 orders in this case. In fact, because of repeated problems involving the CDC’s failure to inform
9 the Special Master about potential conflicts between the Court’s order and its labor contracts, a
10 recent modification to the Use of Force Discipline Policy and Procedure requires the CDC to
11 notify the CCPOA in the event that the CDC amends the policy in a manner that impacts wages,
12 hours or working conditions. (*See Use of Force Discipline Policy and Procedure, Section IX*).

13 To summarize, the Special Master has on numerous occasions allowed the CCPOA to
14 participate in the remedial process, as amicus, when legitimate union interests appeared to
15 interface with the remedial plans. On every occasion that the CCPOA has sought to be heard
16 during the nine year remedial process, the concerns raised by the union have been considered by
17 the Special Master. All conflicts between the MOU and the remedial plans were resolved;
18 indeed, the union has never deemed it necessary over this long period of time to submit pleadings
19 to the Court concerning remedial plan conflicts with the interests of its members.

20 *3. The CCPOA’s Contact with the Special Master After the Filing of the Draft*
21 *Post Powers Report.*

22 The Special Master was contacted by Linda Buzzini of the Department of Personnel
23 Administration several weeks after he issued his draft report. Ms. Buzzini had been called by
24 Ronald Yank, an attorney representing the CCPOA. Mr. Yank requested to meet with the
25 Special Master and Ms. Buzzini to discuss the CCPOA’s concerns about the draft report.

26 The Special Master declined the CCPOA’s invitation for a private meeting for several
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1 in the code of silence, and like YACA and the CDC, the CCPOA had agreed to institute
2 necessary changes in its operation. The CCPOA's amicus brief has quashed those hopes. The
3 union's filing indicates, perhaps inadvertently, that the CCPOA will continue to interfere with
4 administrative and criminal investigations of correctional officers who abuse inmates, and that
5 the union will continue to enforce the code of silence in the CDC's prisons. To a large degree, it
6 appears that the CCPOA's filing is designed to divert focus on the serious problems that exist
7 with investigations and correctional officer discipline, to turn the attention of the Court to issues
8 that the CCPOA deems important instead of the serious problems at hand.

9 Nevertheless, the Special Master reviewed every aspect of the CCPOA's amicus filing,
10 including the Declaration of Ronald Yank, the CCPOA's Points and Authorities (which includes
11 the Declaration of Benjamin Sybesma and two exhibits), and a second Declaration of Ronald
12 Yank Correcting Inadvertent Errors, with attachments. Each of the major arguments raised by
13 the union deserves a response. The CCPOA pleadings make the following contentions:

14 a. Investigation Problems at Other Prisons.

15 First, the CCPOA brings to the Court's attention a series of serious problems it has
16 encountered with the CDC, including a use of force investigation at Corcoran State Prison where
17 the CCPOA successfully obtained judicial relief to protect the due process rights of its members.
18 (Declaration of Ronald Yank, pgs. 1 - 15, CCPOA exhibits B, C & D). The Special Master finds
19 this portion of the CCPOA's argument to be well taken. There is no question that the systemic
20 problems identified by the Special Master, and by the OIG, relative to poorly managed
21 investigations and problems within the ELU have had, on occasion, serious and negative impacts
22 on CCPOA members. OIG reports demonstrate, for example, that internal affairs investigations
23 have, in the past, been used for inappropriate purposes by prison administrators.

24 However, the CCPOA membership has also benefitted from these problems, a point
25 ignored in the amicus filings. In many cases correctional officers who should have been
26 punished or terminated because of serious offenses have faced no discipline because OIS and
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1 ELU failed to complete the case prior to the POBAR one year statute of limitations. For
2 example, significant evidence indicates that Correctional Officers Jones, Matlock, and Tuttle
3 should have faced adverse action discipline, including termination, for their false testimony
4 before Judge Jenkins. Likewise, as explained below, CCPOA representatives Charles “Chuck”
5 Alexander (“Alexander”) and Richard Newton (“Newton”) engaged in very serious misconduct
6 for which they received no sanctions. In fact, as pointed out in the OIG audit report of March
7 2002, *forty percent* of all adverse action cases in CDC prisons were lost because of the failure to
8 complete investigations and discipline within one year. Thus, while it is fair to say that a few
9 CCPOA members may have been unfairly targeted by bad investigations, many others who were
10 guilty of serious offenses have gone without punishment, and continue to work for the CDC and
11 CCPOA today.

12 Furthermore, neither the investigation problems cited by the CCPOA, nor the findings of
13 the OIG, nor counsel’s frustration about years of problems justify the deliberate pattern of
14 CCPOA interference that has been revealed by the Post Powers investigation and hearings.
15 Without question, the State of California and the United States of America had good cause to
16 investigate Powers, Garcia and Lewis for crimes against the inmates of PBSP. As explained in
17 the factual findings below, problems at other prisons do not justify Alexander using his CCPOA
18 position to thwart these criminal investigations, nor do they provide excuses for Newton to
19 withhold evidence provided to him by another correctional officer, nor does it warrant CCPOA
20 Vice President Lance Corcoran (“Corcoran”) pressuring the CDC to prevent an investigator from
21 effectively assisting the United States Attorney.

22 To some degree, the CCPOA’s first argument is indicative of a pattern that exists
23 throughout the amicus filings. The CCPOA attempts to deflect very serious and specific charges
24 against its representatives by generalized attacks on the CDC and criticisms of prisons other than
25 Pelican Bay. While the Special Master has allowed for amicus participation by the union in the
26 past and will encourage participation by the union in the future, he cannot ignore the record in
27

1 this case.

2 b. Objections Concerning Firewall Recommendation.

3 The second concern raised by the CCPOA relates to the Special Master's
4 recommendation that the CDC institute a specific and rigorous firewall between the CCPOA and
5 the CDC's investigation and discipline process at both the institution and Central Office level.
6 (CCPOA Points & Authorities, pgs. 9 - 11). The CCPOA's objections are premature since the
7 specific provisions of the firewall have not yet been developed by the CDC, however in an
8 abundance of caution the Special Master will respond to the issues raised.

9 The Special Master agrees with the CCPOA that the firewall cannot be so rigorous that it
10 would preclude, for example, the CCPOA's attorneys from contacting CDC attorneys about the
11 status of discipline cases. On the other hand, to the extent that the CCPOA argues that
12 Alexander and Newton were performing legitimate duties under the Ralph C. Dills Act (codified
13 at California Government Code section 3512 et seq.) when they engaged in the misconduct
14 documented in the Knowles/Palmer report (Exhibit 26), the CCPOA is simply wrong. The
15 Special Master points out that the CCPOA's generalized argument fails to explain why its
16 representatives engaged in the misconduct that has led the Special Master to recommend a
17 firewall. For example, there was no reason for Alexander to call Alameida about a pending
18 investigation that was already in the hands of attorneys, and Corcoran had no legitimate purpose
19 when he attempted to stop a CDC investigator from assisting the United States Attorney. A
20 firewall will stop an on-going and inappropriate level of CCPOA interference with CDC
21 investigations. A firewall will also protect the confidentiality of investigations, it will protect the
22 privacy rights of the subject officers, it will prevent the CCPOA from "playing" CDC officials as
23 happened in the Post Powers cases, and it will provide written ethical standards for all CDC
24 employees - including CDC employees who serve as CCPOA representatives. The Special
25 Master notes in making this recommendation that neither the CDC nor CCPOA have seen fit,
26 thus far, to implement any effective form of ethical standards for CCPOA representatives.

1 Concerning the firewall recommendation itself, defendants have, with the Special
2 Master's approval, set back the projected implementation date for the firewall to allow for input
3 from the new Inspector General and his staff. In the interim, however, steps can and should be
4 taken at Pelican Bay to institute one portion of a program that is needed at all CDC institutions.

5 At present, CCPOA representatives are invited to observe the weekly Executive Review
6 Committee ("ERC"). Later, these same representatives may represent subject officers whose
7 cases are discussed at the ERC. The title ERC reflects the fact that the meeting should consist of
8 the Warden of PBSP, Associate Wardens, and other prison officials. These officials discuss, in
9 candid terms, all reported use of force cases that have been reviewed for the week. The meeting
10 is for "executives," not for the union. Given the findings of the Post Powers investigation, there
11 is no justifiable reason to allow the CCPOA to continue to observe a process whereby discipline
12 decisions are discussed and often implemented. Furthermore, well established policies and
13 procedures exist to protect the interests of the subject correctional officers, as well as processes
14 such as "Skelly" hearings. Therefore, the Special Master recommends below that PBSP modify
15 the use of force remedial plans to exclude CCPOA representatives from the ERC.

16 c. The CCPOA's Continuing Denial of the Code of Silence.

17 The third issue raised by the CCPOA's amicus pleading concerns the code of silence. To
18 present its position, the union has filed selected portions from the transcript of CCPOA President
19 Mike Jimenez's ("Jimenez") testimony before the Senate on January 20, 2004. (*See* CCPOA
20 Exhibit E to the Declaration of Ronald Yank).

21 Asked to testify under oath about the existence of a code of silence in the CDC, Jimenez
22 dodges the question.

23 Senator Speier: "Do you believe that there is a code of silence in Corrections?"

24 Mike Jimenez: "I believe that there is a code of cowardice with the Department of
25 Corrections. I don't believe it's properly termed in a code of silence."

26 The Special Master finds Jimenez's "code of cowardice" explanation nothing less than an
27

1 attempt to reinforce CCPOA complicity with the code of silence that pervades all CDC
2 institutions. Jimenez’s “code of cowardice” ignores extensive evidence presented by CCPOA
3 members at the Senate hearings about co-worker pressure, and the shunning and intimidation of
4 the few officers who have had the courage to report abuses of force. It also ignores the evidence
5 of a code of silence in the draft report. In effect, Jimenez attempts to brand as cowards the
6 honest correctional officers who are victims of the code of silence, and ridicules those who
7 remain silent because of concern about their personal safety. Jimenez’s statements are a clear
8 signal that the CCPOA continues to support a code of silence about the code of silence itself, and
9 that it will take no action to end the union’s sponsorship of the code of silence in the future.

10 d. The Findings in the Knowles/Palmer Report of Serious Misconduct by
11 CCPOA Representatives Alexander and Newton Are Not Called into
12 Question Because of Subsequent Litigation That Failed to Consider the
13 Court Ordered Remedial Plan.

14 The fourth point made by the CCPOA consists of an argument that extensive litigation
15 filed by the union following the Knowles/Palmer report somehow mitigates the serious factual
16 findings against Alexander and Newton made in that report. (See the Declaration of Ronald
17 Yank at pgs. pages 4 - 7 and CCPOA Exhibit 1 to that declaration; the Declaration of Benjamin
18 Sybesma at pgs. 2 - 3; and CCPOA Exhibits 1 & 2 attached to the Declaration of Ronald Yank
19 Correcting Inadvertent Errors). The Special Master reviewed the materials provided by the
20 CCPOA prior to filing his draft report, he referenced in a general manner the CCPOA’s litigation
21 in the draft report, and referred to the underlying documents in Appendix 4. The CCPOA
22 believes, however, that further discussion concerning their lawsuits is warranted (*see*, for
23 example, the Declaration of Benjamin Sybesma at pg. 2, para. 7).

24 At the CCPOA’s request, the Special Master has again reviewed Public Employment
25 Relations Board (“PERB”) Decision No. SA-CE-1075-S and the State Personnel Board (“SPB”)
26 Decision on case nos. 98-2768 and 98-2697. He finds nothing in either decision which warrants
27

1 a modification of the findings set forth below. The Special Master bases this decision on the
2 following facts:

3 1. Neither the PERB nor the SPB considered the controlling standard that governs the
4 misconduct by CCPOA representatives Alexander and Newton - the Federal Court approved use
5 of force remedial plan. While the PERB arbitrator touches on the existence of a remedial plan,
6 he fails entirely to examine its controlling provisions, including those sections that prohibit
7 concerted actions to hide the abuse of force. The SPB decision simply ignores the Court's
8 orders; apparently, neither the CDC nor CCPOA brought the existence of a remedial plan to its
9 attention. To summarize, nothing said by either board changes the facts. The Knowles/Palmer
10 report found that CCPOA representatives Alexander and Newton engaged in a pattern of
11 misconduct that is prohibited by the remedial plan.

12 The CCPOA contends that the investigation was flawed. The CCPOA is correct;
13 however the investigation was flawed only in that it did not go far enough. For example, under
14 the use of force discipline plan in force at PBSP today, the misconduct reported by Knowles and
15 Palmer would mandate some form of adverse action, including possible termination. The Special
16 Master attaches Dr. Maher May 31, 2004 Memorandum entitled "Qualitative Review of 1997
17 Internal Affairs Investigation of PBSP CCPOA Personnel Investigation 105-96" as Exhibit 67.
18 The Special Master agrees with Dr. Maher: Alexander, Newton, and the CCPOA engaged in
19 conduct to promote the code of silence at PBSP in violation of the Court approved use of force
20 remedial plan. In fact, the outcome of the Knowles/Palmer investigation provides yet another
21 example of how CCPOA members benefit from the CDC's faulty investigation and discipline
22 procedures. In this case, two CCPOA representatives were able to escape punishment despite
23 having committed very serious violations of the Court approved remedial plan.

24 2. Neither board decision makes a finding that the overall investigation was inadequate
25 in any way, or that it was fabricated or false. Both of the decisions touted by the CCPOA are
26 extremely narrow. For example, neither board excuses Newton for withholding, as a CCPOA
27

1 representative, relevant evidence of criminal misconduct on the part of Garcia.

2 3. The draft report points out that the CDC failed to discipline Alexander and Newton
3 under the mandates of the remedial plan after it received the Knowles/Palmer report. The
4 CCPOA's litigation, filed the year *after* the CDC's decision not to discipline is simply not
5 relevant to this finding. Again, the CCPOA attempts to deflect criticism of very serious
6 violations of the Court's orders on the part of CCPOA representatives by launching a generalized
7 attack against the CDC concerning other, irrelevant issues.

8 The remaining comments and objections raised by the CCPOA amicus filing are limited
9 to the MOU. These concerns are addressed at Section VI. below.

10 G. The Special Master's Investigations, Review of Reports, and Attendance at State
11 Hearings After The Filing of the Draft Report.

12 The Special Master's post-draft report meetings and discussions endeavored to obtain
13 relevant and up-to-date information concerning the recommendations set forth below, including
14 an analysis of: (a) what the State of California is attempting to do to solve the problems described
15 below; (b) whether the State's efforts will correct the problems, and (c) what level of Court
16 oversight is needed to ensure the State's remedial efforts succeed.

17 For example, the Special Master held numerous meetings with CDC and YACA officials
18 concerning potential corrective action plans. The Special Master received comments about his
19 draft report from numerous CDC employees, including telephone calls from OIS investigators
20 and face-to-face discussions with PBSP and Central Office personnel. The Special Master also
21 met personally with some of the staff directly involved in the Garcia and Powers criminal cases,
22 including, for example, William Schembri ("Schembri").

23 In addition, the Special Master attended two days of State Senate hearings on January 20-
24 21, 2004 where he heard testimony about the code of silence and problems encountered by CDC
25 "whistle blowers" who report abuses of force at prisons other than Pelican Bay. He attended a
26 subsequent Senate hearing that addressed problems with the CDC/CCPOA MOU. These

1 hearings proved to be informative, providing testimony that demonstrates the investigation and
2 discipline problems found during the Special Master's Post Powers hearings are not limited to
3 incidents arising out of Pelican Bay. For example, recent and serious problems with
4 investigations, the code of silence, and the failure to protect whistle blowers have also arisen out
5 of Folsom State Prison, Salinas Valley State Prison, Corcoran State Prison, and the California
6 Institute for Men. Likewise, the hearings demonstrated that limitations imposed on the ability of
7 investigators to conduct fair and effective investigations because of MOU provisions have
8 seriously hampered efforts to improve the performance of the Office of Investigative Services.

9 The Special Master found the testimony of the Honorable Steven White, the former
10 Inspector General and now Superior Court Judge, to be especially helpful in terms of proposing
11 remedial plan recommendations. Judge White told a panel of California Senators the morning of
12 January 21, 2004, that YACA and the CDC has no center or leadership. As a result, the CCPOA
13 permeates all aspects of CDC operations, essentially filling the vacuum created by the absence of
14 leadership within the Department. What should be a wide ranging CDC agenda has, over the
15 years, become instead the CCPOA's more limited agenda. Judge White predicted there would be
16 the rattling of sabers, sincere commitments to solve the current problem, and the rolling of heads;
17 but that three months later it would be back to the way it was, including more concessions to the
18 CCPOA by the Department of Personnel Administration at the bargaining table - unless YACA
19 and the CDC acquire the type of leadership both organizations so desperately need.

1 V.

2 FINDINGS

3 A. Introduction.

4 During the course of the Special Master’s hearings evidence came to light that:

5 1. The Post Powers internal investigations were inadequately staffed, began four months
6 late, and were shut down by Director Alameida before the investigations were completed.

7 2. The untimely start of the investigations, the processing of the investigations, and
8 Alameida’s decision to shut down the investigations violated the Use of Force Discipline
9 Remedial Plan, the DOM for the OIS, and the Post Powers Plan.

10 3. In conjunction with closing three active investigations, a false and misleading letter
11 was sent to the Special Master. The investigations were never properly closed-out, and no
12 internal affairs reports were prepared.

13 4. The Post Powers investigations are indicative of serious systemic problems in the OIS
14 and the ELU, problems identified two years ago by the OIG and never corrected by the CDC.

15 5. The criminal and administrative investigations concerning misconduct by Powers,
16 Garcia, and former Correctional Officer David Lewis (“Lewis”), and the Post Powers
17 investigations, were disrupted by representatives of the CCPOA.

18 Much of this evidence is not in dispute. There are disputes, however, with respect to
19 what occurred during the period of March 20-27, 2003, when the decision to shut down the Post
20 Powers cases was made.

21 B. History of the Criminal Prosecutions Against Powers, Garcia and Correctional Officer
22 David Lewis..

23 1. *The Shut-Down of the PBSP Internal Affairs Investigation.*

24 The initial Department of Corrections investigations into possible administrative and
25 criminal misconduct by Powers and Garcia began in the mid-1990s. At first, the investigations
26 were conducted by a team of PBSP internal affairs investigators reporting to Captain Dan Smith.

1 The team involved Joe Reynoso (“Reynoso”), Craig Franklin, Chet Miller and Lt.
2 Roussopoulos. (Reynoso Tr. 484 - 485). Almost immediately, the investigation team
3 encountered resistance from local representatives of the CCPOA. Charges and counter charges
4 were filed, and eventually litigation. The Special Master was working on this case as a Court
5 appointed expert at the time and discussed this issue with Warden Steve Cambra on several
6 occasions from 1995 through 1997. Given the level of CCPOA resistance, Warden Cambra
7 became concerned about the ability of local investigators to complete the investigations. He
8 eventually made the decision to close-down the local case and refer the investigation of Powers
9 and Garcia to the CDC’s Law Enforcement Investigation Unit (“LEIU”). LEIU investigates
10 criminal misconduct on the part of staff and inmates. *See also*, Reynoso Tr. 485.

11 *2. The LEIU Investigation and the State Court Criminal Trial of Garcia.*

12 George Ortiz of LEIU assumed responsibility for the investigation. Charges against
13 Officer Garcia were sustained and state court criminal charges were filed alleging a conspiracy to
14 have inmates assaulted, bringing alcohol into a state facility, and assault with a deadly weapon
15 likely to produce great bodily injury. (Reynoso Tr. 486-487). The CDC provided investigative
16 and legal assistance to the District Attorney of Del Norte County in the Garcia criminal
17 prosecution. (Reynoso Tr. 487; Sheldon Tr. 600; Gaultney Tr. 831). The attorneys who
18 represented Garcia in the criminal case were Robert Noel and Marjorie Knoller. Garcia was
19 found guilty of the conspiracy charge, the alcohol charge and the assault charge. Garcia’s state
20 court convictions were later overturned. (Reynoso Tr. 488-489).

21 *3. The Termination of Correctional Officer David Lewis.*

22 ELU staff attorney Barbara Sheldon (“Sheldon”) worked with the district attorney in the
23 Garcia state criminal prosecution. (Sheldon Tr. 600). Sheldon also handled the administrative
24 case against Lewis (Sheldon Tr. 600). Lewis’ employment with the CDC was terminated on
25 October 4, 1996 because of misconduct that included calling inmates “primates,” “monkeys,”
26 “toads,” and “niggers,” and for demeaning actions toward sex offenders. The termination was

1 dated October 31, 1997. (Exhibits 27 and 51). Alexander and Newton sued the CDC over the
2 Knowles/Palmer Report. (Exhibit 28). The litigation subsequently settled. (Sheldon Tr. 634-
3 635).

4 As reported above, the CCPOA's amicus pleadings attempt to attack the Knowles/Palmer
5 report by claiming some sort of "whistle blower" protection for Alexander. Despite filing
6 numerous personnel actions and civil suits, however, the CCPOA has failed entirely to find one
7 judicial tribunal who will criticize or otherwise limit any of the *factual findings* set forth in the
8 Knowles/Palmer report. Without question, the misconduct by Alexander and Newton
9 documented by Knowles and Palmer represent violations of the Court approved use of force
10 policy. (See Exhibit 67).

11 5. *The Federal Criminal Prosecution of Powers and Garcia.*

12 Investigator Reynoso was assigned to assist with the FBI investigation of criminal
13 misconduct by Powers and Garcia in 1998. (Reynoso Tr. 489 - 490). Sheldon was the
14 department liaison for the grand jury in the case. (Sheldon Tr. 601).

15 CCPOA resistance to the Powers/Garcia criminal investigation continued. At one point
16 during the FBI investigation, the union put out a memo notifying staff that internal affairs was
17 going to be at PBSP and informing correctional officers they did not have to talk to them, in
18 essence sending a message not to cooperate with internal affairs no matter what position they
19 were in. (Reynoso Tr. 495). In order to interview correctional staff, subpoenas had to be issued
20 to force their testimony before the grand jury. (Reynoso Tr. 496). Because of the code of silence
21 one officer did not come forward with any information until he left the CDC's employment for
22 fear of his safety. (Reynoso Tr. 497; Haag Tr. 794-795). The Special Master became involved
23 with this problem shortly before the federal criminal trial began, when correctional officers who
24 were willing to testify for the prosecution at trial told the FBI they had been informed by CCPOA
25 representatives that if their testimony at trial differed from their reports at the time of the
26 incident, the CCPOA would request the CDC to initiate discipline charges against them.

1 Furthermore, CCPOA representatives attended the Powers/Garcia criminal trial to monitor
2 correctional officer testimony. The Special Master discussed this problem in two meetings, one
3 at the prison and one in Sacramento with CDC officials from the Central Office.

4 *6. The Federal Criminal Prosecution of Lewis.*

5 While investigating the allegations against Powers and Garcia, the FBI came across
6 evidence which revealed that in 1994 Lewis (the same officer who had been terminated by the
7 CDC for calling inmates “primates,” “monkeys,” “toads,” and “niggers,” and for demeaning
8 actions toward sex offenders) intentionally shot inmate Harry Long while on duty in a Pelican
9 Bay gun tower. (Reynoso Tr. 490-491). Apparently, Lewis erroneously believed that inmate
10 Long was a child molester.

11 As a result of this investigation federal criminal charges were filed against Lewis.
12 Attorneys Noel and Knoller represented Lewis. He was convicted by a jury in the United States
13 District Court for the Northern District of California for deprivation of rights under color of law
14 in violation of 18 U.S.C. § 242 and use of a firearm in relation to a crime of violence in violation
15 of 18 U.S.C. § 924. Lewis’ conviction was overturned by the Ninth Circuit in an unreported
16 decision filed October 26, 2001. Renewed charges against Lewis are pending in the U.S. District
17 Court for the Northern District of California. Various pretrial appeals filed by Lewis were
18 recently rejected by the Ninth Circuit in an unreported decision on May 25, 2004 (Ninth Circuit
19 Case No. 03-10181).

20 C. Defendants’ Post Powers/Garcia Investigation and Discipline Plan.

21 While the Powers/Garcia federal criminal trial was pending, the Special Master was
22 informed that the CDC had no established program to discipline correctional staff who may have
23 been involved in violations of the use of force remedial plan, which, while not rising to the level
24 of criminal misconduct, were serious enough to require administrative discipline. Indeed, the
25 CDC had no precedent to conduct this form of administrative review. For example, no
26 correctional officer was investigated after the Garcia state court trial, even though some officers
27

1 did not testify truthfully in the opinion of the CDC's attorney. (Sheldon Tr. 612).

2 Therefore, in October 2001 the Special Master requested that CDC officials develop a
3 Post Powers administrative investigation and discipline plan. Sheldon was primarily responsible
4 for preparing the plan, in conjunction with John Sugiyama, then Deputy Director of the Legal
5 Affairs Division. (Sheldon Tr. 602). The plan was developed by the ELU in conjunction with
6 the OIS. Sheldon was supervised by Gaultney, who, at the time, was the Assistant Chief Counsel
7 of the ELU. Several meetings were held between CDC officials, the Special Master, and counsel
8 for the parties in *Madrid* during the development of the plan, numerous criticisms were made of
9 early drafts, and extensive changes were made to the final version of the plan. (*See e.g.* the
10 letters and reports from Court expert Dr. Patrick Maher in Exhibits 22-25; *see also* Sheldon Tr.
11 604 – 607). Sheldon took her project very seriously. The final version of the Plan is attached as
12 Exhibit 2. No one disputes the fact that the CDC made a commitment to the Special Master to
13 implement the plan as necessary.

14 Some of the more important provisions of the plan required the following:

15 At all times during the process, Assistant Chief Counsel of the
16 Employment Litigation Unit Robert Gaultney and Supervising Senior Staff
17 Counsels Debra Ashbrook, Vickie Brewer and Barbara Sheldon will be available
18 to monitor the process and be available for consultation.

19 The investigators will follow Department authorized investigation
20 protocols in completing the investigations.

21 The expectation is that the investigations will all be completed within 6
22 months of learning the names of employees who may be subject to discipline.
23 Staff Counsel will be available for consultation throughout the investigations.

24 When the investigations are completed they will be sent to the Warden of
25 the institution or the Regional Administrator of the Parole Region where the
26 employee is assigned. After consultation with the Assistant Chief Counsel and the
27 Supervisors of Legal Affairs, the hiring authority, whether a Warden or a Regional
28 Administrator, will make a recommendation regarding discipline.

29 Numerous Central Office officials were aware of the plan, including Gaultney, Beaty
30 Parry, ELU Attorney Vicki Brewer, and Moore. (Sheldon Tr. 618; Gaultney Tr. 821 - 822).
31 Alameida and Tristan, however, testified they had not seen the plan at the time of the critical
32

1 meeting of March 27, 2003. (Alameida Tr. 695; Tristan Tr. 873). Likewise, as explained below,
2 the investigator and attorney who ended up actually being assigned to the Post Powers
3 administrative cases were kept in the dark about this CDC plan.

4 D. The Meeting Between Melinda Haag and CDC Officials.

5 On June 4, 2002, after Powers and Garcia were found guilty, Assistant United States
6 Attorney Melinda Haag met with Parry (who directed the operations of both LEIU and OIS),
7 Barbara (the ELU attorney assigned to oversee the Post Powers investigations), Moore, and
8 Reynoso. (Barbara Tr. 17; Reynoso Tr. 498-501; Parry Tr. 422-423; Haag Tr. 774).

9 Ms. Haag was told that the CDC was evaluating whether it should conduct administrative
10 investigations to determine whether department employees had been untruthful in their testimony
11 in the Powers/Garcia criminal trial. Ms. Haag was asked if she would meet with various people
12 from the CDC and summarize for them the trial testimony. It was her understanding the
13 Department was particularly interested in circumstances where correctional officers testified
14 contrary to the evidence presented by the government. (Haag Tr. 774 - 776). Ms. Haag provided
15 an oral summary of the evidence presented at trial at the meeting of June 4th. Thereafter, a
16 written summary of seven potential cases was prepared by Parry for Barbara's signature (Barbara
17 Tr. 20; Parry Tr. 422; *see* Exhibit 3).

18 A second meeting was held concerning the seven cases a few days later. This meeting
19 was limited to CDC staff, and included Parry, Barbara, Moore, Reynoso, and Gaultney.
20 (Reynoso 502 - 503). Each case was discussed and analyzed. Moore suggested, given the length
21 of time that had expired since the underlying use of force incident, that the CDC should just let
22 the cases go. Gaultney, however, disagreed. Gaultney instructed the other participants to
23 determine what cases should be investigated. (Reynoso Tr. 504; Parry Tr. 424). The decision
24 was made to proceed with three cases. (Barbara Tr. 25, Parry Tr. 424-428; Gaultney Tr. 821 -
25 823). As explained by Parry at the hearing of August 26, 2003, he felt that three cases were
26 strong enough to pursue. He testified that the participants at the meeting were not "forced" by
27

1 the U.S. Attorney's Office or the Special Master to take the three cases. The CDC's investigators
2 and attorneys made the decision to pursue the cases because there was alleged misconduct and
3 they were presented in such a way that they were going to have to look at them. (Parry Tr. 471;
4 Haag 789).

5 The CDC thereafter requested transcripts and investigation reports from the U.S. Attorney
6 to commence its review of the three selected cases. These documents were provided to the CDC
7 in a timely manner. (Exhibit 5).

8 E. The Substance of the Administrative Investigations of Correctional Officers Jones,
9 Matlock, and Tuttle.

10 The underlying facts of the three Post Powers investigations and the suspected perjurious
11 testimony of Correctional Officer William Jones ("Jones"), Charles Matlock ("Matlock"), and
12 Owen Tuttle ("Tuttle") are set forth below:

13 **Perez Incident**

14 The evidence in the case involving inmate Perez was primarily presented at trial by
15 former C.O. Jim Mather ("Mather"), and by reports and conclusions that could be drawn from
16 those reports. Mather was a PBSP correctional officer at the time of the incident in February
17 1991 and he was assigned to the yard that day. His supervisor was Powers. Mather testified as
18 follows:

19 Powers assigned Mather and Officer Bill Jones to search inmates as they came out of the
20 education area. Mather did not know if there was a particular reason for the searches. Marco
21 Perez ("Perez") was among the group of inmates to be searched. When it came Perez's turn to be
22 searched, Perez was not cooperative. In their efforts to make Perez cooperate, they turned him to
23 a wall. Perez spun off the wall and in doing that he ended-up punching or hitting Mather. In
24 response to Mather being hit, a group of officers converged on Perez, including Jones and an
25 officer named Matlock. The officers took Perez to the ground. Mather was also on the ground
26 and he saw that Matlock was kicking Perez. Mather was aware of that because he was afraid he

1 was going to be kicked and Mather told Matlock to stop. There was testimony in the trial that
2 kicking is not appropriate under the circumstances of the Perez incident.

3 Perez resisted initially, but the officers were able to control and subdue him. Eventually
4 Mr. Perez was under control and on the ground. At that point, Powers, who was watching,
5 instructed the officers to take Perez into a hallway that led to a chapel nearby. The officers
6 picked Perez up and took him into the hallway. Powers followed. Handcuffs were placed on
7 Perez. Once Perez was in the hallway, Powers ordered that the handcuffs be taken off. Powers
8 said “don’t be doing that to my officer, or don’t ever hit my officer, or something like that” and
9 then Powers punched Perez. At that point, Perez was taken to the ground and strip searched.
10 Nothing was found.

11 In the aftermath, Powers told the officers to write reports. Mather wrote a report and
12 included that Perez was taken into the hallway, he did not, however, include anything about
13 punching in the hallway. Mather testified he did not include the punching because of the code of
14 silence. Mather knew he shouldn’t say that Powers hit Perez. Mather submitted his report to
15 Powers. When he received a typed version of the report back, there was no reference at all to the
16 hallway. The report simply said there was an incident; Perez hit Mather, the officers took him to
17 the ground, subdued him, and transported him to medical - leaving out the hallway incident
18 altogether.

19 At trial the government introduced the reports prepared by each of the officers on duty.
20 All of the reports were written the same way; there was no reference to Perez being taken into the
21 chapel hallway. The suspected perjurious testimony Ms. Haag brought to the attention of the
22 CDC was as follows: When the defense called Jones as a witness, Jones said that Powers did not
23 punch Perez. Matlock was also called by the defense, and he said the same thing. (Haag Tr. 776
24 - 780).

25 **Black Incident**

26 The testimony concerning the Black incident came from inmate Michael Black (“Black”),
27
28

1 two other inmates at the prison, a statement made by Powers to the FBI, and statements from Lt.
2 Gary Wise (“Wise”). Black testified about earlier confrontations he had with Garcia and Powers,
3 and with other officers on the Powers’ crew. Black was on the yard when he was approached by
4 Officers Tuttle and Payne, who ordered him to strip out - on the yard. Black testified that in the
5 prison culture, an order to strip out in public is very disrespectful, and not commonly done.
6 Black refused to strip out on the yard and was “hot” with the officers for asking him to do so.
7 The officers called Powers on the radio, Powers instructed the officers to take Black into the gym
8 nearby. Powers ordered that the handcuffs be taken off of Black. Powers said something like,
9 “so you think you are a tough guy,” and then Powers punched Black. At that point, other officers
10 joined in and took Black to the ground.

11 Two other inmates testified. The first was inside the gym, heard a scuffle inside, saw
12 Black go in, saw Black come out and heard what he thought was a scuffle in the gym. Another
13 inmate testified he also heard the scuffle, and saw part of what happened in the gym. Afterwards,
14 Powers instructed the inmate to “clean this mess up,” referring to the inside of the gym. Powers
15 had been interviewed by the FBI at some point during the pre-trial process, and told the FBI he
16 struck Black during that incident in order to bring him under control. Wise testified that he came
17 on duty after the Black incident as a supervisor, checked to see if there had been any incidents
18 that required his attention and found there had been none, nothing was recorded in any way.
19 Soon after Wise started his shift, Payne went to medical and reported an injury. Medical staff
20 then contacted Wise because there were had been no reports to support an incident that would
21 have resulted in an injury to Payne.

22 Wise called Payne to find out what had happened. Payne said there was an incident with
23 an inmate and he had been injured. Wise ordered that reports be written. Those reports were
24 introduced at trial. They all reflected an incident between the group of officers and Black, and
25 they all claimed that Black had assaulted Powers. Wise thought it was very unusual that no
26 administrative action had been taken against Black. Inmate assaults on staff were taken very

1 seriously.

2 The suspected perjurious testimony concerning the Black incident was as follows:
3 Correctional Officer Tuttle testified for the defense and said that Powers did not assault Black.
4 (Haag Tr. 780 - 783).

5 **Chester Incident**

6 The Chester incident was explained to the jury through testimony of Correctional Officer
7 Schembri. Correctional Officer Judy Glover (“Glover”), former Correctional Officer Mather,
8 former Correctional Officer Joe Manzano (“Manzano”) and the inmate/victim, Leonard Chester
9 (“Chester”). A teacher at PBSP and several other witnesses also testified about motive.

10 Schembri testified that he was in a gun tower and was approached by Officer Bill Jones.
11 Jones said something to the effect that Powers wasn’t sure about Schembri and that Powers
12 wanted Jones to come up and check him out and that Jones had told Powers he would take care
13 of it. Jones told Schembri that an inmate was going to be hit on the yard that day and for
14 Schembri to look the other way. Schembri did not know the inmate who Jones was talking
15 about. He didn’t know if Jones was serious or not. Schembri thought it might be a test or a joke.
16 Schembri asked Jones questions about the prisoner and Jones described the inmate as a Black
17 man who normally wore blue sunglasses. Schembri then knew who Jones was talking about.
18 After further questioning, Jones told Schembri the yard was going to be recalled late, and
19 Schembri needed to look the other way. After Jones left the gun tower Schembri called his wife,
20 who also worked at PBSP. Nothing happened that day.

21 The next day Schembri had a different assignment. At some point he left his post and
22 went to run an errand. As Schembri was returning, he heard the yard being called down, looked
23 over and saw that the same inmate whom Jones had been talking about - Chester - had been
24 stabbed on the yard. Schembri responded to the incident. Powers was on-site and ordered
25 Schembri to preserve the crime scene. Schembri saw the weapon that had been used to stab
26 Chester.

1 Judy Glover also testified. She was an investigator at the prison and was called to the
2 yard in response to the stabbing. Glover said Powers was in charge of the yard. Glover went out
3 to the yard and saw that an inmate had been stabbed. Schembri pointed out the weapon. Glover
4 asked Powers if he had any suspects and he said he did not. Glover took control of the weapon
5 and went to interview Chester, who had been taken to medical. Glover asked Chester who
6 stabbed him. Chester said he'd already told Powers who did it. Glover returned to Powers and
7 asked about Chester's statement. Powers said it wasn't true. Glover again asked Powers if he
8 had a suspect. Powers said he didn't because there were too many people on the yard. Glover
9 observed that in her absence, Powers had begun to allow inmates go back to their cells. She later
10 determined he had made no effort to record the names of the inmates on the yard at the time of
11 the stabbing, nor did he search them when they returned to their cells.

12 Chester testified that he had been having run-ins with officers who worked with Powers.
13 He had been approached a couple of days before the stabbing by Officers Sanders and Payne,
14 who strip searched him. Sanders said to Chester something to the effect of, "we know what you
15 are up to and we'll take care of our business on the yard." That made Chester nervous about the
16 officers. Chester wanted to return to his cell the day he was stabbed. He approached Officer
17 Mather and asked to go back to his cell. Mather called the office, and then told Chester that "per
18 the Lieutenant," he was not allowed to let Chester go to his cell. Mather told Chester he needed
19 to talk to the Lieutenant. When Chester crossed the yard to talk to the Lieutenant, he was
20 stabbed.

21 Officer Manzano was in the control booth when Jones came in to speak with Schembri.
22 Manzano remembered Jones coming into the control booth and speaking to Schembri. Manzano
23 also testified the discussion had something to do with an inmate being in trouble.

24 The suspected perjurious testimony presented by Ms. Haag was as follows: Jones
25 testified for the defense and denied that he had a conversation in the gun tower with Schembri.
26 (Haag Tr. 784 - 789).

1 F. The Failure to Promptly Commence the Administrative Investigations.

2 Parry retired from the Department of Corrections on July 17, 2002. Thereafter, the
3 leadership positions he held in LEIU and OIS were filled by a series of “acting” Assistant
4 Directors. (Parry Tr. 430). For example, George Ortiz served for a short period of time as the
5 acting Assistant Director in LEIU, followed by Rick Rimmer. Moore became the acting
6 Assistant Director of OIS. Meanwhile, investigator Reynoso returned to LEIU and began a series
7 of assignments on the streets (Parry Tr. 431; Reynoso Tr. 523).

8 The Jones, Matlock, and Tuttle investigations, which Parry assured the Special Master
9 would begin in June 2002, did not in fact begin for four months. The reason for the four month
10 delay is not in dispute. Moore, the acting Director of OIS, simply did not prepare the requisite
11 989 forms until October 2002. Although OIS agent Ballard was told in May or June 2002 he
12 would be assigned to investigate the cases, he was not officially assigned until October. (Ballard
13 Tr. 271- 272; Barbara Tr. 31, 32, 35-36). *See also* the 989's dated October 8, 2002 (Exhibits 4, 6
14 & 7).

15 An internal affairs investigation cannot begin without a signed 989. Sound policy reasons
16 exist for the 989 requirement, to ensure that the nature of the investigation and the specific
17 subjects are carefully documented. (*See, e.g.* Grout Tr. 559; Ballard Tr. 275, 285). The delay
18 starting the three cases proved critical. Under POBAR, law enforcement personnel have a
19 statutory right to receive formal notice of administrative discipline within one year after the date
20 that management learns of the facts that may justify discipline. The one-year POBAR statute of
21 limitations is “stayed” during criminal prosecutions. Thus, the statute of limitations concerning
22 the investigations of Correctional Officers Jones, Matlock, and Tuttle required that the
23 investigations be completed and the decision to impose discipline or not be made within one year
24 after the Powers/Garcia criminal trial ended. To their credit, the investigator and lawyer team led
25 by Parry made an initial contact with Melinda Haag in a timely manner. Moore’s four month
26 delay, however, dealt the investigations a serious setback from which they never recovered, as
27

1 explained below.

2 The evidence is also undisputed that the 989 forms prepared by Moore in October 2002
3 were vague and repetitive. Indeed, instead of spelling out the different factual situations that
4 required investigations, Moore simply prepared one inaccurate, generic description for all three
5 cases. (Exhibits 4, 6 & 7; Barbara Tr. 37; Ballard T. 295 - 296). *See also* Court expert Dr.
6 Patrick Maher's reports concerning the three investigations, Exhibits 46-48.

7 Finally, the evidence is uncontradicted that, in addition to failing to prepare the 989's in a
8 timely manner and failing to prepare adequately specific 989's, Moore did not tell investigator
9 Ballard about the Post Powers administrative investigation plan. Likewise, Gaultney, the
10 Assistant Chief Counsel of ELU, failed to inform Barbara, the attorney he assigned to the cases,
11 about the Post Powers administrative investigation plan. Thus, the two men directly responsible
12 for implementing the CDC's plan were not aware that it existed. (Barbara Tr. 17; Ballard Tr. 277
13 -279).

14 G. The Post Powers/Garcia Investigation.

15 The course of the three investigations are summarized on the investigation chronologies
16 attached as Exhibits 1, 8 & 9. The investigations were woefully inadequate concerning timing,
17 documentation, and completeness. Court expert Dr. Patrick Maher provides an analysis of the
18 cases in Exhibits 46-48. He concludes the cases were understaffed, were not adequately
19 investigated, and that facts existed, at the time the investigations were shut down by the Director
20 of Corrections, that warranted the cases being completed. Simply stated, Ballard and Barbara
21 were placed into an impossible position given the existing time pressures, inadequate assistance,
22 and their lack of knowledge of the Post Powers investigation and discipline plan. As Dr. Maher
23 reports, there was significant evidence that officer misconduct did take place. At the very least,
24 the investigations were improperly stopped before all of the relevant facts were obtained. The
25 Special Master agrees with Dr. Maher's findings.

26 Some investigative tasks were completed. For example, with respect to Investigation N-
27

1 PBSP-199-02 involving Correctional Officer Tuttle, Ballard interviewed inmate Black on
2 November 26, 2002 at California State Prison Sacramento. Ballard found Black to be truthful.
3 (Ballard Tr. 300). With respect to Investigation N-PBSP-198-02 involving Correctional Officer
4 Jones, Ballard and Barbara traveled to Southern California to interview Correctional Officer
5 Schembri (Barbara Tr. 45; Ballard Tr. 301-303) on December 18, 2002. Schembri informed
6 them, in a taped interview that he had been told by Jones to look away when inmate Chester was
7 to be stabbed in a Pelican Bay recreation yard, consistent with his testimony at the Powers/Garcia
8 criminal trial. Barbara and Ballard found Schembri to be a credible witness (Barbara Tr. 47 &
9 48). After his interview with Schembri, Barbara came to the conclusion that he could prosecute
10 Officer Jones (Barbara Tr. 48).

11 With respect to Investigation N-PBSP-200-02 involving Correctional Officers Matlock
12 and Jones, nothing was completed.

13 Concerning other necessary elements of all three cases, many facts were not properly
14 followed-up and faulty information was obtained that was not properly verified. For example,
15 Ballard requested the personnel file of Mather from PBSP on January 8, 2003. Mather was a
16 critical witness in the Perez incident. Ballard never received the file. (Ballard Tr. 303 - 304).
17 Ballard was also told that inmate Perez had mental health problems. He conveyed this false
18 information to Barbara. (Barbara Tr. 41-42). Neither Ballard nor Barbara took steps to verify the
19 information with PBSP mental health clinicians; indeed, there was no effort to review Mr.
20 Perez's medical file (although Mr. Ballard did attempt to schedule a personal interview with
21 Perez, as explained below). These investigative failures would surface later in the letter
22 conveying false information to the Special Master after the Post Powers investigations were shut-
23 down on March 27, 2003.

24 Throughout the five month investigation period, from October 2002 through March 2003,
25 investigator Ballard essentially worked without guidance or supervision from the Office of
26 Investigative Services. For example, at the hearing of July 30, 2003 the Special Master asked
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1 investigator Ballard the following question: “He (referring to Thomas Moore, Ballard’s
2 supervisor) didn’t sit down with you periodically and have like a status conference and ask you
3 what is the state of these cases?” Ballard responded: “No, not at all.” (Ballard Tr. 277: 14 – 21).

4 H. CCPOA Involvement At the Interview Stage of the Post Powers Investigations.

5 Investigator Ballard planned to interview the witnesses and subjects of the investigations
6 at Pelican Bay during the first week of March 2003. (Ballard Tr. 307-308). Under California
7 law, correctional officers who are the subjects of internal affairs investigations have a statutory
8 right to receive advance notice of investigative interviews and to have a union representative
9 present during the interview. This right does not extend to witnesses who are not the subject of
10 an investigation. Pursuant to “Side Letter Number 12” with the CCPOA, however, the CDC
11 provides advance notice and allows representation not only to the subjects of investigations, *but*
12 *to all other witnesses as well.* (Barbara Tr. 56). The serious negative impact of Side Letter
13 Number 12; for example, how the side letter can be used to enforce the code of silence, is
14 discussed in Section VI. below.

15 Ballard, therefore, had to provide PBSP with written notice of each and every interview
16 he intended to conduct, including Correctional Officers Joseph Manzano, Ronald Parker, Greg
17 Devos, Lt. Maxwell, Tuttle, Jones, and Matlock. Ballard also intended to look for former
18 Correctional Officer Mark Payne, who had left state service. (Ballard Tr. 307-310; Barbara Tr.
19 56 - 58; Miller Tr. 843). In addition, Ballard planned to interview inmate Perez. Ballard
20 informed the internal affairs unit at PBSP which then informed the correctional officer witnesses
21 and subjects. (Yaks Tr. 405 - 406).

22 While Ballard and Barbara believed the incident involving the stabbing of inmate Chester
23 to be their strongest case (based in part on their joint interview of William Schembri), as of
24 March 6, 2003 Ballard had not made up his mind that any case did not have merit and intended to
25 go through the investigation process. (Ballard Tr. 311-312). Thus, the subjects and witnesses for
26 all three cases were to be interviewed.

1 The interviews at PBSP, however, never took place. On March 10, 2003 attorney
2 Christine Albertine of the CCPOA called Ballard and requested he reschedule the interviews.
3 Ballard agreed to postpone the interviews; however, he informed Ms. Albertine that he was under
4 time constraints. A two week postponement was agreed to, subject to a two week extension of
5 the statute of limitations concerning the filing of charges against the subject officers.

6 Thereafter, Ms. Albertine sent Ballard five letters demanding numerous documents prior
7 to conducting the interviews. The documents demanded by the CCPOA included:

8 “[T]he tape of the previous investigatory interview conducted by SSU and trial
9 transcripts . . . any tapes, documents, etc. of previous interviews that (the officer)
10 participated in or transcripts of testimony given by (the officer) regarding the
11 subject of the Federal Trial. These include but are not limited to FBI, grand jury,
12 Department of Justice, or CDC files the Department of Corrections may have. In
addition, if there is any adverse comment contained in any file maintained by the
Department of Corrections regarding this incident, (the officer) is entitled to know
of that comment and respond to it.”

13 Thus, based on the Side Letter Number 12, the CCPOA began a process of demanding
14 documents *prior to allowing* the interviews of witnesses. Ms. Albertine’s letters are attached as
15 Exhibits 10 – 15.

16 Ballard met and conferred with Barbara about the CCPOA’s demand for documents.
17 Barbara told Ballard the CCPOA was not entitled to any documents. Later, however, after
18 Ballard showed Albertine’s letters to Barbara, Barbara recommended they meet and confer with
19 his supervisor, Assistant Chief Counsel Gaultney. (Ballard Tr. 313-315; Barbara Tr. 58-61).

20 I. The March 20, 2003 Meeting Between Ballard, Barbara, and Gaultney and the
21 Decision to Refer the Jones Investigation to the District Attorney of San Francisco.

22 Ballard, Barbara and Gaultney met to discuss the three investigations in Gaultney’s office
23 on March 20, 2003. Gaultney agreed with Barbara, that the CCPOA was not entitled to any
24 documents. Gaultney, however, wanted to know why the U.S. Attorney had not filed criminal
25 charges concerning the Chester investigation, the case with Schembri as a witness and Jones as a
26 subject. Ballard and Barbara did not know. Gaultney told Ballard and Barbara to just “write up
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1 the cases without any interviews, just take your existing docs, and file criminal – submit the case
2 to the San Francisco D.A.’s office.” Gaultney instructed Ballard to submit that case to the D.A.
3 whether the D.A. wants to file it or not. (Ballard Tr. 319). Concerning the Matlock and Tuttle
4 cases, Gaultney instructed Ballard to close them up, to get them done. Investigator Ballard did
5 not interpret that to mean close them with a specific finding, just get them done. (Ballard Tr. 320
6 - 321). It was Ballard’s understanding he should pursue the remaining two cases (Ballard Tr.
7 320-321; 323-324).

8 Two findings are appropriate. First, the side letter agreement that forces CDC
9 investigators to delay interviewing witnesses and allow for CCPOA lawyers to attend the
10 interviews of witnesses, a practice not provided for by POBAR, and the subsequent barrage of
11 demands by the CCPOA had the practical effect of stopping the Post Powers interviews of both
12 witnesses and subjects. Second, the Special Master finds that the legal component of the CDC’s
13 Post Powers investigation suffered from the same lack of competent leadership that plagued the
14 investigation component. Gaultney’s decision to stop all the interviews and refer one of the three
15 cases to the San Francisco District Attorney was either inexcusably negligent or a deliberate
16 attempt to thwart the Post Powers investigations. Gaultney supervised the preparation of the Post
17 Powers Plan. He was briefed about the administrative investigations in June 2002 by Barbara,
18 Parry, and Reynoso. He had reviewed the final version of the Post Powers Plan. He knew the
19 three investigations were looking into violations of the PBSP force policy, and he should have
20 understood that the focus of the investigations was administrative misconduct and discipline.
21 Despite this, Gaultney testified he did not consider the Post Powers investigative plan for
22 administrative discipline when he recommended the case be referred to the district attorney.
23 (Gaultney Tr. 827).

24 Gaultney’s record of conduct is worsened by the fact that the ELU, under his supervision,
25 has no written policy concerning when to recommend that a case under administrative
26 investigation be referred for criminal prosecution. Furthermore, Gaultney failed entirely to
27

1 document the reasons why he made this decision. Under oath on November 21, 2003, Gaultney
2 admitted he had not looked at the applicable California Penal Code section when he referred the
3 case to the district attorney. (Gaultney Tr. 840). California Penal Code § 118 is attached as
4 Exhibit 53. On its face, it appears the statute applies only to oaths “by law of the State of
5 California.” From a practical perspective, given its workload and budget shortfalls, the chances
6 that a federal court perjury claim would receive attention by the San Francisco District Attorney’s
7 Office is nil. It should also be noted that contrary to his recollections under oath (Gaultney Tr.
8 824 & 827), Gaultney discussed the Post Powers interviews at PBSP with the CCPOA’s Chief
9 Counsel, Benjamin C. Sybesma. See the e-mail attached as Exhibit 54.

10 On the other hand, the testimony demonstrates that both Gaultney and Barbara believed
11 there was significant evidence against Jones. For example, Gaultney made the referral to the
12 D.A. because there was reasonable cause to believe perjury had been committed and most cases
13 are submitted to the district attorney on reasonable cause (Gaultney Tr. 826). On the date of the
14 meeting, March 20, 2003, Barbara believed that there was evidence “beyond a reasonable doubt”
15 concerning the guilt of Correctional Officer Jones in the Chester stabbing incident. (Barbara Tr.
16 67, 68, 112). Barbara also believed he could win the case (Barbara Tr. 113).

17 After leaving Gaultney’s office on Thursday, March 20, 2003, investigator Ballard
18 dutifully opened a “criminal” internal affairs case concerning Correctional Officer Jones.
19 (Ballard Tr. 321; Exhibit 16). Ballard then called Lt. Yax and informed him the case was going
20 criminal (Yax Tr. 413). Ballard also called attorney Christine Albertine of the CCPOA and left
21 her a message on March 24, 2003, stating: “I am canceling our interviews. I am not doing any
22 interviews. I am not giving you any documents and I am taking at least one case criminal.”
23 (Ballard Tr. 326 - 327).

1 J. The Divergence of Testimony Concerning the Events of March 24, 2003 to March 27,
2 2003.

3 1. *Introduction.*

4 Seven days after Robert Gaultney decided to file criminal charges against Officer Jones,
5 three days after Ballard called Albertine, a meeting was held in the Office of the Director of
6 Corrections, Edward Alameida, where the decision was made to shut-down the three
7 investigations and prepare a “fact finding” letter to the Special Master that emphasized only the
8 negatives of each case. The attendees at the meeting included Ballard, Barbara, Parry, Moore,
9 Alameida, Tristan, Kinser, and Legal Affairs attorney Beaty.

10 There are two very different versions of what transpired between March 24, 2003 and
11 March 27, 2003. The testimony at the Special Master’s hearings differed dramatically depending
12 upon the job position of the witness. The investigator and the lawyer directly involved in the
13 Post Powers investigations, Bob Ballard and Joe Barbara, testified one way. Alameida, Tristan,
14 and Kinser, collectively referred to as “The Directorate,” had a different recollection.

15 All witnesses, however, agree that it was an extraordinary event to be called to the
16 Director’s Office to discuss an internal affairs investigation. For example, Moore testified that
17 the Post Powers investigations were the only investigations where he met with the Director about
18 a pending case and thereafter closed the case before it was completed. (Moore Tr. 169 - 170).
19 Barbara had met with the Director only once before, concerning the David Lewis case. (Barbara
20 Tr. 84). Ballard had never met Director Alameida concerning a work-related matter, and was
21 apprehensive about being called to the Director’s Office. (Ballard Tr. 392). Even Gaultney, the
22 Assistant Chief Counsel over the Employment Law Unit, who was not invited to the meeting of
23 March 27, 2003, could not recall ever being called into the Director’s office to discuss pending
24 staff discipline. (Gaultney Tr. 839).

1 The meeting in the Director's Office began late. Beaty was the last to arrive. It started
2 with Alameida asking, "Okay, how did we get here?" Ballard and Barbara explained what was
3 going on with the cases. Ballard testified that he started out with an introduction and then started
4 giving a briefing on the Perez, Black, and Chester cases. Someone asked Ballard, "Well,
5 where're we at? What's going on?" Ballard testified that he then pulled out notices that been
6 delivered by the CCPOA. But when he attempted to show the Director the letters, both Alameida
7 and Tristan "looked up and away." (Ballard Tr. 343 – 345). Beaty asked if any of the
8 allegations were true. Ballard said they were all true. The Director said, "How can you say
9 that?" Ballard explained it was because his standard was a preponderance versus reasonable
10 doubt. (Ballard Tr. 346: 14 – 23). Tristan then made a statement about prison gang leader Joe
11 Morgan, which Ballard interpreted as questioning his statement that all of the allegations were
12 true. An exchange of words followed. (Ballard Tr. 346 - 347).

13 Alameida wanted to know where they go from there. Barbara said, "Look, I can take
14 these cases. I've had worse." Alameida became upset and he slammed his fist and said, "That's
15 the problem with all these cases, we should never have had them in the first place." Alameida
16 asked, "How do they go away?" Someone suggested closing the cases with a fact finder and
17 Alameida said, "Let's go with that." It was discussed that the fact finder would state the negative
18 points of the case. (Ballard Tr. 347-348). Barbara asked about how the Special Master would
19 take the decision. It was decided that Parry would inform the Special Master. Ballard
20 understood that he was to write the fact finder letter. (Ballard Tr. 349-350).

21 On March 31, 2003, Moore left Ballard a message saying that Alameida wanted to know
22 where the cases were at. (Ballard Tr. 353; Exhibit 1). Ballard completed the fact finder letter on
23 April 1, 2003. Moore reviewed the letter and told Ballard he would send it up the chain of
24 command. (Ballard Tr. 354). Moore did not tell Ballard to prepare formal IA reports. (Ballard
25 Tr. 357). The fact finder letter that was prepared for the Special Master focused only on the
26 negatives about each Post Powers investigation. (Ballard Tr. 359).

1 A discussion ensued concerning how to make the cases go away. “[I]t was presented to
2 us what are the negatives in the case, present the negatives in the case.” Ballard was assigned the
3 task of preparing a “fact finding” letter to the Special Master, but Barbara, Gaultney, Beaty and
4 Moore also reviewed the letter. Ballard was told to emphasize the negatives in his letter to the
5 Special Master. Ballard did not prepare a formal IA report because of the decision at the March
6 27, 2003 meeting. (Barbara Tr 90- 91, 94, 100, 104).

7 *c. Brian Parry, Retired Annuitant.*

8 Brian Parry was working in LEIU as a “retired annuitant” in March 2003. He received
9 notice of the March 27, 2003 Director’s Office meeting via e-mail. (Parry Tr. 418-420, 438). A
10 few minutes before the meeting, Thomas Moore called Parry and asked him to come upstairs.
11 When Parry arrived, Moore and Ballard were on their way to the Director’s office, so Parry went
12 over with them. Parry did not participate in the pre-meeting between Ballard, Barbara, and
13 Moore, and did not know why Moore asked him to come to his office. (Parry Tr. 440). Parry
14 recalls that the Director was late. (Parry Tr. 440). The meeting began with Ballard giving a
15 briefing on the cases. Barbara also chimed in. Parry did not recall whether or not it was made
16 clear they were planning to go criminal with the Chester case. Parry testified that Ballard did
17 have documents from the CCPOA that he placed on the table. (Parry Tr. 443 - 444). Parry did
18 not remember Alameida’s reaction when Ballard showed him the letters from the CCPOA; nor
19 did he recall David Tristan making a reference to Joe Morgan. (Parry Tr. 452). The focus shifted
20 to the Chester case and Parry remembers Barbara saying he could put the case on but he could
21 not win it. (Parry Tr. 443- 444). Parry remembers Alameida reacting, he pushed away from the
22 table and said something like, “Well, that’s the problem, why are we going to put on cases that
23 we can’t win.”

24 Parry saw that Barbara realized Alameida was getting angry. (Parry Tr. 445). Parry
25 described the Director’s reaction as being frustrated. Following Alameida’s reaction, there was a
26 discussion as to how the cases would be finished-up. It was not Parry’s idea to close the cases
27

1 out as a fact finder. (Parry Tr. 445). In response to the Special Master asking: “Did you ever ask,
2 why am I here?” Brian Parry responded: “I thought it. It wasn’t my case anymore. I didn’t have
3 anything to do with it anymore, but I felt Tom Moore dragged me into it. Why, I don’t know, but
4 I was there.” (Parry Tr. 446). “Then I think Agent Ballard was given direction to close it out
5 with a fact finder, and I think that’s the way it was left. When I left there, I am not so sure that I
6 felt Ballard had been given clear direction.” (Parry Tr. 446).

7 Parry was asked to contact the Special Master about the decision made to close down the
8 investigations. Dennis Beaty made this suggestion, after which Alameida said, “Brian would you
9 do me the favor, call Mr. Hagar and tell him it’s my decision is [sic] insufficient evidence to go
10 further on these cases.” Parry was also asked to contact CCPOA Vice President Chuck
11 Alexander and tell him about the decisions. Parry left Alexander a voice mail explaining they
12 were not going further on the cases because of insufficient evidence. (Parry Tr. 448 & 450).
13 Parry called the Special Master a day or two later.

14 *2. The Testimony of the Directorate.*

15 *a. Edward Alameida, Director.*

16 Alameida testified that he was contacted by CCPOA Vice President Chuck Alexander in
17 mid-March 2003. He was alone in his office when he received the call. Alexander spoke about
18 three different subjects; fire camp uniforms for staff, employee compensation for a correctional
19 officer who had been in Iraq, and the Post Powers perjury investigation at PBSP. Alexander
20 asked whether the Director knew the status of that case, to which Alameida replied “no.”
21 (Alameida Tr. 696 - 698). Alameida did not recall whether he indicated to Alexander that he
22 would look into the situation, nor did he document the call or receive anything in writing from
23 Alexander. (Alameida Tr. 698). He considered the question to be run-of-the-mill, a conversation
24 that lasted “about a minute or two at the most.” (Alameida Tr. 803 - 804).

25 Alameida was not aware of Alexander’s role as the CCPOA representative during the IA
26 and FBI interviews of correctional officers concerning the Powers/Garcia criminal cases; nor was

1 he aware that Alexander had been investigated by the office of investigative services based on a
2 request from Regional Director Pickett, nor was he aware of the findings of the Knowles/Palmer
3 report, nor was he aware that charges had been sustained against Alexander concerning his
4 conduct during the criminal investigations, nor was he aware that Alexander had sued the CDC
5 concerning the investigation. (Alameida Tr. 700- 703). Alameida testified that had he known
6 about the investigation and lawsuit he would not have dealt with Alexander any differently in
7 March 2003. (Alameida Tr. 704).

8 Alameida did not know who set up the March 27, 2003 meeting. He received a card from
9 his secretary on the morning of March 27th showing a 4:00 p.m. meeting with OIS. Tristan and
10 Kinser came to the meeting through Alameida's intervention. (Alameida Tr. 706) . At the time
11 of the meeting, Alameida did not know what the meeting was about. He was aware that there
12 were problems with the administration of the OIS; however, at the time of the meeting he
13 believed the problems identified by the OIG had been corrected. He subsequently determined
14 that was not correct. (Alameida Tr. 708-709; *see also* Exhibit 29).

15 The March 27th meeting began with discussion about the CCPOA demand for documents
16 and it was decided that the documents should not be provided. Alameida had the impression that
17 a decision was being sought from him as Director as to how the cases would proceed. Although
18 he was not given a written investigative report, he thought the cases were completed. Alameida
19 never specifically asked Moore if the investigation was completed (Alameida Tr. 712 - 713).
20 Then Ballard and Barbara talked about the merits of the cases that were the focus of the meeting.
21 Two cases did not merit further action, so they focused on one case. There were a number of
22 different facets of the case that were discussed in detail, e.g. a witness was out of state, an
23 inmate's mental health capacity, and conflicting testimony between officers in a control booth.
24 The personnel at the meeting also discussed why the U.S. Attorney chose not to prosecute the
25 cases, as well as the recanting of testimony. (Alameida Tr. 714). Alameida asked all of the
26 meeting attendees if there were any reservations about not proceeding with the case. He made
27

1 the decision not to proceed, he is the ultimate decision maker. (Alameida Tr. 717).

2 Alameida did not recall Tristan making a reference to Joe Morgan, he did not recall an
3 argument between Ballard and Tristan. He did recall Barbara saying he didn't believe he had a
4 winnable case. Alameida did not ask why the case was brought to him rather than Warden
5 McGrath. He assumed it was presented to him as Director because it was high profile. He did
6 not know about the Post Powers Plan. No one told him that the Post Powers Plan called for the
7 case to be referred to the Warden of the institution where the employee worked. (Alameida Tr.
8 714 - 716). The cases were not presented to him in terms of the allegations being sustained or
9 not sustained, and he did not ask for the cases to be presented to him in those terms because he
10 did not call the meeting. (Alameida Tr. 720 - 721). Had a potential criminal matter been brought
11 to his attention, he would have asked who made the recommendation. If that person was not at
12 the meeting, he would have halted the meeting and had the recommending party join the meeting.
13 If that person could not join the meeting Alameida would not have made the decision he did
14 without first speaking to that person. Alameida was not aware that Gaultney had referred the
15 Chester case to the San Francisco County District Attorney until 3 months later. (Alameida Tr.
16 805 - 807; 728). If Alameida had known he had eight weeks rather than two weeks before the
17 POBAR statute of limitations expired, he would have handled the matter differently. There
18 would have been more opportunity to cull out the issues associated with the case if there were
19 any. It may not have made a difference concerning the actual decision, but they would have had
20 more than forty-five minutes to discuss the investigation. (Alameida Tr. 811 - 812).

21 Once the decision was made not to go forward with the case, a discussion ensued
22 concerning how the decision should be communicated to the Special Master. Beaty mentioned
23 that the Special Master needed to be contacted. There was no discussion to emphasize the
24 negatives of the case. (Alameida Tr. 718-719). The decision was made that Parry would contact
25 the Special Master. Alameida also instructed Parry to contact Alexander. Alameida instructed
26 Parry to contact Alexander because Alameida thought that he should respond to Alexander's

1 earlier inquiries. Specifically, Alameida told Parry, “Would you please contact Chuck Alexander
2 and let him know the outcome of our discussions?” (Alameida Tr. 724). Alameida did not
3 instruct the investigators to provide the Special Master with investigative reports because he felt
4 they were appraising the Special Master of the outcome. He expected a formalized investigative
5 report would be done and transmitted in due course, and that the letter sent to the Special Master
6 was just an initial communication. (Alameida Tr. 719 - 720).

7 *b. David Tristan, Chief Deputy Director.*

8 David Tristan retired from the CDC in June 2003. In March 2003, he was the Chief
9 Deputy Director of field operations, with administrative responsibility for the institutions
10 division, parole, and health care services (Tristan Tr. 853-855).

11 Tristan arrived at the March 27, 2003 meeting with Alameida and Kinser. The meeting
12 began with the Director asking what was the purpose of the meeting. Moore asked that the
13 Director be briefed on the status of the cases, turning the meeting over to Ballard and Barbara.
14 (Tristan Tr. 856.). Ballard and Barbara presented the strengths and weaknesses of the cases in a
15 general sense, it was not a briefing in terms of specifics. The only case for which Tristan
16 remembers evidence being discussed was the case involving the assault on inmate Chester. The
17 Director did not make the statement, “how do we make these cases go away?” (Tristan Tr. 864).
18 Tristan did not make a reference to Joe Morgan during the meeting. (Tristan Tr. 859 - 860).
19 Tristan recalled that there were discussions about CCPOA requesting documents, however he did
20 not recall any discussion of any witness interviews that were or weren’t held. (Tristan Tr. 859).
21 Someone asked Ballard whether or not the case could be proved and Ballard responded by stating
22 that perjury had occurred, but it would be difficult to prove. Someone also asked whether
23 Barbara could present the case and Barbara replied he has presented worse. (Tristan Tr. 856 -
24 858). Tristan was under the impression that the evidence in the cases was very weak. At the end
25 of the meeting, the Director asked everyone in the meeting individually whether they should
26 move forward with adverse action on the cases. The Directorate, without exception, stated the

1 cases should not go forward. Ballard and Barbara remained silent. (Tristan Tr. 861 - 863).
2 Someone at the meeting said the Special Master should be informed of the decision. The
3 Director asked Moore to write a letter to the Special Master, and asked Legal to help with the
4 letter. There was no discussion as to what the letter should say. The Director asked Parry to
5 inform the union. (Tristan Tr. 864 - 865).

6 Mr. Tristan testified there was no mention of specific documents being requested by the
7 CCPOA at the meeting, there was, however, a discussion of a request for documents. He does
8 not know why the Director did not ask for a written investigation report. He acknowledged the
9 CDC rules that require an investigation to have a written report at its conclusion. (Tristan Tr.
10 866 - 867). It wasn't until after the March 27 meeting that Tristan found out that the
11 investigations had not been concluded. In retrospect Tristan knows there should have been a
12 written report on the investigations before a decision was made. (Tristan Tr. 884). He did not ask
13 why the Directorate was involved in the cases. No one told Tristan the investigations were
14 complete, nevertheless, he made an assumption that they were. (Tristan Tr. 881). Considering
15 the high profile of the cases, Tristan did not know why he hadn't heard anything about the cases
16 before the March 27, 2003 meeting. He did not get the details about the evidence that had been
17 presented or discovered because he took everything that was being presented at face value. He
18 did not realize the magnitude of the problem until the Special Master's Post Powers hearings
19 began. Only then did Tristan start asking specific questions about the three Post Powers internal
20 affairs investigations. (Tristan Tr. 871 - 872). Tristan has determined that no case conferences
21 were held by Moore concerning the investigation, and no one was monitoring the cases. He
22 believes that even if a case does not proceed criminally, it does not absolve the CDC of the
23 responsibility to handle it administratively. (Tristan Tr. 884 - 885). He now knows that there are
24 systemic problems with OIS. His knowledge of these problems, however, stems from the Post
25 Powers hearings conducted by the Special Master, department reviews, the OIG's review, senate
26 hearings and a review by Mike Pickett. Some of Pickett's findings indicated the corrective

1 actions that had been presented to the Director from Moore were not in place. (Tristan Tr. 885 -
2 886).

3 *c. Kathy Kinser, Chief Deputy Director.*

4 Kinser was notified by computer scheduling about the March 27, 2003 meeting in the
5 Director's Office. The meeting appeared on her calendar as an OIS case review (Kinser Tr. 232-
6 235). She perceived the meeting as requiring a decision whether to go forward on three cases.
7 At the time of the meeting Kinser did not know of the CDC's Post-Powers Plan. (Kinser Tr. 226-
8 227). The plan was not discussed at the meeting. (Kinser Tr. 228). The meeting involved
9 Ballard and Barbara describing the three cases; however, it was not made clear to Kinser that the
10 investigations were not yet completed. She did not know of the decision to go criminal. (Kinser
11 Tr. 236).

12 In Kinser's opinion, the Directorate should not have held a meeting if the investigations
13 were not completed. (Kinser Tr. 237). Kinser did not recall Alameida's exact words when he
14 made the decision not to go forward, did not recall a discussion about providing the Special
15 Master with a letter containing more negatives than positives, did not recall a discussion between
16 Tristan and Ballard about Joe Morgan, and she did not recall Alameida putting his fist into his
17 hand or being frustrated. (Kinser Tr. 242-246). She admits Alameida "challenges" participants
18 at meetings and recalled that Parry was to contact the Special Master after the meeting. (Kinser
19 Tr. 243 - 245). Kinser testified that the Special Master received an inaccurate memo about three
20 very important investigations that were never completed. (Kinser Tr. 246-247).

21 *3. The Testimony of Dennis Beaty and Thomas Moore.*

22 *a. Dennis Beaty, Legal Affairs Attorney,*

23 Beaty came to the meeting in the Director's Office because of a telephone message from
24 Moore on his answering machine. He denied being responsible for setting up the meeting with
25 the director. (Beaty Tr. 648 - 650). Beaty arrived at the meeting approximately 20 minutes late.
26 He summarized that portion of the meeting he observed as follows: there were a lot of comments
27

1 about the evidence and there was no real confidence that there was a “criminal” case in view of
2 the evidence. Beaty attempted to get a consensus that the case was a good administrative case,
3 where the standard is a preponderance of the evidence rather than beyond a reasonable doubt.
4 (Beaty Tr. 651-652). He recalled Barbara’s statement that he had taken worse cases to trial;
5 however, Beaty had the impression that Barbara meant he would give it the “old college try” but
6 the case was not strong. (Beaty Tr. 654). According to Beaty, Alameida’s reaction was to
7 grimace and back away from the table while holding his fist in his hand, and then asked everyone
8 in the room what they thought. There was a consensus among the Directorate not to proceed on
9 the cases for lack of evidence. (Beaty Tr. 654 - 655).

10 At the time of the meeting, Beaty thought the investigations were complete. It was
11 decided that Parry would inform the Special Master that they were closing the investigations.
12 (Beaty Tr. 658-659). After the meeting Beaty walked out with Ballard and Barbara. Ballard and
13 Barbara were a bit disturbed and didn’t seem happy with the decision to close out. Beaty
14 testified Ballard and Barbara seemed “unsettled.” (Beaty Tr. 661). Beaty did not remember who
15 was to prepare the letter to the Special Master, did not recall Parry being instructed to call
16 Alexander, did not recall a statement that referenced Joe Morgan, did not recall an argument
17 about the difference between an administrator and an investigator, did not recall Brian Parry
18 talking to the director about the Post Powers Plan nor hearing the Director say “how did we get
19 here,” and he did not see Ballard put the letters from the CCPOA on the table at the meeting.
20 (Beaty Tr. 657, 658, 660, 662).

21 *b. Thomas Moore, Deputy Director OIS.*

22 Thomas Moore testified to three different explanations as to why he calendared a 4:00
23 p.m. meeting for the Director’s Office on March 27, 2003. First, he claimed that Brian Parry had
24 contacted him in the hallway of his office and this led to the need for a meeting (Moore Tr. 155-
25 156). After additional questions, however, Moore retracted this testimony (Moore Tr. 156 at 17-
26 23). Moore then testified that after he and Parry heard the briefing from Ballard and Barbara at
27

1 the “pre-meeting of March 27th, “that we realized we had to brief Mr. Alameida now.” Moore
2 had checked the Director’s calendar and knew that he was available. (Moore Tr. 159 at 22-25).
3 Finally, Moore also testified that he called Ballard for a status report on March 25, 2003 based on
4 a call from Dennis Beaty, and this led to the meeting. (Moore Tr. 154, 155). Moore also
5 testified that “on my recall” the Director didn’t contact him to set up the meeting. (Moore Tr.
6 155).

7 At the meeting itself, Moore testified that Mr. Ballard was not passive, indicated he had
8 some work to be done and the case would be difficult to prove, while Barbara said it was a bad
9 case but that he had worse, it was 50/50. (Moore Tr. 167). According to Moore, Ballard stated
10 at the meeting that “I think there’s perjury here but I can’t prove it.” (Moore Tr. 195-196).
11 Moore testified he did not know one of the cases had been referred for criminal prosecution, and
12 that the referral to the D.A. was not mentioned at the meeting. He also did not recall Alameida
13 hitting his fist in his hand. (Moore Tr. 166 & 190). Moore believed they had done enough to
14 draw the conclusion that the cases had no merit, although he also admitted he did not tell the
15 Director the investigations were not completed. (Moore Tr. 168, 193-194). He testified it
16 appears the Special Master “got the negatives” in the close out letter (Moore Tr. 175). Moore
17 expected a formal closure report, the letter to the Special Master was only a cover memo.
18 (Moore Tr. 177-179, 203).

19 K. The Special Master’s Credibility Determination.

20 The Special Master finds the testimony of Ballard and Barbara to be credible. The
21 testimony of Edward Alameida and Thomas Moore, on the other hand, is not believable. In
22 addition to making this assessment based on the demeanor of the witnesses and their credibility
23 during direct and cross examination, the Special Master considered the following factors:

24 1. Ballard and Barbara testified about details. It was apparent, from their
25 perspective, that the events of March 27, 2003 were traumatic. They recalled critical events with
26 more specificity than did Alameida, Moore, Kinser, and Tristan. To a significant degree, the
27

1 testimony of Brian Parry supported Ballard and Barbara's versions of the events of March 25-27,
2 2003. Ballard's testimony is also consistent with his contemporaneously prepared investigation
3 summary (Exhibit 1). Exhibit 1 contradicts Thomas Moore's version of events.

4 2. Ballard and Barbara testified against their career interests. They had nothing to
5 gain by contradicting the statements of the Director of Corrections. Ballard and Barbara admitted
6 being involved in the preparation of a misleading letter to the Special Master. There was no
7 reason for either man to make admissions relating to the letter except to testify honestly,
8 regardless of the consequences. Alameida, and Moore, on the other hand, had much to gain by
9 attempting to convince the Special Master that the meeting in the Director's Office of March 27,
10 2003 did not come about through the influence of the CCPOA.

11 3. It is difficult to believe Alameida's, Moore's, Kinser's, and Tristan's version
12 of what transpired at the meeting of March 27th. Even the most gross incompetence by the
13 Directorate does not excuse their collective failure to inquire whether the investigations were
14 complete. Nor does mere negligence explain the decision to shut-down the investigations
15 without consulting the hiring authority at PBSP, the failure to ensure the preparation of a formal
16 IA report, and their complicity in preparing a misleading letter to be sent to the Federal Court.
17 (Exhibits 18 & 19).

18 4. Mr. Alameida's explanation about his conversation with CCPOA Vice
19 President Chuck Alexander is not believable. Mr. Alexander is an aggressive and intelligent
20 advocate for correctional officer interests. He has been at the forefront of the CCPOA resistance
21 to both the State and Federal criminal investigations of Powers, Garcia, and Lewis for more than
22 a decade. Alexander was investigated by the CDC. Charges were sustained concerning
23 Alexander's inappropriate activity under the guise of Union business (for example, for preparing
24 a SPB request for adverse action with malice, and for misusing his authority as a CCPOA
25 representative to access confidential information). (See Exhibit 26). It is not believable that
26 Alexander would call the Director of Corrections, ask about the status of investigations directly
27

1 Perkins. (Perkins Tr. 961, 963; Clifford Tr. 978 - 979; Exhibits 32, 39, 40).

2 6. There are numerous inconsistencies in the testimony of the members of the
3 Directorate concerning critical aspects of the March 27, 2003 meeting. For example,
4 inconsistencies exist concerning the Directorate's collective recollection of whether Bob Ballard
5 showed Alameida and Tristan the CCPOA letters from Albertine. Inconsistencies also exist
6 concerning whether Alameida told Parry to call Alexander. In addition, the recollection of events
7 by Kinser and Tristan is not as complete as the memory of Bob Ballard and Joseph Barbara. For
8 example, Ms. Kinser responded "I don't recall" or "I do not recall" nine times during her
9 testimony (Kinser Tr. 234:21; 235:22; 242:15; 242:18; 245:23; 246:8; 246:14; 250:24; 259:14).
10 Kinser also testified that it was unclear whether the investigations were completed or not.
11 (Kinser Tr. 276-277). On March 11, 2003, however, Kinser was a recipient of an e-mail from
12 Dennis Beaty wherein Mr. Beaty made it perfectly clear to Moore, Gaultney and Kinser that the
13 cases were not completed. As emphasized by Mr. Beaty: "Blowing the statute of limitations will
14 have major adverse consequences for the Department in the Madrid litigation." Beaty concluded
15 his e-mail by requesting that Moore "make every effort to see that the investigation is concluded
16 quickly and that it is processed expeditiously." (Exhibit 52). Kinser, however, failed to inquire
17 whether the investigations were in fact completed.

18 7. The Special Master finds that Thomas Moore testified falsely. His false
19 testimony was in response to critical questions going to the heart of the Special Master's
20 investigation. For example:

21 a. Moore testified Ballard was tasked in June 2002 with reviewing transcripts, legwork,
22 and giving a report if there was sufficient cause for the three cases to go forward. (Moore Tr.
23 143). Moore testified under oath that Ballard had taken time in July and August to review the
24 Powers' criminal case files and was giving periodic feedback. (Moore Tr. 145). These
25 statements are false. Ballard did not conduct any case review in June 2002. Ballard did not
26 begin to conduct an internal affairs investigation until he received a 989, and Moore did not
27

1 prepare the 989 until October 2002. (Ballard Tr. 274 - 275; Exhibits 4, 6, 7).

2 b. Moore testified: “Agent Ballard was not assigned any other cases and I was
3 transitioning his existing cases off of him.” (Moore Tr. 140). This statement is false. Moore
4 assigned Ballard to the Lewis case between October 2002 and January 2003, telling him he was
5 to be re-assigned to San Francisco and become the liaison between the CDC and the federal
6 government in assisting with the prosecution of Lewis. The Lewis case was not one that Ballard
7 could take on a part-time basis, and Moore told Ballard the Powers/Garcia cases would be
8 reassigned to someone else. Ballard worked on the Lewis case for about three weeks. The case
9 was eventually reassigned to Joe Reynoso. (Ballard 281- 283; Reynoso 514). Thus, not only was
10 Ballard assigned to three Post Powers investigations that were so complicated they were
11 impossible to complete in eight months, he was actually removed from the Post Powers cases for
12 several weeks during October 2002 and temporarily assigned to another complicated matter.

13 c. Moore testified he called Ballard on March 25, 2003 based on a call from Dennis
14 Beaty (Moore Tr. 154, 172). This statement is false. Beaty did not instruct Moore to call Ballard
15 in March 2003 (Beaty Tr. 649-650).

16 d. Moore testified that after he and Parry were briefed about the Post Powers
17 investigations by Ballard and Barbara on March 27, 2003, they realized that they had to “brief
18 Mr. Alameida now.” Moore goes on to state that he had checked Mr. Alameida’s calendar and
19 knew that he was available. (Moore Tr. 159). This explanation concerning why Ballard and
20 Barbara were suddenly called before the Director is false. Moore arranged the March 27th
21 meeting the day prior, on March 26, 2003. The meeting was calendared the day prior, on March
22 26, 2003, and was confirmed by both Moore’s and Alameida’s secretaries (Perkins Tr. 963 -
23 964; Clifford Tr. 979; Exhibits 32, 39, 40). In addition, Ballard received a telephone call from
24 Moore about the meeting on March 25th and also received an e-mail on March 26th about the
25 meeting. (Ballard Tr. 338). Furthermore, Brian Parry did not attend the pre-meeting on March
26 27, 2003, and had nothing to do with calendaring the meeting with the Director. (“No, it wasn’t

1 my case. I wouldn't have set the meeting up with the Director on this." (Parry Tr. 439). Parry
2 also received prior notice of the meeting from Thomas Moore via e-mail. (Parry Tr. 438).
3 Likewise, Beaty received prior notice through a telephone message. (Beaty Tr. 649-650).

4 e. Moore testified that one of the problems with the Post Powers investigations was a
5 lack of supervision by the Special Agent in Charge of the Northern Region, Art Smith. He
6 testified Mr. Smith was inundated with other duties and therefore did not oversee the cases in an
7 adequate manner. (Moore Tr. 138). These statements are false. The Post Powers cases were
8 supervised by Thomas Moore himself. Mr. Smith had no supervisory responsibility for the Post
9 Powers investigations. (Grout Tr. 545; Ballard Tr. 276-277, 380).

10 8. Alameida seriously undermined his credibility by providing the Special Master
11 with two different and incomplete versions of how the decision was made by the CDC to pay for
12 the criminal defense of former Correctional Officer David Lewis' retrial. The first version
13 occurred in the Fall of 2002 after the Special Master was contacted by Assistant United States
14 Attorney Miranda Kane concerning Lewis' retrial. Ms. Kane expressed concerns to the Special
15 Master about the ability of the United States to effectively prosecute the Lewis case after being
16 told by the CDC that Agent Joe Reynoso would not be assigned to assist her. The Special Master
17 had a second meeting with Ms. Kane, Assistant United States Attorney Ismail J. Ramsey, and
18 Agent Joe Reynoso. He was told that the CDC had informed the U.S. Attorney that if another
19 agent was assigned to the Lewis case, the agent would not be allowed to sit at counsel's table.
20 Apparently, the agent would have to wait in the hallway for instructions. In addition, the Special
21 Master was told that the CDC would be paying for the criminal defense of Lewis. This decision
22 was contrary to the position taken at the first Lewis trial, when Acting Director of Corrections
23 Steve Cambra made the decision not to pay for Lewis' defense.

24 Because of these concerns, the Special Master arranged for a meeting with Alameida in
25 late October 2002. After a series of delays, the Director and Special Master met in the Special
26 Master's office in San Francisco. After the one-on-one meeting, Alameida, the Special Master,
27

1 meeting of March 27, 2003 was calendared by Thomas Moore in response to a request from
2 Edward Alameida – after Alameida received a telephone inquiry from CCPOA Vice President
3 Chuck Alexander shortly after Ballard notified the CCPOA of the decision to go criminal in the
4 Chester case on March 24, 2003. Thereafter, the Director shut-down the Post Powers
5 investigations at the March 27, 2003 meeting. The Directorate and Thomas Moore instructed
6 Ballard and Barbara to send a letter to the Special Master that contained only those facts which
7 supported the Director’s decision, a letter that emphasized only the “negatives” of each case.

8 L. The Department of Corrections’ Failure to Comply With the Post Powers
9 Administrative Investigation and Discipline Plan.

10 The evidence is undisputed that the CDC failed to comply with every critical element of
11 the Post Powers Investigative Plan and Disciplinary Review Process plan submitted to the
12 Special Master. (Exhibit 2). Rather than monitoring the plan, Robert Gaultney simply ignored it,
13 and recommended that one of the three investigations “go criminal.” Rather than assigning a
14 team of investigators, only one was assigned. Neither the investigator nor the attorney assigned
15 to the case were told about the plan. Department protocols and procedures were ignored. Instead
16 of completing the investigation in six months, it did not start for four months. The investigations
17 were not completed within the POBAR statute of limitations, thereby precluding administrative
18 employee discipline. Finally, instead of referring completed cases to the Pelican Bay Warden, as
19 called for by the plan, the cases were shut down by the Director of Corrections. No one disputes
20 these facts; indeed Alameida, Tristan, and Kinser admit that problems and misunderstandings
21 adversely affected their decision making process on March 27, 2003. (Alameida Tr. 708 - 709,
22 714 - 716, 805 - 807, 811 - 812; Tristan Tr. 866 - 877, 884, 871 - 872, 885 - 886; Kinser Tr. 226 -
23 227, 236, 246 - 247).

24 While the Special Master is convinced that Barbara Sheldon prepared the plan with the
25 best of intentions, in terms of its implementation, the CDC’s submission to the Special Master
26 was a sham. After the retirement of Brian Parry, no one at the highest level of the Department
27

1 displayed either the will or competence to put the plan into effect. Moore, Gaultney, and the
2 Directorate knew that the criminal acts of Powers and Garcia implicated the most serious of
3 problems at Pelican Bay. Despite this knowledge, they did nothing to pursue three necessary
4 administrative investigations. Collectively, their failure is more than mere negligence, it is
5 nothing less than the awareness of a serious integrity related problem and the subsequent
6 deliberate disregard of that problem.

7 M. The Department of Corrections' Failure to Comply with Department Operating
8 Procedures and OIS Policies Concerning the Post Powers/Garcia Internal Affairs
9 Investigations.

10 The evidence is also undisputed that the CDC failed to comply with almost every critical
11 DOM section and OIS policy during the Post Powers administrative investigations. (Exhibit 20).
12 The cases were started in an untimely manner, the 989's were not adequate, there were no case
13 conferences, and no supervision by Moore. (Moore Tr. 135). None of the cases were
14 completed, none complied with OIS protocols, and every critical step of the normal investigative
15 process did not take place. (Moore Tr. 146-150; Barbara Tr. 26-27; Parry Tr. 447). Even worse,
16 the cases were shut-down by the Director of Corrections without a formal report, and without
17 informing the hiring authority at Pelican Bay State Prison.

18 N. The Department of Corrections' Failure to Comply With the Court Ordered PBSP
19 Use of Force Remedial Plan.

20 1. *Introduction.*

21 As explained at page 4 above, under the Court approved remedial plan, all managers and
22 supervisors involved with PBSP investigations and discipline have the responsibility to
23 investigate incidents of abuse of force, including incidents where correctional officers cover-up,
24 withhold, or act in concert with others to prohibit factual information from being reported as
25 required by the Use of Force Policy.

1 2. *Defendants Violated the Remedial Plan By Failing to Adequately Investigate*
2 *the Perjury Allegations Against Correctional Officers Jones, Matlock, and Tuttle.*

3 Uncontradicted evidence proves that defendants violated the PBSP remedial plan.
4 Simply stated, the CDC failed to investigate the evidence they obtained from the U.S. Attorney
5 that Correctional Officer Jones, Matlock, and Tuttle perjured themselves during the
6 Powers/Garcia criminal case. The investigation began four months late, it was inadequately
7 staffed, Department protocols were ignored, Moore failed to manage the investigations, and the
8 Director of Corrections shut-down the investigations prior to their completion. As Brian Parry
9 testified:

10 Special Master: Have you ever had a Director before March 27, 2003 issue
11 instructions that a pending IA would be closed out through a letter?

12 Brian Parry: Not that I recall.

13 Special Master: And have you ever been at a meeting with a director about a
14 pending IA case when, after the Director made his decision to end the
15 investigation, you were instructed to call the union representative?

16 Brian Parry: No, I don't ever recall that before. (Parry Tr. 472: 9 – 17; *see also*
17 472: 21-25).

18 What happened in the Director's office on March 27, 2003 meeting was reminiscent of
19 what used to take place at Pelican Bay State Prison.

20 It is clear to the Court that while the IAD goes through the necessary
21 motions, it is invariably a counterfeit investigation pursued with one outcome in
22 mind: to avoid finding officer misconduct as often as possible. As described
23 below, not only are all presumptions in favor of the officer, but evidence is
24 routinely strained, twisted or ignored to reached the desired result . . . the IAD
25 applies standards more consistent with criminal than civil or administrative
26 proceedings. Defendants' witnesses testified that an inmate allegation of
27 excessive force will only be sustained if the wrongdoing was "clearly prove[d]
28 with certainty," or "beyond a reasonable doubt." Long Tr. 17-2801; Beckwith Tr.
 17-2764. Suspicions that officers are withholding information are ignored unless
 such misconduct can be "absolutely prove[d]." Beckwith Tr. 17-2752-53. As
 Nathan observed, "If the inmate must establish the misuse of force 'conclusively'
 and by evidence that excludes every 'possibility' other than officer misconduct, he
 will never prevail." Nathan Decl. at 88.

1
2 Second, not only are the above standards exacting on their face, but the
3 manner in which they are applied at Pelican Bay makes them almost impossible to
4 meet. Internal Affairs routinely minimizes or ignores evidence adverse to staff,
5 and strains to find explanations (however implausible) that can be used to reject
6 allegations of excessive force. Thus, as long as some theoretically possible
7 version of events exculpates the officer, it will be relied upon to avoid a finding of
8 culpability, even though it may be highly improbable and lack any credible basis
9 in the record. *Madrid v. Gomez*, supra, 889 F. 1146, 1192-93 (N.D. Cal. 1995)

6 The March 2003 violations of the remedial plan are especially serious because the
7 underlying offenses involve the most egregious form of the code of silence; lying in Federal
8 Court. Furthermore, the CDC employees responsible for the failure to adequately investigate
9 Officers Jones, Matlock, and Tuttle were the Director of Corrections, Edward Alameida, and his
10 highest ranking investigator, Thomas Moore. Nine years after the Order of January 10, 1995 it is
11 apparent that top officials of the Department of Corrections neither understand nor care about the
12 need for fair investigations, nor are they likely to impose discipline in the face of CCPOA
13 objections.

14 3. *Defendants Violated the Remedial Plan By Failing to Prepare a Report of the*
15 *Investigations on the CDC Forms 989 A and B.*

16 Defendants further violated the remedial plan by failing to close out the four open internal
17 affairs investigations with a formal investigative report. The evidence supporting this factual
18 finding is not in dispute: instead of completing a Form 989 A and B report, the CDC sent a
19 misleading and false letter to the Special Master.

20 While a fact finder letter can never substitute for a formal internal affairs report under
21 either the remedial plan or the DOM sections that pertain to OIS, there are circumstances where a
22 fact finder level of review is an appropriate form of investigation. However, as pointed out by
23 Dr. Maher in Exhibit 49, a fact finder investigation under the remedial plan requires the
24 following:

- 25 1. The allegations made
- 26 2. An explanation of the incident

1 3. The written or verbal statements of the witnesses

2 4. The health care information

3 5. A conclusive recommendation.

4 Exhibits 18 & 19 contained the allegations and an explanation of each incident. However,
5 they did not contain written or verbal statements of the witnesses, the health care information, or
6 a recommendation, and they do not conform with the remedial plan. *Use of Force Procedures*
7 *Reporting Allegations of Unnecessary or Excessive Use of Force, Section I.C.*

8 4. *Alameida and Moore Violated the Remedial Plan By Organizing and*
9 *Condoning a Cover-Up Concerning the Shut-Down of the Post Powers*
10 *Investigations.*

11 The false and misleading letters sent to the Special Master in April 2003 (Exhibits 18 &
12 19) violate the Court's use of force remedial orders. The decision to shut down the
13 investigations and subsequently send the Special Master a letter emphasizing only the negatives
14 was an attempt by the Director of Corrections and the Deputy Director of OIS to act in concert
15 with others to prohibit accurate factual information from being reported as required by the Use of
16 Force Policy. Alameida ordered the fact finding letters. Moore not only supervised their
17 completion, he also controlled the actual mailing. In addition, Moore testified that he briefed
18 Alameida about the letters. (Moore Tr. page 185 at 18-21). Consistent with this testimony,
19 Moore's cover letter is dated seven days after the date of the letter signed by Ballard. (Compare
20 Exhibits 18 & 19). Ballard's testimony, as well as his contemporaneously entered notes in
21 Exhibit 1 also affirm that Alameida followed-up with Moore at least once to verify the letters
22 were being completed. Finally, neither Moore, nor any member of the Directorate, including
23 Alameida, Tristan, and Kinser, took action to ensure that the requisite internal affairs reports
24 were prepared.

25 The errors, omissions, and false statements in Exhibits 18 & 19 are serious. They go
26 directly to the question of whether charges against Correctional Officers Jones, Matlock, and

1 Tuttle should be sustained. Assistant U.S. Attorney Melinda Haag summarized the major
2 inaccuracies in Exhibit 19 as follows:

3 ***Perez Incident (2nd Paragraph of Exhibit 19)***

4 The information in the letter concerning this incident is not complete. It fails to include
5 Jim Mather's testimony which, other than the reports themselves, provided essentially all of the
6 evidence in support of the incident at trial. The prosecution did not present any evidence to CDC
7 officials in the meeting in June 2002 that Mr. Perez had a history of mental illness. The
8 government did not call Perez as a witness at trial; they relied solely on Mather's testimony and
9 the reports themselves.

10 ***Chester Incident (3rd Paragraph of Exhibit 19)***

11 This is not a complete summary of the facts concerning this incident. Prior to his
12 appearance at trial, Officer Manzano had made statements that he did not hear the conversation
13 or did not remember the conversation. When Manzano testified at trial, he said he remembered
14 something about it, which was that it had something to do with an inmate in trouble. With
15 respect to Schembri being delinquent in reporting the conversation, he testified that he was
16 troubled by the stabbing and introduced a note he had written and carried in his wallet. Schembri
17 testified at trial that because of the code of silence at the prison that he did not come forward, but
18 when asked four years later in an internal affairs interview, he told the truth.

19 ***Black Incident (1st Paragraph of Exhibit 20)***

20 The first paragraph of the letter does not completely summarize what Ms. Haag told the
21 CDC representatives in the meeting. It does not address Powers telling the FBI agents that he had
22 hit Black. It also does not include the testimony regarding Wise and his concerns about the fact
23 that no reports had been written, as well as the conclusions to be drawn from Wise's testimony.
24 (Haag Tr. 776 - 789).

25 Court expert Dr. Patrick Maher's Memoranda entitled "Review of OIA Northern Region
26 April 1, 2003 Fact Finder - Powers/Garcia Perjury Issues" is attached as Exhibit 49. Dr. Maher
27

1 summarizes the defects of Exhibit 19, and concludes it does not conform to the remedial plan,
2 was an inappropriate method of closing an internal affairs investigation, was misleading and
3 inaccurate, failed to indicate the cases were closed with incomplete investigations, failed to
4 provide any of the evidence that supported the fact there was sufficient evidence to at least
5 warrant the completion of the investigations, and did not meet the industry standard for reporting
6 on investigations. The Special Master agrees with each of Dr. Maher's conclusions.

7 O. The OIS Failure to Conduct Adequate Post Powers Investigations is Indicative of
8 Serious Systemic Problems the Department of Corrections has Failed to Correct for More
9 Than Two Years.

10 There is undisputed evidence that the Department of Corrections' failures with the Post
11 Powers investigation are indicative of serious systemic shortfalls that impact all OIS
12 investigations. In October 2001, the OIG completed an audit/assessment of OIS and found a
13 series of very serious systemic problems that included the following: an inaccurate and unreliable
14 management reporting system, the absence of a system for assessing case priority, inadequate
15 controls to prevent abuse of overtime pay, ineffective oversight of regional offices, inadequate
16 background checks of investigators, failure to conduct background checks of borrowed staff,
17 inadequate staff training, inadequate control over access to the case tracking system, inadequate
18 documentation in case files, inconsistencies among regional offices in rejecting cases for
19 investigation, deficiencies in handling and storing evidence, and deficiencies in armory policies
20 and procedures. (Exhibit 29).

21 The OIG's report was submitted directly from the then Inspector General, Steve White, to
22 Alameida. Parry was the acting Assistant Director of OIS when the report issued. He reviewed
23 the report at the Director's request and prepared a responsive letter. Parry agreed with the
24 findings of the Inspector General. (Parry Tr. 457-458). After Parry's retirement, Moore was
25 charged with preparing a corrective action plan to correct the problems found by the OIG.
26 Moore's January 21, 2003 report about the status of the corrective action plan is attached as
27

1 Exhibit 21. The information reported by Mr. Moore in this document is almost entirely false.
2 There has been no real corrective action. Concerning almost every major problem found by the
3 OIG, nothing had changed from October 30, 2001, the date of Mr. White's letter, to July 30,
4 2003, the date of the first of the Special Master's hearings.

5 For example, when Moore wrote his report there was not an approved OIS policy manual
6 available for OIS agents, a problem that has existed since the beginning of the unit. (Grout Tr.
7 555). Thus, some offices utilized a six month standard for completing cases, while others
8 attempt to comply with a ninety day standard. There had been changes to the management
9 information system, but it is not much different from the old format. (Grout Tr. 564). There
10 were no written procedures for prioritizing cases, nor was there a standardized policy or
11 procedure to control overtime abuse that exists in the three OIS offices. (Grout Tr. 565-568).
12 There was no formalized plan for training for OIS agents, and while a system for the tracking of
13 training existed, not all offices utilized it. (Grout Tr. 572-573). There were no instructive
14 memoranda to ensure that the three OIS regional offices process category II rejections
15 consistently and properly. (Grout Tr. 574). OIS was also not meeting its mandate to review the
16 category I investigations completed by the prisons, and there was no quarterly report to track
17 category I investigations. (Grout Tr. 575).

18 One of the OIG's findings may have public safety implications. The OIG discovered that
19 the CDC has placed an "eleven hour" hour limit on conducting background investigations of
20 potential OIS agents. This limitation apparently applies to all applicants for California
21 correctional officer positions. Sandy Grout, the Agent in Charge of the OIS's Northern Region,
22 has also served the CDC as the Captain over the background check unit. To her knowledge, the
23 eleven hour limitation has not been corrected. (Grout Tr. 586-589).

24 The CDC is required by California Penal Code section 1029.1 to utilize the standards
25 established by the Commission on Peace Office Standards and Training ("POST") as guidelines
26 concerning correctional officer background investigations. A survey of California law
27

1 enforcement agencies indicate that approximately forty hours is required to complete an adequate
2 peace officer background check. Thus, forty hours is the standard benchmark for completing an
3 adequate background investigation of a potential peace officer candidate.

4 The CDC, however, is allocated only eleven hours per correctional officer candidate for
5 this task. Two POST audits of CDC recruitment found that the elements of the background
6 checks of potential correctional officers that were being completed by the CDC were done in an
7 appropriate manner; however, not all of the fieldwork required by POST is completed by the
8 CDC, including credit checks and the critical door to door reference check. CDC has recognized
9 the need for additional funding to correct this problem. Two prior Budget Change Proposals
10 (“BCP”) to obtain the funds necessary to staff an adequate background check unit have, however,
11 been rejected.

12 Important policy considerations mandate the forty hour minimum for background checks
13 for peace officers, including the need to verify the applicant’s background, his mental health, and
14 possible affiliation with criminal gangs. (Grout Tr. 570). If CDC correctional officers are being
15 hired without adequate background checks, both institutional and public safety are compromised.

16 The Special Master finds Moore’s “corrective action summary” dated January 31, 2003
17 (Exhibit 21) to be defective on its face. Even a cursory evaluation of the document puts a reader
18 on notice that no real corrective actions were envisioned. For example, Moore responded to the
19 OIG’s finding about investigation time limits by stating that the DOM has been changed. This
20 statement is false, and reasonable CDC officials should have known it was false. Moore
21 responded to the OIG’s findings about problems with management information by stating: “A
22 completion date in December 2002 was targeted but may be delayed if the project requires
23 additional findings and unforeseen problems with other Divisions impacted by the rewrite.” It is
24 not clear what Moore actually meant by this statement; however, since his update was provided
25 to Alameida in January 2003, it was obvious the target date was not met. No one in the
26 Directorate, however, questioned this explanation. Concerning the OIG’s finding of inconsistent

1 policies, Moore’s report was non-responsive, stating: “A review of the operating procedures
2 revealed the three (3) regional offices are fairly consistent but have some differences due to
3 differences in workload, nature of cases, geography, and available resources.” Moore’s response
4 to the OIG’s finding of a Departmentally imposed 11-hour limit on background checks was also
5 non-responsive, stating: “All investigations are completed within 45-days; however,
6 psychological interviews take longer as they are scheduled and controlled by the State Personnel
7 Board.”

8 The Special Master finds almost all of Moore’s responses to be either inadequate or non-
9 responsive. Nonetheless, Alameida and Tristan testified that they were unaware of problems
10 with OIS. They believed, until the Special Master’s hearings began, that the corrective actions
11 instituted by Thomas Moore were in place. (Alameida Tr. 709; Tristan Tr. 885-886). The
12 CDC’s complete failure to develop and implement an adequate OIG corrective action program
13 after a period of more than two years, indicates that the State of California, without assistance,
14 may be unable to fix the investigation problems that plague the CDC.

15 P. The ELU Failure to Manage Adequate Post Powers/Garcia Administrative
16 Investigations and Discipline is Indicative of Serious Systemic Problems With ELU
17 Operations that the Department of Corrections has Failed to Correct for Two Years.

18 The Special Master finds the Department of Corrections’ failure to complete the Post
19 Powers/Garcia investigations in a timely manner, and its failure to commence discipline, is not
20 an isolated problem. Rather, what happened to the Post Powers investigations are examples of
21 serious systemic shortfalls in the CDC’s adverse action discipline process.

22 The Special Master previously reported to the Court about the *Mayo* cases, which
23 involved MTA’s at PBSP who were not disciplined for very serious violations of CDC policy
24 because the CDC’s investigation and discipline process took more than one year. Because of the
25 *Mayo* cases, in 2001 the Special Master requested that the OIG conduct an audit of the CDC’s
26 adverse action process. Similar to the OIG’s findings in the OIS audit, the OIG audit report of
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1 March 2002 (which has previously been filed under seal with the Court), found numerous
2 systemic problems with the processing of adverse action cases, including a lack of coordination
3 between ELU and OIS, inadequate or non-existent policies concerning important issues such as
4 when to file an appeal or how to settle a case, inadequate training for OIS agents and the
5 Employee Relations Officers in the prisons, inadequate tracking of discipline related processes,
6 confusion about the POBAR one year statute of limitations, and a lack of clarity concerning the
7 roles and responsibilities of the CDC officials involved with employee discipline. The OIG
8 found that these problems led to *forty percent* of all adverse actions being dismissed or otherwise
9 compromised because the CDC was unable to complete the cases in a one year period of time.

10 In subsequent reports the Special Master informed the Court of the CDC's effort to
11 develop and implement an adequate corrective action plan, and how the CDC's efforts were beset
12 with untimely actions and inadequate responses. While the Special Master has been assured by
13 the highest levels of CDC officials, and their attorneys, that adequate controls now exist on
14 adverse action cases, what happened with the Post Powers investigations reveals the ELU
15 corrective actions are simply not working. Two years have passed since the OIG issued its
16 report. While the CDC attempts to argue that losing *forty percent* of cases is mere incompetence,
17 its failure to fix the problem is tantamount to a deliberate decision to continue business as usual,
18 untimely investigations, untimely discipline, and the failure to track and manage casework,
19 despite the findings of the Court and the Inspector General.

20 The CDC's failure is not a matter of funding; rather, it represents serious management
21 problems at the Directorate level of the Department. The solution is not more money, it is a
22 question of will. Similar to the systemic problems with OIS, the failure to discipline employees
23 in a timely manner presents a serious threat to institutional and public safety. The CDC's
24 inability to fix the ELU indicate that the State of California may be unable to solve the serious
25 problems identified by the Federal Court and the OIG.

1 Q. The Problems Encountered During the Post Powers Investigations are Representative
2 of a Systemic Failure to Adequately Discipline PBSP Correction Officers by the Highest
3 Level of CDC Officials.

4 1. *Introduction.*

5 The Post Powers investigative failures were caused by faulty leadership in the OIS and
6 ELU and the shut-down of three investigations by Alameida. As demonstrated above, this
7 conduct violated the Court's Orders, the Post Powers Plan, and the Departmental Operations
8 Manual. The Post Powers cases, however, are far from unique. Indeed, in the course of the
9 Special Master's hearings, the testimony by a number of witnesses brought at least four other
10 cases to light where the highest levels of CDC officials failed to discipline correctional officers
11 because of their fear of a CCPOA reaction. The acquiescence by the CDC to CCPOA demands,
12 no matter how intrusive, an active code of silence, inept CDC officials, and retaliation against
13 whistle blowers and the investigators brave enough to attempt to enforce the law, has rendered
14 the adverse action process in the California Department of Corrections almost entirely
15 ineffective. The Special Master describes below the four PBSP specific examples of the type of
16 interaction that goes on between the CCPOA and the CDC's top officials.

17 2. *The Director of Correction's Failure to Discipline CCPOA Representatives*
18 *Alexander and Newton.*

19 As documented in the Knowles/Palmer internal affairs report, the charges sustained
20 against CCPOA representatives Alexander and Newton were extremely serious. For example,
21 CCPOA representative Newton received information about Correctional Officer Garcia's illegal
22 conduct and failed to report that conduct. During the same time period, Newton represented
23 Garcia at Garcia's State Personnel Board hearing. The evidence also indicates that Newton lied
24 during the IA investigation itself. Likewise, both Alexander and Newton repeatedly engaged in
25 inappropriate business under the guise of CCPOA business. Essentially, both CCPOA
26 representatives attempted to use the excuse of union representation as cover for their concerted
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1 program to thwart the PBSP investigation into the criminal activities of Garcia and Powers.
2 Alexander and Newton also filed false SPB complaints with malice, dishonest actions that call
3 into question whether either representative has the ethics required of a California Peace Officer.
4 (*See Exhibit 26*). All in all, the interviews recorded in the Knowles/Palmer report present a
5 frightening portrait of union representatives bent on covering-up the criminal abuse of prisoners.

6 Nevertheless, neither CCPOA representative was disciplined in any manner (*Exhibit 57*).
7 Newton remains the CCPOA representative at Pelican Bay. Alexander is now a CCPOA Vice
8 President employed at CCPOA headquarters in Sacramento. He continues to draw a full-time
9 correctional officer salary from Pelican Bay State Prison.

10 3. *The Decision To Pay For the Criminal Defense of Former PBSP Correctional*
11 *Officer David Lewis.*

12 a. *The Court's Findings Re CDC Shooting Reviews.*

13 In its Order of January 10, 1995, the Court found as follows concerning lethal force
14 shooting reviews at Pelican Bay State Prison:

15 As an initial matter, we note that a significant number of shootings go
16 unreviewed altogether. Department regulations require that all firearm discharges
17 be reviewed to determine whether staff actions comply with policy guidelines
18 governing the use of firearms. When the shooting incident results in serious
19 injury or death, the review must be conducted by a departmental Shooting Review
20 Board ("SRB"). Shootings that do not result in serious injury or death must be
21 reviewed by an institutional Shooting Review Team ("SRT"). DOM § 55050.13.
22 Prison records show, however, that at least 24 rifle shots in 19 separate incidents
(between December 1989 and March 31, 1993) were never reviewed at all. Trial
Exh. P- 5571. Some of these shots were shots "for effect" (i.e. shots intended to
hit a person) or shots resulting in injury. In an additional 17 incidents, involving
30 shots, a shooting review number was assigned to the incident, but there is no
evidence that the shooting was ever actually reviewed. Trial Exh. P-5571. Given
defendants' failure to refute the apparent lack of review in these incidents, we
conclude that no such review occurred.

23 Nor have regulations concerning the composition of SRTs been adhered
24 to. Pursuant to the DOM, SRTs must consist of a chairperson plus three officers
25 from different correctional ranks. DOM § 55050.13.1. Yet, until three months
26 before trial, SRTs at Pelican Bay inexplicably consisted of only one administrator.
Not only does a one person "team" clearly defeat the very purpose behind the
group approach to shooting reviews, but it also signals that such shootings are not
considered serious enough to warrant review by more than one person.

1 Of most concern, however, is that the actual review process has been
2 rendered a mockery of its intended purpose. The shooting officer's incident report
3 is typically taken at face value and given little scrutiny, even where it fails to
4 identify any facts that would justify use of lethal force. One administrator
5 candidly expressed the prevailing deferential attitude toward incident reports: "I
6 can't second- guess the officer The only person who can make the
7 determination on whether to fire or not is the officer at the time of the incident."
Lopez Tr. 14-2223. Nor is it a matter of practice to interview persons who either
witnessed or were directly involved in the incident. And although reviewers are
charged with determining whether a shooting was in complete compliance with
relevant policies and procedures, they are not always aware of what those policies
are. Consequently, shooting reviews at Pelican Bay are little more than a
perfunctory validation of the incident report itself.

8 A notable illustration of the lack of meaningful review is provided by the
9 administration's response to officer claims of "stabbing motions" to justify the use
10 of lethal force. As plaintiffs' expert observed, "nobody ever makes a stabbing
11 motion if they don't have a weapon," yet officers at Pelican Bay repeatedly
12 attribute such motions to inmates to explain shooting incidents when after the fact
13 no weapon is found and no one has been cut. Fenton Tr. 5-759. Such a claim
14 suggests that the officer has either made an honest mistake or is engaged in after-
15 the-fact justification. Under either circumstance, some supervisory action is
16 warranted (further training in the former, or training and discipline for lack of
17 candor in the latter). There is no evidence in the record, however, that such action
18 ever took place; on the contrary, a statement that an officer saw "stabbing
19 motions" appears to automatically sanction the shooting.

20 Plaintiffs' expert Nathan joined in Fenton's condemnation of the shooting
21 review process, calling it a "farce." Tr. 13-2038. Defendants' expert also had
22 little positive to say about the shooting review process, and agreed that shootings
23 "could stand more scrutiny" at Pelican Bay. DuBois Tr. 29-4766-4767. The
24 Warden, however, expressed no dissatisfaction with shooting review practices at
25 the prison. Although Warden Marshall receives a copy of all shooting reviews, he
26 could not recall a single review that he had found unsatisfactory. Tr. 22-3815.
27 (*Madrid v. Gomez, supra*, 889 F. Supp. 1190-1192 (footnotes deleted)).

28 b. *The Lewis Shooting Review Failed To Select An Appropriate Review Board,
Failed to Assess Witness Credibility, Failed to Call Inmate Witnesses, Failed to
Call the Correctional Officers Who Observed the Shooting, and Failed Entirely to
Make an Adequate Assessment of Whether Lewis' Shooting of Inmate Long
Complied With CDC Policy.*

The SRB concerning Officer Lewis' shooting of inmate Long is a classic example of the
inadequate lethal force reviews found by the Court in its 1995 opinion. The 1994 SRB (attached
as Exhibit 55) failed to interview the following inmates who were on the yard at the time of the

1 incident and who later provided information to the FBI that Long and Willis (the two inmates
2 who had been fighting) were standing between eight and fifteen feet apart when Lewis shot
3 Long: Levert Brookshire, Lou Costa, Kenny Green, and Steve Conklin. The following staff
4 members were on duty during the incident, they witnessed the incident, and later told the FBI the
5 altercation appeared to be “a weak, sissy fight” or a “fight between a couple of girls.” Noel
6 Patton, Kip Wentz, Rick Aguirre, and Ronald Parker. These correctional officers, however, were
7 also not interviewed by the SRB. The SRB also took no steps to interview staff and inmates
8 about Lewis’ widely know hatred of child molesters, nor did the SRB conduct any form of
9 review of Lewis’ extensive post-incident comments such as, “Long had it coming, he should
10 have died.” Just as important, the SRB failed to review the PBSP “shoot don’t shoot” training
11 video tape. (*See also*, Reynoso Tr. 942-943). Finally, neither the victim, inmate Long, nor
12 inmate Willis, who was allegedly fighting with Long, were interviewed by the SRB.

13 The Special Master has reviewed numerous shooting reviews. He finds the Lewis/Long
14 SRB review entirely inadequate; indeed, there appears to have been an orchestrated attempt to
15 focus the majority of its evaluation on the testimony of PBSP staff who arrived on the scene *after*
16 *the warning shot*. For example, Lt. Larry Scribner testified he responded to the yard only after
17 the first shot, as did Sergeant Madrid, MTA Gordon, Correctional Officer Rice, and Correctional
18 Officer Gonzales. According to the report, however, the second shot was fired within 10 to 30
19 seconds. The SRB asked no questions concerning how, in each of these cases, the reporting
20 officer had time to leave his post, run to the yard, accurately assess what had happened, then
21 watch the second shot and its consequences in a 10 to 30 second time frame.

22 Dr. Patrick Maher’s Memorandum entitled “Lewis SRB Decision Dated July 28, 1994” is
23 attached as Exhibit 59. It points out additional deficiencies in the Board’s composition, the
24 failure to call witnesses, the failure to assess credibility and bias, the failure to properly evaluate
25 the shooting, and the failure to cite relevant policy when making its determination. The Special
26 Master agrees with these findings, including Dr. Maher’s finding that “[n]o competent manager
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1 would use the SRB report as a valid basis for finding Lewis acted in conformance with policy in
2 the use of lethal force against inmate Long.”

3 *c. Director Terhune’s Overhaul of the SRB Process and Acting Director*
4 *Cambra’s Decision Not to Pay for Lewis’ Criminal Trial.*

5 After 1995, the CDC determined that its shooting review process was deeply flawed.
6 Under Cal Terhune’s direction, an entirely new procedure was implemented which requires the
7 prompt investigation of all deadly use of force by LEIU, and the evaluation of all completed
8 investigations by an independent group of law enforcement experts in the context of a Deadly
9 Force Review Board. Given all of this, and after being briefed on the facts surrounding Lewis
10 shooting Harry Long, Acting Director Cambra made the decision, after Lewis was charged with a
11 civil rights violation, not to pay for Long’s criminal defense. (See Parry Tr. 458).

12 Under California law, government entities have no obligation to reimburse their
13 employees for the cost of their criminal defense. (See California Government Code §995.8).
14 Government Code §996.6, however allows a government entity to negotiate with a labor
15 organization a more generous standard of reimbursement. During the Davis administration, the
16 Department of Personnel Administration and the CDC agreed to modify the MOU with the
17 CCPOA to utilize the civil reimbursement standard set forth in Government Code § 995.2 for all
18 claims for criminal defense reimbursement. No explanation has been provided for this change.

19 Even under the civil standard, however, certain types of misconduct, including malice,
20 may preclude an entity from paying for the employee’s defense, as discussed below.

21 *d. Alameida’s and Jensen’s Contacts With the CCPOA and Their*
22 *Decision to Pay For Lewis’ Criminal Defense at the Retrial.*

23 When Lewis’ conviction was overturned by the Ninth Circuit, Alameida, Jensen, and
24 YACA Secretary Robert Presley reversed Cambra’s decision. At the hearing of January 9, 2004,
25 Jensen, the former Under Secretary of YACA, testified that he made the decision to pay for
26 Lewis’ criminal defense at the request of the President of the CCPOA, Mike Jimenez (Jensen Tr.

1 906-908).

2 Jensen was apparently not aware that on June 7, 2002 Benjamin C. Sybesma, Chief
3 Counsel for the CCPOA had meanwhile also sent a letter to Alameida requesting the CDC pay
4 for Lewis' representation. Indeed, the CCPOA had already selected the attorney they wanted to
5 defend Lewis. (Exhibit 35). The CCPOA letter focused entirely on a recently negotiated
6 provision of the union contract, and ignored Government Code § 995.2.

7 Thus, at the same time that Jensen was dealing with CCPOA President Jimenez,
8 Alameida was responding to CCPOA Chief Counsel Sybesma, almost identical to what
9 transpired during the stoppage of the Post Powers interviews at PBSP: Ballard received a series
10 of letters and demands from CCPOA attorney Albertine (Exhibits 10-15), Gaultney was
11 contacted by CCPOA Chief Counsel Sybesma (Exhibit 54), and Alameida was talking with
12 CCPOA Vice President Chuck Alexander.

13 While Jensen's memory has faded (Jensen Tr. 911), CDC documents indicate at least two
14 meetings between CDC/ YACA officials and the CCPOA, the first on June 25, 2002 (*see* the fax
15 face sheet and legal analysis dated June 24, 2002 attached as Exhibit 36), and the second
16 sometime after July 15, 2002 (*see* the fax face sheet and legal opinion of Mark A Mustybrook
17 ("Mustybrook"), Senior Staff Counsel, attached as Exhibit 37). Mustybrook prepared a four page
18 written legal opinion on July 12, 2002 for Alameida that considered both the contract provision
19 and the requirements of the Government Code § 995.2. Mustybrook recommended that "the
20 Department refuse to provide Lewis with a defense in his pending criminal action." (Exhibit 37).

21 At first, Jensen testified that he did not recall seeing Mustybrook's legal opinion prior to
22 making the decision that the CDC should pay for Lewis' retrial. (Jensen Tr. 909). However,
23 after the Special Master showed Jensen a copy of Mustybrook's opinion appended with Jensen's
24 own handwritten notes, he admitted reviewing the opinion. Jensen testified, however, that he
25 relied upon recent revisions to the CCPOA MOU, his discussions with CCPOA President Mike
26 Jimenez, and the fact that the 1994 SRB found the Lewis/Long shooting within policy when he

1 made the decision to pay for Lewis' criminal defense - notwithstanding the contrary legal
2 opinion. Jensen justified the CDC paying for Lewis' criminal defense because he believed the
3 CCPOA Memorandum of Understanding ("MOU") "compelled us to pay for his defense unless
4 there was some uncontradicted evidence to one of these (statutory) exceptions" (Jensen Tr. 938).
5 To Jensen, the MOU established an "uncontradicted evidence" standard of proof that is absent
6 from California Government Code § 995.2. Thus, despite the findings of this Court discussed
7 above, despite the dramatic changes in lethal force reviews initiated by former Director Cal
8 Terhune, despite the compelling evidence that Lewis intentionally shot Long, and the advice of
9 CDC legal counsel, Alameida, Jensen, and Secretary Robert Presley began the process of
10 obtaining a Governor's Action Request ("GAR") to pay for Lewis' defense. A GAR, if
11 approved, would have obligated California taxpayers to fund Lewis' defense by an attorney
12 selected by the CCPOA.

13 Alameida testified that Jensen, not he, made this decision (Alameida Tr. 738-739).
14 Jensen also claims responsibility for the decision. (Jensen Tr. 907). However, an e-mail dated
15 July 25, 2002 from the CDC's Deputy Director of Legal Affairs, John Sugiyama, casts doubt on
16 both claims. Mr. Sugiyama informs two of his attorneys that: "Ed [Alameida] has decided that
17 we will pay for Officer Lewis's representation. According to Kathy Kinser, Ed apparently has in
18 mind that the start date for our obligation will extend backwards only about a month and go
19 forward from that date. Does that time frame correspond to a discrete identifiable event that
20 makes sense? In any event, please prepare the GAR, and alert Bruce that he will need to explain
21 that this is a Unit 6 bargaining matter to the Governor's Office." (See the July 25, 2002 e-mail
22 from John Sugiyama to Catherine Bernstein and Mark Mustybrook attached as Exhibit 38).

23 e. *Summary.*

24 The Special Master finds that the decision to reverse course and pay for Lewis' second
25 defense was based entirely on concerns about the CCPOA. The facts, as well as the legal opinion
26 by the Department's own attorney, mandate the opposite decision. The Special Master notes,
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1 however, that neither Jensen nor Alameida followed-up on their decision and no GAR was sent
2 to Governor Davis. (Keeshen Tr. 957). The new administration has indicated publically that it
3 will not in fact reimburse David Lewis for the cost of his criminal re-trial at this time.

4 4. *CCPOA Vice President Lance Corcoran's Objections to Joe Reynoso Sitting*
5 *At Counsel's Table During the Lewis Re-Trial.*

6 The long arm of the CCPOA's influence over the highest level of CDC officials is also
7 reflected in John Sugiyama's July 25, 2002 e-mail. (Exhibit 38). As the Special Master
8 explained above, in the Fall of 2002 the U.S. Attorney and Joe Reynoso were informed by CDC
9 officials that Reynoso would not be allowed to sit at counsel's table during the re-trial of David
10 Lewis. Alameida told the Special Master he believed this to be important to impart an aura of
11 "neutrality" to the jury.

12 It is now clear, however, that the Director's decision was in fact made because of
13 objections by "Lance." Lance is a reference to Lance Corcoran, the CCPOA Vice President who
14 represents the union before the press. In July 2000 Corcoran apparently also functioned as the
15 CCPOA official who imposed limitations on the CDC's assistance to the United States Attorney.
16 As stated by Mr. Sugiyama, "Lance apparently objected to the fact that CDC personnel in the
17 earlier trial sat at the prosecutor's table. Ed was unclear about the reference - I think Lance was
18 probably referring to CDC investigators who for several years now have been working
19 exclusively for the U.S. Attorney."

20 That the Director of Corrections would entertain and act upon such an objection from a
21 Vice President of the CCPOA, given the history of the union's interference with the
22 Powers/Garcia/Lewis cases, is nothing less than shocking. Mr. Sugiyama continues his e-mail
23 with a practical and valid argument: "If in fact these are the 'CDC' people whom Lance finds
24 objectionable, we (CDC) can do nothing about where the U.S. Attorney may want them to sit."

25 Similar to ignoring Mr. Mustybrook's legal opinion, however, CDC officials ignored Mr.
26 Sugiyama. Joe Reynoso, assigned after several months of delay to assist the U.S. Attorney with
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1 the Lewis re-trial, testified as follows: "I had a conversation with the then assistant director of
2 internal affairs, Thomas Moore, that one of the conditions, one of the conditions being placed
3 upon my assisting the United States Attorney in the prosecution of David Lewis was that I was
4 not to sit at the Government's table; that I was to stand outside the courtroom. And if the
5 Government lawyer had a question, they can somehow get word to me that they had a question
6 and I was supposed to come back into the courtroom see what the question was and then go try
7 and deal with it somehow." (Reynoso Tr. 944-945). Fortunately, the new administration at
8 YACA and CDC have reversed this CCPOA influenced decision. Mr. Reynoso will assist the
9 United States Attorney in the Lewis retrial in the manner deemed appropriate by the United
10 States Attorney.

11 *5. Sergeant George Arquilla's Incompatible Practice of Testifying as a CCPOA*
12 *Expert and the CDC's Failure To Investigate Possible Violations of California*
13 *Code of Regulations, Title 15, Section 3413.*

14 Counsel for the CDC have argued during the hearings that recommendations issued by
15 the Special Master should be limited because violations of the use of force policy at PBSP are
16 rare, as are adverse action discipline cases at the prison. Defendants correctly argue that over the
17 course of several years of Court monitoring, through the effective use of the ERC and corrective
18 actions, PBSP has significantly reduced the amount of force used to control inmates. The prison
19 is far safer today for both inmates and staff than it was at any time between 1990 and 1995.
20 However, the shortfall with defendants' argument is that the Central Office ELU unit has lost
21 almost every case it has taken to the SPB. Furthermore, in almost every case, the loss is caused
22 by something that could and should have been prevented. The June 30, 2003 SPB decision in the
23 case of PBSP Correctional Officer Jerry Reynoso, Case number 03-0405, is a typical example of
24 the ELU's inability to counter the tactics used by the CCPOA during SPB hearings.

25 Jerry Reynoso (no relationship to Joe Reynoso) was appointed at PBSP on October 31,
26 1998. On February 6, 2002 he was found to have used unreasonable force when striking an
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1 inmate in the face while the prisoner was restrained and wearing a spit hood. Reynoso was
2 disciplined by Warden McGrath (five percent salary reduction for six months). He appealed his
3 decision to the SPB.

4 At the SPB hearing of April 16, 2003, George Arquilla, Senior Training Sergeant at the
5 Richard A. McGee Correctional Training Center *testified as an expert CDC witness for the*
6 *CCPOA.* (See Exhibit 61). Diane Robbins, the ELU Staff Counsel representing Warden
7 McGrath, told the Special Master she received no notice from the CCPOA of Sergeant Arquilla's
8 appearance. Ms. Robbins did not, however, object to Sergeant Arquilla's testimony. (Exhibit 61
9 at pages 29-30).

10 The Special Master reviewed other SPB records concerning PBSP cases and discovered
11 that Arquilla testified as a CDC expert for the CCPOA in at least one prior PBSP SPB matter
12 involving Correctional Officer Bridges. Records have not yet been reviewed to determine the
13 number times Arquilla testified as a CCPOA expert in cases at other prisons. The Special Master
14 met with Alameida, counsel for the parties, and two attorneys from the Legal Affairs Division to
15 discuss, among other things, Arquilla's appearance as a CCPOA expert. Alameida and his
16 attorneys informed the Special Master that they were powerless to stop an employee from
17 working as an expert for the CCPOA.

18 The California Code of Regulations contains specific provisions that address the
19 incompatible employment of CDC employees. CDC policy should require obtaining formal
20 approval prior to engaging in any outside activity, and limitations should be imposed on working
21 as an outside expert with formal approval of the CDC. The CDC is not, in fact, powerless to
22 prevent an employee from working as a CDC "expert" for the CCPOA. Apparently, there are no
23 effective CDC policies relating to incompatible outside employment that provide guidance for
24 the wardens and other administrators.

25 The negative outcome of the Reynoso case raises numerous questions relevant to the use
26 of force discipline plan. How many times has Arquilla testified for the CCPOA? How many
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1 times has he informed his superiors prior to testifying? Do Arquilla’s time records reflect his
2 testimony, or has he fraudulently doctored those records? In each of Sergeant Arquilla’s
3 appearances as a CCPOA “expert,” did he testify under the compulsion of a subpoena? When
4 did he receive the subpoena, and when did he inform his superiors? Did the Sergeant obtain the
5 appropriate approval prior to working for the CCPOA as a CDC expert against the CDC itself?
6 Did the CDC pay for Arquilla to testify as a CDC expert against itself? Why? Who paid for
7 Arquilla’s plane flights from Sacramento to Crescent City? When did Arquilla receive the funds
8 for the travel, before or after the issuance of the subpoena (if in fact a subpoena was utilized)?
9 Why didn’t the approving administrator inform the ELU? Why hasn’t Arquilla been disciplined?

10 After the issuance of the Special Master’s draft report, defendants opened an internal
11 affairs case concerning Arquilla’s conduct relative to one incident of his testifying as an expert
12 for the CCPOA. That report, completed on March 15, 2004, was not provided to the Special
13 Master until the Special Master requested a copy in early June 2004. After review, the Special
14 Master finds that the IA report, and the ELU legal opinion upon which the report was based, to
15 be entirely inadequate. Defendants have requested a brief period of additional time to perform a
16 second investigation that addresses the full scope of Arquilla’s conduct, including the legal and
17 ethical consequences that arise when a CDC trainer serves as an expert witness for the CCPOA at
18 the expense of California taxpayers. After receiving assurances that the second investigation will
19 be provided with appropriate level of legal assistance from the ELU, the Special Master has
20 granted defendants’ request. A supplemental report concerning Sergeant Arquilla’s conduct will
21 be filed at a later date.

22 6. *Summary*

23 The Special Master finds the above cases to be indicative of a pattern of interaction
24 between the CCPOA and the highest levels of corrections officials that have adversely affected
25 the implementation of the Use of Force Remedial Plans.

1 R. The Directorate of the Department of Corrections Sanctioned the Code of Silence By
2 Their Decision to Shut-Down the Post Powers/Garcia Administrative Investigations.

3 1. *The CCPOA and the Code of Silence at Pelican Bay*

4 LEIU Agent Joe Reynoso encountered a code of silence on numerous occasions during
5 the course of his investigations at PBSP. Reynoso defined the code of silence as follows:
6 “[W]hen a staff member is aware of misconduct, observed misconduct and fails to come forward
7 or is aware of it and when asked about it refuses to tell the truth.” (Reynoso Tr. 494). As
8 Reynoso testified at the Special Master’s hearing of September 25, 2003:

9 Steven Fama: Why wouldn’t an officer want to provide information that was
10 critical of another officer in your opinion?

11 Joe Reynoso: That’s part of working in a job where you have code of silence
12 issues; you don’t talk about an officer because it could come back to put you in a
13 situation where those officers who you count on may see you as a rat or an
14 informant and they might not come to your assistance. (Reynoso Tr. 527- 528).

15 During the Powers/Garcia/Lewis criminal interviews at PBSP, the CCPOA put out a
16 memo notifying staff that IA was going to be at PBSP and that staff did not have to talk to them
17 if they did not want to. Thus, the union sent a message to correctional officers not to cooperate
18 with IA no matter what position they were in (in other words, even if a correctional officer was a
19 witness to an abuse of force). Because the CCPOA’s intervention resulted in officers refusing to
20 be interviewed by the FBI, the FBI was required to issue subpoenas to force officers to testify
21 before the grand jury. (Reynoso Tr. 496). Reynoso also described the adverse impact of the code
22 of silence on potential witnesses. For example, because of the code of silence one officer did not
23 come forward with any information until he left the CDC’s employment for fear of his safety.
24 (Reynoso Tr. 497).

25 Likewise, Assistant United States Attorney Melinda Haag found a code of silence among
26 PBSP correctional officers that adversely affected the United States’ attempt to prosecute Powers

1 and Garcia. During the June 2002 meeting with the CDC officials, Ms. Haag discussed the code
2 of silence as it related to Officer Schembri and why he did not come forward initially. The code
3 of silence was also discussed with respect to Correctional Officer Mather, who was no longer
4 employed by the Department when he finally came forward and told the truth. Mather had been
5 previously untruthful about the incident; for example, when he provided a declaration in
6 connection with a civil lawsuit that had been filed by inmate Perez. Mather testified he was
7 untruthful in that case because of the code of silence. Since he was still employed by the
8 Department he did not feel like he could tell the truth. (Haag Tr. 794 - 795).

9 Correctional Officer Matlock, one of the three subjects in the Post Powers internal affairs
10 investigations, testified under oath about the process established by the CCPOA for PBSP
11 correctional officers to respond to FBI requests for interviews. Matlock was originally contacted
12 by the FBI in the Fall of 1999. The FBI asked him if they could talk about allegations of staff
13 misconduct. Matlock called the FBI back and told the FBI that after talking to the union, he did
14 not want to talk with them. Matlock told the FBI he would prefer to talk in front of the grand
15 jury, based on the advice from an attorney from CCPOA headquarters. Pursuant to a subpoena,
16 Matlock came to the U.S. Courthouse in San Francisco. He was represented by an attorney hired
17 by the CCPOA for his grand jury appearance. Matlock came to the courthouse in response to the
18 grand jury subpoena involuntarily. He stated on the record that he did not want to be there.
19 [Criminal Trial Transcript, Volume 15 at 2963:1-2966:2].

20 *2. Alameida, Tristan, and Kinser Sanctioned the Code of Silence When They Shut*
21 *Down the Post Powers Investigations on March 27, 2003.*

22 The code of silence, while pervasive, is not a reflection of the ethics and sense of duty of
23 the majority of Pelican Bay correctional officers. A minority of rogue officers can establish a
24 code of silence, threaten the majority, damage cars, isolate uncooperative co-workers, and create
25 an overall atmosphere of deceit and corruption. And if the minority are supported by a powerful
26 CCPOA, and management as well as the CCPOA condones the code of silence, the consequences

1 are severe. For this reason, the highest level of CDC officials must take decisive steps to control
2 the code. Concerning the Post Powers investigations, the Directorate did the very opposite.

3 In many respects, what took place the during the Post Powers internal affairs investigation
4 is identical to the cover-up of the abuse of force detailed at trial. As noted by the Court more
5 than nine years ago:

6 [W]hen (prison administrators) let highly suspicious incidents and investigative
7 reports go unchallenged, and when they promote the code of silence by failing to
8 support those who come forward, they lead us to conclude that they have
9 implicitly sanctioned the misuse of force and acted with a knowing willingness
10 that harm occur. *Madrid v. Gomez, supra*, 889 F.Supp. 1200.

11 The only significant difference between the Post-Powers cases and the testimony at trial
12 is that the Post Powers investigations were shut-down not by prison personnel, but by the highest
13 ranking leaders of the California Department of Corrections, working closely with the Deputy
14 Director of the Office of Investigative Services. The March 27, 2003 meeting in the Director's
15 Office was designed to shut down the investigations. Neither the investigator nor the attorney
16 assigned to the cases were provided an opportunity to prepare for the meeting, the concerns they
17 expressed at the meeting were essentially ignored, and they were excluded from the decision
18 making process.

19 Dr. Maher's Report entitled "Analysis of Organization Culture and Structural Influences
20 on Reporting and Decision Making" is attached as Exhibit 50. As Dr. Maher points out, the code
21 of silence is encouraged by inaction on the part of a correctional leader. Investigating those who
22 are willing to come forward, despite the code of silence, for minor infractions that they readily
23 admit to is one way that staff are discouraged from resisting the code of silence. Likewise,
24 ignoring or not pro-actively obtaining the evidence of misconduct, especially if that misconduct
25 involves the covering-up of serious misconduct, sends a clear message that the administration is
26 indifferent to such actions. If correctional officers are not supported for honesty, and if they
27 observe cover-ups being tolerated by CDC leadership, they will conform to pressure from their
28 peers to conform to the code of silence.

1 For example, while the CDC failed to properly investigate Officers Jones, Matlock, and
2 Tuttle for perjury in Federal Court, the CDC completed a timely investigation of Schembri for
3 having minimal contact with his lieutenant when he was first served notice of his interview with
4 the FBI. The charges against Schembri were sustained; indeed, Schembri never denied them.
5 However, once the investigation was complete, the CDC did nothing. In fact, the CDC is unable
6 to provide documents showing the resolution of the Schembri investigation. *See* Exhibit 56:
7 Letter from Reynando J. Accooe stating that the CDC is unable to provide any documents that
8 summarize the disposition of IA Report No. 40-002-96 - subject William Schembri. *See also*
9 Exhibit 50. As Dr. Maher points out, investigating a whistle-blower for an act he readily admits
10 to, finding misconduct, then ignoring the alleged misconduct is an all too typical method used to
11 foster the code of silence.

12 3. *Summary*

13 Based on all the evidence, the Special Master finds that the CDC's Directorate sanctioned
14 the code of silence in the following manner with respect to the Post Powers investigations.

15 1. Failing to properly investigate potentially egregious examples of the code of silence:
16 perjury in Federal Court to cover-up misconduct of a fellow officer.

17 2. Shutting down internal affairs investigations without consulting the prison hiring
18 authority and in violation of the DOM and the Court ordered Use of Force Remedial Plan.

19 3. Punishing the Post Powers whistle-blower, William Schembri.

20 4. Attempting to hide the facts supporting misconduct by Correctional Officers Jones,
21 Matlock, and Tuttle by submitting a false and misleading document to the Special Master.

22 The Special Master also finds there is a code of silence about the code of silence in the
23 CDC's Central Office, an attitude of benign neglect concerning the history of CCPOA's
24 interference with criminal investigations, which in turn allows continued interference by the
25 union that causes many investigations and adverse action cases to end without success.

1 retrieval, and (4) failure to stop a CDC Training Sergeant from repeatedly testifying as a CDC
2 expert witness for the CCPOA against the CDC, in violation of California Code of Regulations
3 Title 15. This evidence, combined with the failures in the Post Powers investigation, and the
4 comprehensive reports from the Office of Inspector General finding serious systemic failings in
5 both the Office of Investigative Services and the Employment Law Unit, demonstrates that the
6 California Department of Corrections has lost control of its investigative and discipline
7 processes.

8 Perhaps most importantly, the evidence demonstrates that without the Special Master's
9 hearings the investigation and discipline problems discussed in this report would never have
10 come to light. This underscores the fact that the State of California has no effective mechanism
11 for monitoring and correcting abuses when they occur within the Department of Corrections'
12 investigation and discipline system. Without question, a competent, independent review process
13 is needed to oversee CDC investigations and discipline, an organization with the authority to
14 provide oversight on a real time basis and to report its monitoring findings to government
15 officials and the public.

16 VI.

17 DISCUSSION OF RECOMMENDATIONS

18 A. Introduction.

19 The formulation of recommendations that adequately address the pervasive CDC
20 problems concerning investigations and adverse action discipline cases presents serious
21 challenges. On the one hand, the imposition of correctional officer discipline is governed by
22 California statutes and the CDC/CCPOA MOU. To a significant degree, employee discipline is
23 peculiarly a matter of State law.

24 On the other hand, the CDC's failure to properly investigate Correctional Officers Jones,
25 Matlock, and Tuttle represents a blatant violation of the remedial plan. Simply stated, significant
26 evidence existed that three correctional officers perjured themselves in Federal Court about
27

1 incidents where PBSP employees beat two prisoners, and set up an incident where one prisoner
2 stabbed another. The Post Powers hearings demonstrate that after nine years of remedial work,
3 the CDC's Central Office still is unable to discipline correctional officers for their involvement
4 in the abuse of inmates.

5 To make matters worse, this failure was initiated and condoned by the highest levels of
6 CDC management, and it was followed by an attempt to deceive the Special Master and Federal
7 Court. Furthermore, the Post Powers cases are not isolated examples, they are indicative of a
8 pattern of inadequate investigations and the failure to discipline correctional officers for serious
9 abuses of force, as reflected in the OIG audit reports.

10 The evidence also reveals a long standing and pervasive pattern of interference by the
11 CCPOA, the most powerful labor organization in the State of California. Instead of working to
12 correct these problems, the union denies that they exist. To complicate matters, the CDC and
13 Department of Personnel Administration, with the approval of the California Legislature, have
14 entered into a series of MOU modifications whereby the delicate balance struck by California
15 statutes between holding a peace officer to the high standards expected by the public and
16 safeguarding that peace officer's due process rights, has been prejudiced to a degree where
17 timely, fair, and effective investigations of inmate abuse may well be impossible. As detailed
18 below, the MOU places inmate victims in immediate jeopardy whenever they report the abuse of
19 force. It also serves to prevent timely and cost effective investigations, and provides the CCPOA
20 with the ideal instrument to enforce the code of silence.

21 As the Court is aware, the Special Master has steadily recommended the cessation of
22 monitoring at Pelican Bay State Prison. As a result, the scope of *Madrid* monitoring is today
23 only a small fraction of the monitoring which began in 1995. However, after completion of the
24 Post Powers hearings, after working with State officials, attending Senate Hearings, and
25 reviewing the amicus submission of the CCPOA, the Special Master is convinced that the Court
26 must take firm steps to ensure the fairness and effectiveness of the CDC's adverse action process.

1 Without some level of intervention by the Federal Court, the problems described above will not
2 be corrected by the State of California at Pelican Bay State Prison or at any other CDC
3 institution.

4 An important additional factor justifies Court intervention. Bad investigations and the
5 failure to discipline staff who abuse prisoners jeopardizes prison security. Likewise, an active
6 code of silence threatens inmates, honest officers, security, and public safety. The Special
7 Master has, over the course of seven years, talked with numerous PBSP employees, including
8 recently hired correctional officers, nurses, and MTAs. The correctional officer recruits who
9 seek employment within the CDC do so with high expectations. They come to the CDC with
10 positive motives, consistent with other applicants who seek a career in law enforcement. The
11 young men and women who seek CDC employment do not apply for peace officer jobs to
12 commit crimes, or to lie, or to cover-up the abuses of individuals like Powers or Garcia. Rookie
13 correctional officers, however, are forced to adopt the code of silence in order to survive. Rather
14 than CDC staff *correcting* the prisoners, some correctional officers end up acquiring a prisoner's
15 mentality: they form gangs, align with gangs, and spread the code of silence.

16 The code of silence is taught to new recruits because of a longstanding CDC culture,
17 turning good officers bad. The Department has failed to address the situation in any effective
18 manner; indeed, the evidence demonstrates that the Directorate turned its head when confronted
19 with the code of silence, especially if the CCPOA was involved. To make matters worse, the
20 CCPOA, as explained above, continues to deny that a code of silence exists. It cannot be
21 emphasized too strongly that the code of silence is always accompanied by corruption. It serves
22 no legitimate penological purpose. It harms inmates and destroys the careers of correctional
23 officers. If the CDC cannot correct a serious problem that threatens the security of its prisons
24 and allows for abuse of prisoners by correctional officers in violation of the long standing
25 remedial orders, the Court has the obligation to intervene.

1 Mr. Hickman has announced a “zero tolerance” policy concerning the code of silence
2 (Exhibit 65). YACA and CDC officials, counsel for plaintiffs, and the Special Master have
3 engaged in a series of meetings concerning possible remedial efforts. The Special Master
4 characterizes the progress as positive. All in all, defendants’ effort to formulate an adequate
5 remedial plan is better organized and staffed today than at any time in the past nine years.

6 In addition, Governor Schwarzenegger made the decision to re-institute a strong Office of
7 the Inspector General. Matthew Cate has been nominated as the Inspector General and has
8 actively participated in the Post Powers remedial process. Michael Gennaco, an experienced
9 civil rights litigator who manages the Office of Independent Review that monitors the internal
10 affairs investigations of the Los Angeles County Sheriff, has been appointed the Court’s expert to
11 assist the parties with the remedial process.

12 D. Summary and Evaluation of the CDC’s Proposed Post Powers Remedial Plan.

13 1. *Introduction.*

14 As of the date of the filing of this report, defendants, working with the Special Master,
15 the Court experts, the lawyers for the parties, and the Inspector General, have proposed a Post
16 Powers remedial plan that contains the following elements:

17 1. A program to improve the integrity, quality, efficiency, and timeliness of
18 investigations in OIS, including new management; the preparation of consistent
19 polices, procedures and expectations; improvements with both recruitment and
20 training; the implementation of policies to protect investigation confidentiality;
21 establishing adequate computerized controls to monitor case processing and to
22 interface more efficiently with ELU and the prisons; the development of an
23 Administrative Support Unit; and the development of more effective and open
24 reporting mechanisms for the legislature and other interested agencies.

25 2. A program to improve the integrity, quality, efficiency, and timeliness of the
26 ELU, including short term and long term restructuring of the unit, new
27

1 management, and the implementation of vertical prosecution of employee
2 discipline cases at all CDC correctional institutions.

3 3. The re-structuring of the employee discipline process, including the
4 streamlining and simplification of the process; the establishment of adequate
5 computerized controls to track and monitor discipline processing; and the
6 establishment and implementation of a discipline matrix whereby specific acts of
7 employee misconduct will be assigned an associated punishment that will apply
8 regardless of the rank of the employee to be disciplined.

9 4. The development of discipline related policies and procedures, including
10 modifications to the DOM, that will set forth specific requirements to settle cases,
11 to appeal cases, and punish employees who violate Title 15 or who fail to observe
12 and properly report correctional officer misconduct.

13 5. Enhanced training and improved selection procedures for Employment
14 Relations Officers and ELU Attorneys.

15 6. A comprehensive program to address the code of silence, including the
16 implementation of a range of punishments for code of silence violations, the
17 training of management staff on code of silence issues, the development of a code
18 of ethics program to be taught to all employee at all CDC facilities, and an
19 evaluation of the CDC's "prison culture" by the National Institute of Corrections.

20 7. Last, but perhaps most important, a Bureau of Independent Review ("BIR")
21 will be established within the Office of the Inspector General. After an initial roll
22 out period, BIR lawyers and investigators will be assigned to each of the three OIS
23 offices. The BIR will perform a real time evaluation of every CDC abuse of force
24 and employee ethics related internal affairs case, including all code of silence
25 cases. The real time evaluation will include reviewing the charging documents,
26 the investigation plan, the progress, quality, and timeliness of the investigation,
27

1 the investigative findings, the discipline imposed by the hiring authority, and all
2 SPB hearings, appeals, and other actions related to employee discipline. The BIR
3 will also have authority to initiate special investigations and to investigate the
4 absence of charging documents where appropriate. The BIR will prepare periodic
5 reports to the Governor, Legislature, and the Court and provide a transparency to
6 the employee discipline process that has been lacking in the past.

7 A chart providing more detail and estimated project completion dates is attached as
8 Exhibit 66.

9 *2. Evaluation and Recommendations.*

10 The Special Master finds that defendants are making a strong effort to address the serious
11 and persistent problems with inadequate investigations and correctional officer discipline. The
12 right people have been assembled to continue the remedial effort, and there has been a consistent
13 effort to work with the Special Master and plaintiffs. At this point in time, the Special Master
14 does not believe the remedial process will benefit from the appointment of a receiver; nor will it
15 be served by citing newly appointed Director Woodford with civil contempt. Instead, the Special
16 Master recommends that he continue to work with YACA and the CDC to: (1) complete the
17 development of an adequate remedial program; and (2) monitor the implementation of the
18 remedial program to ensure that it corrects all of the problems identified in this report.

19 The Special Master emphasizes that defendants were in civil contempt of court when the
20 draft recommendations issued because the evidence showed that defendants were in clear
21 violation of the Court's orders, and it appeared that coercive measures would be required to
22 secure defendants' compliance. The Special Master has concluded, however, that holding Ms.
23 Woodford in contempt will not assist the remedial process given the concrete remedial activities
24 that have taken place since the draft report. The Special Master's decision not to recommend
25 holding Ms. Woodford in civil contempt should not be construed to mean that the problems have
26 been corrected. Powerful outside forces oppose the implementation of fair and effective
27

1 investigations and discipline in the Department of Corrections, and development and
2 implementation of an effective remedy is far from complete.

3 In fact, it is now clear that two barriers exist which, if not removed, will prevent the
4 State's remedial plan from being implemented. The Court should not assume that defendants
5 will be able to solve the problems set forth in this report until the barriers discussed below are
6 overcome. Furthermore, if the barriers that are preventing adequate CDC investigations and
7 discipline cannot be overcome, more intrusive intervention by the Court will be necessary to fully
8 implement its long standing use of force remedial orders.

9 E. Barriers to State's Implementation of an Remedial Plan that the Court Must Consider
10 When Issuing its Remedial Orders.

11 1. *Introduction.*

12 Two problems have an adverse impact on the YACA/CDC attempt to remedy the
13 problems described in this report. The first is the fact that legislation and funding are needed to
14 implement defendants' remedial plan. The second are provisions within the CDC/CCPOA MOU
15 which prevent inmates from reporting abuses of force and render timely, cost efficient and fair
16 investigations very difficult, if not impossible, to complete.

17 2. *Necessary Legislation and Funding.*

18 There are several different remedial options available to correct the problems described in
19 this report. For example, the Court can appoint a group of attorneys, investigators, and use of
20 force experts who review, on a real time basis, every OIS case that involved the abuse of inmates
21 or ethical problems (such as correctional officers promoting or hiding behind the code of
22 silence). The State of California can retain a law firm, or a panel of civil rights attorneys, who
23 perform the same real time function on a contract basis. The State can also establish an agency
24 to perform this function, and thereby provide the Governor and Legislature with a renewed sense
25 of confidence in the adequacy of CDC investigations and discipline.

26 The choice between these competing options should be left to defendants. In this case,
27

1 State officials have determined that the best way to fix investigation and discipline problems is
2 for the State to re-organize an existing agency, the OIG, and establish a new watchdog agency,
3 the Bureau of Independent Review, within the OIG. In practice, the State's plan, as described
4 above, also calls for the CDC to overhaul both the OIS and the ELU.

5 While this policy choice appropriately belongs to the State, the Special Master
6 emphasizes that he agrees with the State's decision. If the State can fix this problem through
7 State agencies, it will provide assurances that mechanisms exist to prevent the problems from
8 reoccurring, which should lead to a more rapid cessation of Federal Court monitoring. In
9 addition, rather than the Special Master monitoring investigations and correctional officer
10 discipline, the Special Master can limit his monitoring to verifying that the BIR is doing its
11 function appropriately, which will reduce the scope and expense of Federal Court monitoring. In
12 a very real and practical way, the State can impact on the extent of Federal Court oversight by the
13 manner and timeliness with which it remedies the problems described in this report.

14 To accomplish this goal, however, the State officials working on the remedial plan need
15 to obtain changes in legislation to implement changes in CDC and OIG operations. In addition,
16 the OIG and BIR require funding. This process takes time, and the cooperation of different
17 branches of State government. The Special Master recommends that the Court allow defendants
18 the opportunity to implement their remedial plan during the current State budget cycle, which
19 should be completed during July 2004. To this end, an in-chambers status conference has been
20 scheduled for July 7, 2004 for defendants to report on their progress.

21 Defendants proposed remedial program will not be easy to implement. As emphasized by
22 Court expert Michael Gennaco, who has first hand experience establishing a real time
23 independent review process, "the devil is in the details." For example, OIG investigations,
24 including the BIR's investigations, should be entirely transparent. In fact, the BIR's findings
25 should be made public to the degree that the status and finding of every BIR monitored internal
26 affairs case be available for review at a website on the internet. Likewise, once the BIR is

1 operational, inmates and correctional officers will report abuses of force and code of silence
2 cases in greater number than are presently reported, because the BIR should ensure timely, fair,
3 and effective use of force investigations. Thus, it is essential that the BIR be staffed
4 appropriately right from the start. It is also critical that the Inspector General remain independent
5 of political pressures; for example, it is important that threats of funding reductions cannot be
6 made in retaliation for honest reports. In addition, it is essential that the State of California
7 provide real protections for CDC whistle blowers, services and guarantees of safety that actually
8 work.

9 The Special Master has been kept apprised of pending legislation concerning these and
10 other issues. He will report to the Court about the adequacy of the operational capabilities of
11 defendants' remedial plan after the enabling legislation is enacted. If necessary, that report will
12 include additional recommendations for more specific Federal Court remedial orders.

13 *3. Provisions of the CDC/CCPOA MOU that Preclude the Reporting of Abuses of*
14 *Force and Impedes the Completion of Timely, Fair, and Cost Effective*
15 *Investigations.*

16 a. Introduction.

17 As discussed below, considerable evidence exists indicating that the current MOU
18 between the CDC and CCPOA renders fair investigations into the abuse of force almost
19 impossible. The Special Master, however, is not proposing recommendations about the MOU in
20 this report. He recommends only that the Court issue an order allowing him to investigate this
21 problem further; that he examine, for example, how the MOU functions in practice. The
22 evidence indicates that the MOU cannot be adequately examined by focusing only upon its
23 written provisions. An adequate review must encompass how the CCPOA has interpreted the
24 MOU, and how, given their extensive financial resources, the CCPOA deals with investigations
25 in practice. In addition, an impartial evaluation of the MOU's impact on inmates' ability to
26 report officer misconduct is warranted, given the potential dangers faced by inmates who dare to
27

1 report abuses under the provisions of the MOU that exist today. At the completion of this
2 investigation the Special Master will report to the Court and issue recommendations, if
3 appropriate.

4 The Special Master addresses three sections of the MOU below. This analysis is not all
5 inclusive, it focuses only on a few of the problematic MOU provisions in order to explain why
6 further investigation is needed.

7 2. Examples of Problematic MOU Provisions.

8 i. *MOU Section 9.09(d).*

9 Section 9.09(d) requires the CDC to immediately turn over to correctional officers all
10 inmate grievances that could result in adverse action. For example, if during the Powers
11 investigation an inmate had submitted a grievance which stated: "Help. I am a convicted sex
12 offender. Powers, Garcia, and Lewis have told the prison gang leaders in my yard that I was
13 convicted for child molestation. I am now being threatened," the CDC would have immediately
14 provided a copy of this grievance to Powers, Garcia, and Lewis.

15 The consequences are obvious. First, an inmate who wants to report an abuse of force
16 knows that the officer who abused him will immediately receive a copy of his complaint. In
17 essence, the victim is required to notify the perpetrator that he has informed on his misbehavior.
18 The MOU also requires turning over all documents, even video taped interviews. Second,
19 because neither the CDC nor the CCPOA have policies, procedures, or rules to the contrary, the
20 officer who receives the complaint can tell other officers at the prison. Third, in the event of an
21 internal affairs investigation, the investigation is immediately compromised. The subject officer,
22 and his CCPOA representative, now have details of the claims against him; enabling the subject
23 and fellow officers to develop consistent alibis to thwart the investigation.

24 The CCPOA's amicus filings addresses section 909(d) at pages 5 - 9 of their Points &
25 Authorities. The union offers several justifications for the provision, none of which are
26 convincing given the section's application in day-to-day life in the prisons. First, the CCPOA

1 First, the provision can be utilized by CCPOA representatives to ensure a strict code of
2 silence concerning inmate abuse cases. Correctional officers who meet with investigators do so
3 under the watchful eye of their CCPOA representatives. Correctional Officers who meet with an
4 investigator without their CCPOA representation are readily identified by the CCPOA, and can
5 be subjected to shunning and other misconduct by the correctional officers under investigation.
6 (In similar fashion the CCPOA continues to post instructions at PBSP for correctional officers to
7 call the union in the event they are contacted by the Federal Bureau of Investigations, even
8 though the FBI investigation concerning the Powers and Garcia cases concluded three years ago.
9 (*See Exhibit 71*)).

10 Second, the same CCPOA representative is allowed to attend each witness interview and
11 thereafter attend the subject officer's interview. Thus, by the time the subject is interviewed, he
12 not only has the original complaint by the inmate, he also has knowledge of what each of the
13 witnesses said. This problem is aggravated by the fact that neither the CDC nor the CCPOA
14 have issued policies that govern the behavior of CCPOA representatives who serve as
15 representatives during both witness and subject officer interviews.

16 Third, what should be a relatively simple and straightforward process becomes extremely
17 time consuming (creating delays which jeopardize the one year statute of limitations) and overly
18 expensive, often taxing the limited resources of the CDC. In addition, Side Letter Number 12
19 can become a procedural hurdle whereby the CCPOA simply refuses to produce correctional
20 officers for testimony until and unless the CDC complies with demands that are both
21 unwarranted and not called for by the MOU. This, for example, is exactly what took place
22 during the CDC's attempt to calendar Post Powers interviews when CCPOA attorney Albertine
23 demanded a host of documents prior to making witnesses and subjects available for an interview
24 with Bob Ballard. (Exhibits 10 - 15). Again, the real life problems created by Side Letter
25 Number 12 are aggravated by the fact that neither the CCPOA nor the CDC have written policies
26 and standards concerning document requests demands by the union. An investigation and report
27

1 that details the impact of this MOU section operated in practice will provide the Court with
2 relevant information to determine whether the MOU renders fair investigations impossible.

3 *iii. MOU Section 9.16.*

4 As explained above, MOU Section 9.16, requires the CDC to utilize the civil standards of
5 Government Code §995.2 when considering whether to reimburse a correctional officer for his
6 defense in a criminal case, rather than the more restrictive standard for criminal cases set forth in
7 Government Code §995.8. The CCPOA argues, in its amicus filings, that section 9.16 is
8 compatible with Government Code §996.6 (CCPOA Points and Authorities, pgs. 2 - 5). This
9 section of the Government Code does provide for labor contracts that gives employees more
10 defense than the statutory minimum. The CCPOA thus is correct that section 9.16 of the MOU is
11 supported by Government Code §996.6.

12 The problem, however, is not the statute; it is in the language of section 9.16 and how that
13 language is interpreted by the CCPOA. The CCPOA position in the David Lewis case, as set
14 forth in Exhibit 35, exemplifies how Section 9.16 can be utilized to force the State of California
15 to pay for unconstitutional and criminal misconduct by correctional officers.

16 This Court found the CDC shooting review process constitutionally flawed. The Special
17 Master and Court expert Dr. Patrick Maher found the specific shooting review in the Lewis case
18 to be so flawed it should not have been relied upon by a reasonable correctional manager.
19 Nevertheless, under Section 9.16 (2), the State of California was required, according to the
20 CCPOA, to pay for Lewis' criminal defense because he was "cleared" by the very same faulty
21 shooting review process. Section 9.16 appears to conflict with a number of important remedial
22 plan and legal principles, and a further investigation into its actual impact is warranted.

23 *3. Summary.*

24 The Special Master has addressed only three of numerous MOU provisions that appear to
25 preclude fair, timely, efficient, and cost effective investigations in the CDC. In requesting that
26 the Court instruct him to conduct a formal investigation into MOU related problems, the Special
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1 Master notes that many of the problems presented by the MOU do not represent a conflict
2 between state contracts and federal concerns. Indeed, the MOU sections at issue may conflict
3 with important principles of California law as well as the use of force remedial plan. In this
4 regard, the Special Master brings to the Court's attention Chief Deputy Attorney General Peter
5 Siggins' July 9, 2003 letter to the Honorable Jackie Speier, Chair, Government Oversight
6 Committee and the Honorable Gloria Romero, Chair, California Correctional System Committee
7 re the Attorney General's Investigation of Incident at California Institution for Men in Chino
8 (Exhibit 68).

9 F. Posting.

10 The final recommendation considered by the Special Master concerns the posting of the
11 Court's orders, this final report, and the appropriate exhibits in the prisoner law libraries at
12 PBSP. Over the past nine years the Special Master has utilized a posting policy that has never
13 led to a security related concern on the part of the CDC. Pursuant to this policy, the Special
14 Master's reports and Court remedial orders have been made available for prisoner review in the
15 inmate law libraries. Exhibits are screened for the following: (1) security concerns; (2) staff
16 privacy concerns; and (3) inmate privacy concerns (primarily centered around medical/mental
17 health information). For example, no internal affairs reports, even if the report was an exhibit to
18 the Special Master's report, are posted in the inmate law libraries. Staff who are involved in
19 non-adverse action discipline (the great majority of PBSP cases) are not referred to by name in
20 the Special Master's or Dr. Maher's reports. Staff who choose to make their case part of a public
21 record, for example by deciding to file a public SPB appeal, are referred to by name in the
22 reports, and if relevant the public record of the SPB proceeding is posted in the inmate law
23 libraries. *In addition to all of the above*, the PBSP Madrid Unit performs a security review of all
24 filings, excising, for example, sensitive personal information, documents which may pose a
25 special concern, etc. The Madrid Unit discusses these deletions with counsel for plaintiffs. To
26 the Special Master's best recollection, plaintiffs have never disputed a Madrid Unit decision to
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1 the degree whereby the dispute had to be brought to the Special Master's attention.

2 The Special Master finds that a similar approach to posting is appropriate concerning this
3 report. However, in an abundance of caution, and because this report was filed in its draft form,
4 the Special Master requested comments from the parties. Defendants' letter of May 17, 2004 is
5 attached as Exhibit 68. Plaintiffs' letter of May 25, 2004 is attached as Exhibit 69.

6 The Special Master agrees with defendants' concern about the posting of the draft report.
7 That issue, however, is now moot at this point. The Special Master does take exception to
8 defendants' generalized and non-specific claims that the filing of this report and certain public
9 exhibits will somehow jeopardize security or inmate/staff hierarchy.

10 First, defendants should point to specific problems that they believe jeopardize the
11 "security and safety" of PBSP given that no problem has arisen in the nine year experience with
12 the present policy. Generalized comments do not justify exclusion from prisoner review. As
13 plaintiffs' letter points out, the Court rejected an almost identical argument from defendants in its
14 Order filed April 17, 2001 (attached as part of Exhibit 69). Second, this report is about
15 correctional officers who engaged in serious misconduct and who, because of poor investigations
16 and a faulty discipline system, were not subjected to sanctions. In many respects, as plaintiffs
17 emphasize, this report identifies and describes cases similar to those reported in the Court's 1995
18 published opinion. If the Special Master excised all reference to correctional officers who were
19 not properly disciplined, as urged by the defendants, the heart of this report would be excised.
20 Finally, censoring exhibits that do not pose security concerns from inmates serves no legitimate
21 correctional interest; indeed, hiding the truth from the prisoners at Pelican Bay State Prison may
22 jeopardize prison security. For example, prisoners will not know whether legitimate complaints
23 against correctional officers are being dealt with in an appropriate manner by the CDC, and may
24 come to believe the entire grievance system serves no purpose. Furthermore, the inmate
25 plaintiffs in this class action have a right to know what happened at Pelican Bay and in the
26 Central Office concerning cases of officer misconduct that posed very serious dangers to them.

1 As class members, they also need to understand that the State is now attempting to provide for
2 fair and timely investigations into allegations of abuses of force at the prison.

3 Given the above, and after evaluating the arguments raised by both parties, the Special
4 Master recommends the posting of all orders, this final report, and certain of the exhibits, as set
5 forth in the Recommendations section below. He also recommends a review by the Madrid Unit
6 of all exhibits, and the excising of specific data that may jeopardize PBSP security.

7 VII.

8 RECOMMENDATIONS

9 Considering all of the evidence and the findings above, the Special Master recommends
10 as follows:

11 1. The Court should consider issuing an Order to Show Cause re Criminal Contempt for
12 Edward Alameida and Thomas Moore because of willful violations of the Court approved Use of
13 Force Discipline Remedial Policy, Use of Force Disciplinary Procedure, and the Use of Force
14 Investigation Policy and Procedure, specifically:

15 A. Failing to adequately investigate the perjury allegations against Correctional
16 Officers Jones, Matlock, and Tuttle in violation of PBSP Use of Force
17 Disciplinary Policy Section II.D, adopted by the Court in its Order of December 2,
18 2002.

19 B. Failing to prepare a report of the Post Powers investigations on the CDC
20 Forms 989 A and B in violation of Use of Force Investigation Policy and
21 Procedure Section VIII.B.3, adopted by the Court in its Order of June 21, 2000
22 and approved by the Special Master in his "Report Concerning Defendants'
23 Compliance With the Court's Orders re Use of Force Investigations and
24 Discipline filed June 21 2000," filed October 17, 2000, and adopted by the Court
25 in the Order Re Use of Force Investigation Policies filed April 24. 1998.

26 C. Failing to set forth findings concerning each of the allegations against Officers
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1 Jones, Tuttle, and Matlock in a manner where it was noted whether the inquiry
2 supports or refutes the allegations, and failing to arrive at one of the findings
3 identified in Section VII, Subsection B, (5), (b), of the Use of Force Investigation
4 policy and procedure, violations of Use of Force Investigation Policy and
5 Procedure Section VIII.B.4, adopted by the Court in its Order of June 21, 2000
6 and approved by the Special Master in his "Report Concerning Defendants'
7 Compliance With the Court's Orders re Use of Force Investigations and
8 Discipline filed June 21 2000," filed October 17, 2000, and adopted by the Court
9 in the Order Re Use of Force Investigation Policies filed April 24. 1998.

10 D. Organizing and condoning a cover-up concerning Director Alameida's
11 decision to shut-down the Post Powers investigations on March 27, 2003 through
12 the submission of a false and misleading letter to the Special Master, and thereby
13 to the Court, in violation of Use of Force Disciplinary Procedure Section V.C. 2-
14 3, adopted by the Court in its Order of December 2, 2002.

15 On June 15, 2004 Alameida filed a "Supplemental Submission" to his objections (CR
16 1752). This submission, submitted after the close of the Special Master's investigation and
17 hearings, brings to the Court's attention new information. First, the supplemental pleading
18 describes a history of adversity between Alameida and the CCPOA. It provides new information
19 disclosing the extensive degree to which the CCPOA influences the day to day management of
20 the Department of Corrections; for example, how the CCPOA attempted to stop the closure of
21 the Northern California Womens' Facility ("NCWF") and the CCPOA's subsequent attempt to
22 convince the Gray administration to reduce 120 management positions in the CDC. Specifically,
23 the report describes a breakfast between Alameida and Alexander during which Alexander made
24 it clear that the CCPOA intended to reduce the CDC by 120 management positions in retaliation
25 against Alameida because of his decision to close NCWF.

26 Second, the supplemental pleading provides new information concerning Alameida's
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1 mental health problems and his current psychiatric treatment. Third, the pleading expresses a
2 willingness to publicly apologize. The Court can consider this new information when it
3 considers the recommendation above as it pertains to Alameida. The Special Master does not
4 believe it appropriate to comment on this pleading given the date of its submission.

5 2. The Court should consider referring this report and the Transcript of the July 30, 2003
6 hearing to the United States Attorney of the Northern District of California for the filing of
7 perjury charges against Thomas Moore because of the following false testimony:

8 A. Moore testified: "Agent Ballard was not assigned any other cases and I was
9 transitioning his existing cases off of him." (Moore Tr. 140: 2-3).

10 B. Moore testified: "And Mr. Ballard was tasked with reviewing the transcripts,
11 doing as much legwork as possible, and giving a report as to whether there would
12 be sufficient cause to go forward in the investigative process." (Moore Tr. 143:
13 22 - 25).

14 C. Moore testified: "But I must qualify that statement by saying that Ballard had
15 taken time in month of July and August, I believe, he was down there reviewing
16 the files and me giving periodic feedback." (Moore Tr. 145: 6 - 9).

17 D. Moore testified: "I told him I wanted a status report on the investigation. I
18 believe staff counsel, Dennis Beaty, had contacted me and wanted to know the
19 status of the case." (Moore Tr. 154: 20 - 22).

20 E. Moore testified: "He gave myself a briefing as to, meaning Ballard and
21 Barbara gave myself and Brian Parry, Parry was privy to the briefing. And it was
22 then that we realized we had to brief Mr. Alameida now. I believe the day before
23 I contacted Mr. Alameida to make sure his calendar would be available because I
24 knew this case had to be reviewed." (Moore Tr. 159: 19 - 25).

25 3. The Court should order the following:

26 A. Special Master should continue to work with defendants concerning the development
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1 and implementation of an adequate remedial plan to address the problems with investigations,
2 adverse action discipline and the code of silence identified in the Special Master's Final Report
3 re Department of Corrections "Post Powers" Investigations and Employee Discipline. The
4 Special Master should report to the Court as necessary during this process, and submit
5 recommendations for further Court orders if warranted.

6 B. Defendants should modify, within ten days, the use of force remedial plans to exclude
7 CCPOA participation from Executive Review Committee evaluations of the use of force at
8 PBSP.

9 C. Special Master should investigate, hold hearings if necessary, prepare a report,
10 consider comments from the parties and CCPOA, and issue recommendations concerning
11 CCPOA/CDC MOU provisions that violate, by their terms or practice, the Court's use of force
12 remedial plans.

13 D. The Special Master, working with the parties, should develop and implement an
14 appropriate program to evaluate the status of CDC use of force investigations and discipline, and
15 to monitor the progress of defendants' implementation of Post Powers remedial programs. The
16 Special Master should report to the Court concerning this monitoring program within sixty days.

17 When developing the monitoring program, the Special Master recommends that the Court
18 instruct the parties to consider the following:

19 Scope of Monitoring: The Special Master's monitoring should encompass investigations
20 and discipline cases arising from violations of use of force policies, including integrity issues
21 such as the code of silence. This monitoring should, of necessity, involve monitoring
22 defendants' and the BIR's handling of casework from prisons other than PBSP. For example, if
23 defendants or the BIR fail to adequately manage statute of limitations issues concerning
24 employee discipline that arise from use of force cases on a systemic basis, or fail to adequately
25 monitor the scope of internal affairs investigations, that failure is subject to monitoring and may
26 be the basis of a report by the Special Master to the Court. Neither counsel for plaintiffs nor the
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1 Special Master, however, should have the authority to conduct on-site inspections of any CDC
2 prison other than Pelican Bay State Prison. Likewise, neither counsel for plaintiffs nor the
3 Special Master should have the authority to oversee the investigations or discipline of specific
4 use of force cases that arise from CDC prisons other than Pelican Bay State Prison. The parties
5 agree that monitoring of defendants' Post Powers remedial plan efforts and of the BIR should
6 focus on the adequacy of defendants' and the BIR's monitoring rather than the specific
7 investigations being reviewed by BIR. This does not, however, preclude discussion with
8 defendants and/or the BIR about individual cases when the systemic problems identified in the
9 Special Master's Final Report re Department of Corrections "Post Powers" Investigations and
10 Employee Discipline are implicated.

11 Modification of Monitoring: If, at any time, either party believes the Post Powers
12 monitoring plan is ineffective in operation, unnecessarily intrusive, or that it exceeds in operation
13 the jurisdictional limitations of the *Madrid v. Woodford* class action, that party shall notify
14 opposing counsel and the Special Master of its concerns. Thereafter, the Special Master shall
15 hold a timely meeting to address the party's concerns. If consensus cannot be reached for a
16 prompt resolution of the dispute, either party may request relief from the Court.

17 Cessation of Monitoring: The Special Master should report to the Court when each of the
18 specific corrective actions set forth in Exhibit 66 to the Special Master's Final Report re
19 Department of Corrections "Post Powers" Investigations and Employee Discipline has been
20 implemented. The Special Master should also report to the Court when the BIR is operational in
21 each of its three regional offices. Following the implementation of each corrective action, and
22 after the BIR is operational in all three regional offices, monitoring will continue for a period of
23 no more than two years, unless serious systemic problems arise or the corrective action fails to
24 meet the goals established by defendants to a degree that justify an additional period of
25 monitoring. The Special Master may issue recommendations to the Court to cease monitoring at
26 the request of either party or based upon his own motion. Consistent with present practices, the
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1 Special Master may recommend cessation of monitoring of certain elements of defendants' Post
2 Powers remedial plan while continuing to monitor other elements. All reports prepared by the
3 Special Master concerning the implementation, operation, and cessation of monitoring of this
4 remedial plan should conform to the terms of the Order of Reference of January 23, 1995.

5 E. Defendants should post in the prisoner law libraries at PBSP, within ten business days,
6 the Court's Order re the Special Master's Final Report re Department of Corrections "Post
7 Powers" Investigations and Employee Discipline; the Special Master's Final Report re
8 Department of Corrections "Post Powers" Investigations and Employee Discipline; and the
9 following exhibits to that report: Exhibits 2-7 (subject to redaction of personal information), 10-
10 16, 18-25, 28-44, 46-50, and 52-72. The Madrid Unit should examine each of the exhibits and
11 report to the Special Master if it believes any exhibit should be subject to additional redaction
12 prior to placement in the prisoner law libraries at Pelican Bay State Prison.

13 **VIII.**

14 **CONCLUSION**

15 It is important not to lose sight of the toll on personal lives and correctional officer
16 careers created by the code of silence. This report concludes by returning to where the United
17 States began its criminal case against Powers and Garcia, with Correctional Officer William
18 Schembri.

19 In 1996 Schembri was subpoenaed to testify about his knowledge of the 1992 assault on
20 inmate Chester. As explained above, the first consequence of Schembri telling the truth was that
21 the CDC investigated him for discussing what he knew with his lieutenant. After the
22 investigation was complete, however, the CDC did nothing (Exhibit 56).

23 Schembri made the decision to tell the truth at his interview. Prior to meeting with LEIU
24 investigators Schembri requested an emergency transfer to another CDC prison for both he and
25 his wife, who was also a correctional officer at PBSP. Schembri's request was denied.
26 Meanwhile, a sergeant at PBSP instructed Schembri's wife to tell Schembri to "keep his mouth
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1 shut.”

2 Following the interview, Schembri noticed that correctional officers began to avoid him,
3 although some showed support for what he had done. Schembri began to feel as if he had a
4 target on his back. As a result of the tension he felt following the interview, he developed
5 serious stomach ailments that at one point required stomach surgery based on a doctor’s
6 recommendation. While Schembri and his wife had planned to raise their children in Crescent
7 City, they decided to transfer to another prison.

8 On April 21, 1997 Schembri was promoted to Sergeant at R. J Donovan Correctional
9 Facility (“RJDCF”). Immediately following Schembri’s transfer, his wife, who planned to follow
10 him to RJDCF after their children completed the school semester, was moved from her duty post
11 in the PBSP visiting area (where she had worked for a number of years) to a new position
12 directly under Sergeant Powers, against whom Schembri had testified during the investigative
13 interviews. Mrs. Schembri resigned from the CDC rather than work for Powers.

14 Schembri encountered a series of problems at RJDCF. For example, he was assigned to
15 vacation relief and first watch positions, the most undesirable jobs in the prison, for much longer
16 periods than normal for newly appointed sergeants. He continued to be shunned by other
17 officers. He continued to be concerned about his personal safety.

18 On November 3, 1998 Schembri was interviewed by CDC and FBI investigators about
19 the Chester stabbing. Thereafter, he was assigned to a shift relief position that on occasion
20 required him to return to work at the prison eight hours after he left his prior duty assignment.
21 Schembri began to experience more severe stomach problems, and left work for a period of time
22 due to stress. No effort was made by the CDC to provide Schembri with whistle blower
23 protections or any other form of support during the six year period between 1996 and 2002. No
24 effort was made to provide him with protection or other assistance when he testified for the
25 United States at the criminal trial of Powers and Garcia. Schembri left CDC employment on
26 permanent disability in early 2003.

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1 In 1996, when Schembri asked CCPOA representative Chuck Alexander for a attorney to
2 accompany him to his interview with LEIU agents, Alexander recommended the same attorney
3 who was representing Powers. Schembri refused. He told Alexander that he needed a separate
4 lawyer from everyone else because he was going to be telling the full truth. Eventually, a
5 Crescent City lawyer was provided for Schembri by the CCPOA. After his interview, however,
6 Schembri found himself being shunned by CCPOA representatives Alexander and Newton.

7 Sometime after he transferred to RJDCF, Schembri was told by the RJDCF CCPOA
8 Chapter President, K. Laird that Alexander told him Schembri testified against fellow
9 correctional officers, that Schembri was a "RAT," and to keep his distance from Schembri. At
10 no time did the CCPOA provide Schembri with assistance concerning the stress related disorders
11 created by his telling the truth to the FBI. At no time did the CCPOA provide support for
12 Schembri when he testified for the United States at the Powers/Garcia criminal trial.

13 Opposite of how it treated William Schembri, the CCPOA gave a hero's welcome to
14 David Lewis, the former PBSP correctional officer who was terminated for calling inmates
15 "primates," "monkeys," "toads," and "niggers." As explained above, Lewis faces a retrial in
16 Federal Court for the shooting of inmate Harry Long. To the CCPOA, however, Lewis is a hero.

17 Two weeks after the Twin Towers were destroyed by terrorists, the California
18 Correctional Peace Officers' Association traveled to Sparks, Nevada for its 2001 Annual
19 Convention. The theme for this conference was "a time for healing, and a time to honor our
20 heros" (*see* Exhibit 70, End of Year 2001 issue of the CCPOA "PeaceKeeper").

21 One of the CCPOA's heros was David Lewis, who gave a speech on the subject of
22 professionalism to the union representatives gathered at the meeting. Falsely telling CCPOA
23 members that Lewis is "now retired," the Peacekeeper article includes a photograph of the
24 terminated officer standing alongside Pelican Bay CCPOA representatives Alexander and
25 Newton, and words of praise from then CCPOA Vice President, Mike Jimenez. (Exhibit 70).

26 What happened to William Schembri when he told the truth, contrasted to the CCPOA's
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1 designation of David Lewis as a hero, provide real life examples of the almost impossible to
2 overcome barriers that prevent honest investigations in the CDC. Without question, a number of
3 very fundamental changes in leadership, operations, and attitudes are necessary before the
4 California Department of Corrections achieves compliance with the Court's use of force remedial
5 orders. Given the findings described above and the powerful outside forces arrayed to defeat all
6 efforts to reform the Department of Corrections, continued Court oversight, and perhaps
7 additional orders, will be necessary to assist defendants with the implementation of the remedial
8 plan they have selected.

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10 Dated: June 24, 2004

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John Hagar
Special Master

1 **Appendix 1**

2 **POST POWERS WITNESS LIST AND DATES OF TESTIMONY**

3
4 *Transcript Vol. 1 – July 30, 2003*

5 Witness	From page #	To page #
6 Thomas Moore	7	13
7 Joseph Barbara	13	94
8 Patrick Maher	95	96
9 Joseph Barbara	96	132
10 Thomas Moore	132	222
11 Kathy Kinser	223	265

12
13 *Transcript Vol. 2 – August 26, 2003*

14 Witness	From page #	To page #
15 Robert Ballard	270	402
16 Mark Yax	402	416
17 Brian Parry	418	474

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19 *Transcript Vol. 3 – September 25, 2003*

20 Witness	From page #	To page #
21 Jose Reynoso	481	539
22 Cassandra Grout	539	597
23 Barbara Sheldon	598	638
24 Dennis Beaty	638	677

1 *Transcript Vol. 4 – November 21, 2003*

2	Witness	From page #	To page #
3	Edward Alameida	693	770
4	Melinda Haag	771	799
5	Edward Alameida	800	819
6	Robert Gaultney	820	840
7	Michael Miller	842	852
8	David Tristan	853	893

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10 *Transcript Vol. 5 – January 9, 2004*

11	Witness	From page #	To page #
12	Peter Jensen	901	940
13	Joe Reynoso	941	947
14	Francis King	947	951
15	Dorothy Perkins	958	973
16	Linda Clifford	973	992

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1 **Appendix 2**

2 **EXHIBITS PLACED INTO EVIDENCE DURING THE HEARINGS**

3 *Transcript Vol. 1 – Hearing of 7/30/03*

4 **Exhibit Number:**

- 5 1. Bob Ballard’s Chronological Summary of the Jones IA investigation
- 6 2. Post Powers Investigative Plan and Disciplinary Review Process dated October 2001
- 7 3. 6 unsigned letters to Bob Gaultney dated June 19, 2002. Each letter addresses a different
8 incident. The incidents were the Williford, Perez, Black, Chester, Smith and Longacre
9 incidents.
- 10 4. Internal Affairs Investigation Request, subject, Charles Matlock, dated 10/8/02 and Case
11 Assignment Sheet for case # N-PBSP-200-02 dated 10/16/02
- 12 5. Letter to Brian Parry from U.S. Attorney dated June 28, 2002 that was sent with the
13 Powers/Garcia trial transcripts that had been requested by the CDC.
- 14 6. Internal Affairs Investigation Request, subject, Owen Tuttle, dated 10/8/02 and Case
15 Assignment Sheet for case # N-PBSP-199-02 dated 10/16/02
- 16 7. Internal Affairs Investigation Request, subject, William Jones, dated 10/8/02 and Case
17 Assignment Sheet for case # N-PBSP-198-02 dated 10/16/02
- 18 8. Bob Ballard’s Chronological Summary for the Tuttle IA investigation (refers back to the
19 Jones Chronological Summary)
- 20 9. Bob Ballard’s Chronological Summary of the Matlock IA investigation (refers back to the
21 Jones Chronological Summary)
- 22 10. Letter to Bob Ballard from CCPOA lawyer Christine Albertine requesting documents
23 regarding William Jones (case 198-02) dated March 18, 2003.
- 24 11. Letter to Bob Ballard from CCPOA lawyer Christine Albertine requesting documents
25 regarding Greg Devos (case 199-02) dated March 17, 2003.
- 26 12. Letter to Bob Ballard from CCPOA lawyer Christine Albertine requesting documents
27 regarding Ronald Parker (case 199-02) dated March 18, 2003.
- 28 13. Letter to Bob Ballard from CCPOA lawyer Christine Albertine requesting documents
regarding Mark Maxwell (cases 198/200-02) dated March 18, 2003.
14. Letter to Bob Ballard from CCPOA lawyer Christine Albertine requesting documents
regarding Owen Tuttle (case 199-02) dated March 18, 2003.
15. Letter to Bob Ballard from CCPOA lawyer Christine Albertine requesting documents
regarding Charles Matlock (case 200-02) dated March 18, 2003.

- 1 16. Internal Affairs Investigation Request, subject, William Jones, dated 10/8/02 and Case
Assignment Sheet for case #'s N-PBSP-036-03 and N-PBSP-198-02 dated 10/16/02
- 2
- 3 17. Chronological Summary of investigation for case #'s N-PBSP-036-03 and N-PBSP-198-02
- 4 18. Letter to Special Master from Thomas Moore regarding the decision made at the 3/27/03
meeting, dated April 8, 2003.
- 5 19. Fact Finder Memorandum from Bob Ballard to Thomas Moore re the Powers/Garcia perjury
cases, dated April 1, 2003.

6 ***Transcript Vol. 3 – Hearing of 9/25/03***

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- 8 20. Article 13 of the Department Operation Manual (Employee Misconduct
Investigations/Inquiries).
- 9 21. Memo from Thomas Moore to Ed Alameida regarding the Updated Corrective Action Plan –
Office of Investigative Services dated January 31, 2003 and the Updated Corrective Action
10 Plan
- 11 22. Letter to Counsel from Special Master re the CDC Investigation and Follow-Up Plan, dated
November 21, 2001 and a Memorandum from Pat Maher to the Special Master re Dr.
12 Maher's review of the follow-up investigation plan and disciplinary review process for cases
arising out of the Powers/Garcia trial.
- 13 23. Letter to the Special Master from Scott Mather re Response to Dr. Maher's review of the
14 follow-up investigation plan and the disciplinary review process, dated January 24, 2001
(should be 2002).
- 15 24. Letter from the Special Master to Pat Maher re the Revised Post Powers Trial Discipline
16 Plan, dated February 5, 2002 and the Revised Post Powers Trial Discipline Plan.

17 ***Transcript Vol. 4 – Hearing of 11/21/03***

- 18 25. Court Order from Judge Henderson re the Use of Force Investigation Policies, dated April 21,
1998; Special Master's Initial Report Re Phase-Out of Monitoring of Use of Force Remedial
19 Plan – Recommendations Re Phase-Out of Use of Force Monitoring and the Partial
Termination of Force Related Orders, dated August 24, 1999; Attorney General's Stipulation
20 and [Proposed] Order for Periodic Production of Documents, dated August 18, 1999; Special
Master's Report and Recommendations Re Phase-Out of Use of Force Monitoring, and the
21 Partial Termination of Force Related Orders, dated June 5, 2000; Court Order from Judge
Henderson re Defendants Revised Use of Force Policies, Phase-Out of Use of Force
22 Monitoring, and Partial Termination of Force Related Orders, dated July 7, 2000
- 23 26. 9/22/97 IA investigation, subjects: Chuck Alexander, Richard Newton, Robert Rice, Jean
Rupert, Roy Alvarado and Deanna Freitag
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- 25 27. Memo to Chuck Alexander from Barry O'Neill re the IA investigation of Alexander and the
findings of that investigation, dated October 31, 1997
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- 1 28. Complaint in the case of Alexander and Newton v. CDC, dated August 10, 1998; two copies
2 of Memo to Chuck Alexander from Barry O'Neill re the IA investigation of Alexander and
the findings of that investigation, dated October 31, 1997.
- 3 29. Letter to Ed Alameida from Steve White re Special Review of the CDC OIS (filed under
4 seal), dated October 29, 2001.
- 5 30. Letter to U.S. Attorney for the Northern District Kevin Ryan from the Special Master re
6 anticipated testimony of Melinda Haag in Post Powers hearing, dated November 14, 2003;
Fact Finder Memorandum from Bob Ballard to Thomas Moore re the Powers/Garcia perjury
cases, dated April 1, 2003.
- 7 31. Letter to Special Master from Kevin Ryan authorizing the testimony of Melinda Haag in the
8 Post Powers hearing, dated November 19, 2003 (two copies).
- 9 32. Starts with note from Linda Clifford (Ed Alameida's secretary) explaining the following
10 documents; Copy of page of Ed Alameida's calendar from 3/27/03; Copy of 3/27 meeting
request from Dottie Perkins (Tom Moore's secretary); Copy of Ed Alameida's calendar from
Schedule Plus showing that the meeting had been accepted.
- 11 ***Transcript Vol. 5 – Hearing of 1/9/04***
- 12 33. Special Master's letter of December 8, 2003 re: Document Request Re January 9, 2004 Post-
13 Powers Hearing.
- 14 34. Letter to Special Master from Sara Turner, Supervising Deputy Attorney General re:
Document Production – Post-Powers/Garcia Hearing.
- 15 35. Letter to Edward Alameida, Director, California Department of Corrections from Benjamin
16 Sybesma re: David G. Lewis, Request for Representation in United States of America v.
David Gene Lewis Criminal Matter CR-99-00186-MMC, enclosures included.
- 17 36. Fax Transmittal to Peter Jensen from Edward Alameida re: CCPOA's Request for
18 Reimbursement of Fees and Costs for the Criminal Defense of David Lewis.
- 19 37. Memorandum to Edward Alameida from Mark Mustybrook re: CCPOA's Request for
20 Reimbursement of Fees and Costs for the Criminal Defense of Former Correctional Officer
David Lewis.
- 21 38. E-mail Transmittal from John Sugiyama to Catherine Bernstein and Mark Mustybrook re:
Officer Lewis Representation.
- 22 39. E-mail Transmittal from Dottie Perkins on behalf of Thomas Moore to Linda Clifford re:
23 Meeting on OIS Confidential Matter in Director's Office for March 27, 2003. Meeting Status
– Not yet responded
- 24 40. E-mail Transmittal from Dottie Perkins on behalf of Thomas Moore to Linda Clifford re: OIS
25 Confidential Matter in Director's Office for March 27, 2003. Meeting Status – Accepted.
- 26 41. Computerized Appointment Calendar of Kathy Kinser for March 25 – 27, 2003
- 27 42. Linda Clifford's Appointment Calendar for Edward Alameida for March 24 – 27, 2003

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43. Microsoft Outlook History Document

44. Microsoft Outlook History Document with Modification Pop-Up

1 **Appendix 3**

2 **EXHIBITS NOT PLACED INTO EVIDENCE DURING THE HEARINGS**

3 Exhibit 45: Memorandum from Dr. Patrick T. Maher re Interview of William Schembri.

4 Exhibit 46: Memorandum from Dr. Patrick T. Maher re Northern Region Investigation N-PBSP-198-02.

5 Exhibit 47: Memorandum from Dr. Patrick T. Maher re Northern Region Investigation N-PBSP-199-02

6 Exhibit 48: Memorandum from Dr. Patrick T. Maher re Northern Region Investigation N-PBSP-200-02

7 Exhibit 49: Memorandum from Dr. Patrick T. Maher re Northern Region Fact Finder -
8 Powers/Garcia Perjury Issues.

9 Exhibit 50: Memorandum from Dr. Patrick T. Maher re Analysis of Organization Culture and
10 Structural Influences on Reporting and Decision Making.

11 Exhibit 51: Memorandum to Richard Newton from Barry O'Neill re the IA investigation of
12 Alexander and the findings of that investigation, dated October 31, 1997

13 Exhibit 52: E-mail from Dennis Beaty to Tom Moore, with Ccs. to Kathy M. Kinser, Kathleen
14 Keeshen, and Robert Gaultney dated March 11, 2003.

15 Exhibit 53: California Penal Code § 118.

16 Exhibit 54: E-mail from Robert Gaultney to Joseph Barbara with Cc. to Robert Ballard dated
17 March 10, 2003.

18 Exhibit 55: David Lewis Shooting Review Board decision dated July 28, 1994.

19 Exhibit 56: Letter from Reynando J. Accooe stating that the CDC is unable to provide any
20 documents that summarize the disposition of IA Report No. 40-002-96 - subject William
21 Schembri.

22 Exhibit 57: Declaration of Director of Corrections Cal Terhune dated November 25, 1998.

23 Exhibit 58: California Code of Regulations: Title 15, section 3413 "Incompatible Activity"

24 Exhibit 59: Dr. Patrick Maher's Memorandum re Lewis SRB Decision dated July 28, 1994.

25 Exhibit 60: Transcript of the Reynoso (SPB Case # 030046) hearing of April 16, 2003.

26 Exhibit 61: February 20, 2004 letter from Ronald Yank to the Special Master.

27 Exhibit 62: February 24, 2004 letter from the Special Master to Ronald Yank and Benjamin C.
28 Sybesma.

1 Exhibit 63: Special Master's letter of August 21, 2003 re David Lewis to the Honorable Thelton
E. Henderson.

2 Exhibit 64: Order re Special Master's Request filed September 23, 2003.

3 Exhibit 65: February 17, 2004 Memorandum entitled Zero Tolerance Regarding the "Code of
4 Silence" signed by Richard Rimmer and Roderick Q. Hickman.

5 Exhibit 66: Chart detailing the status of defendants' Post Powers remedial plans.

6 Exhibit 67: Patrick Maher's Memorandum of May 31, 2004 entitled: "Qualitative Review of
1997 Internal Affairs Investigation of PBSP CCPOA Personnel Investigation 105-96."

7 Exhibit 68: Chief Deputy Attorney General Peter Siggins' letter of July 9, 2003 to the Honorable
8 Jackie Speier and the Honorable Gloria Romero.

9 Exhibit 69: Defendants' Comments and Objections re the posting of Post Powers reports and
exhibits in the prisoner law libraries at PBSP.

10 Exhibit 70: Plaintiffs Comments re the posting of Post Powers reports and exhibits in the
11 prisoner law libraries at PBSP.

12 Exhibit 71: End of Year 2001 CCPOA Peacekeeper Magazine article entitled "The Season of
Heros and Healing."

13 Exhibit 72: CCPOA Memorandum dated June 31, 2001 re FBI investigation at PBSP.

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1 **Appendix 4**

2 **DOCUMENTS REVIEWED BY THE SPECIAL MASTER**
3 **BUT NOT ATTACHED AS EXHIBITS**

- 4 1. *U.S. v. M. Powers and J. Garcia* (CR-00-0105-MJJ) Criminal Trial Transcript Vols. 1 – 22
5 2. Personnel File of Correctional Officer James Mather
6 3. PBSP Internal Affairs Transcript of Interview with Christopher Caldwell – October 6, 1995
7 4. PBSP Internal Affairs Transcript of Interview with Christopher Caldwell – November 1,
8 1995
9 5. Testimony of Christopher Caldwell in First Powers/Garcia Criminal Trial – pages 1906
10 through 1947
11 6. In the Matter of Pelican Bay State Prison: Interview with Christopher Caldwell – October 2,
12 1995
13 7. In the Matter of Pelican Bay State Prison: Interview with Christopher Caldwell – October 6,
14 1995
15 8. Internal Affairs Investigation Request re: Case no. N-PBSP-198-02 – October 8, 2002
16 9. Internal Affairs Investigation Case Assignment: Case no. N-PBSP-198-02 – October 16,
17 2002
18 10. Internal Affairs Northern Region Investigation Worksheet – Case no. N-PBSP-198-02
19 11. CDC Special Service Unit Sacramento Personnel Investigation Report no. 40-002-96 –
20 February 9, 1996
21 12. FBI Investigation Report 282A-SF-116046 – November 3, 1998
22 13. CDC Special Service Unit Personnel Investigation Report no. 40-003-96 – March 21, 1996
23 14. Memorandum to M.T. Pickett from Warden Steven Cambra re: Internal Affairs Investigation
24 # 40-003-96 – April 22, 1996
25 15. Office of Investigative Services Investigation Plan re: Case no. N-PBSP-198-02 – October
26 16, 2002
27 16. PBSP Internal Affairs Transcript of Interview with Officer William Schembri – January 11,
28 1996
17. PBSP Internal Affairs Transcript of Interview with Officer Joseph Manzano – January 18,
1996
18. Memorandum to FBI Agents Stan Walker and Brent Miller from OIS Special Agent C.A.
Franklin re: Interview of William Schembri – June 21, 1998

- 1 19. PBSP Internal Affairs Transcript of Interview with Officer William Jones – January 11, 1996
- 2 20. Internal Affairs Investigation Request re: Edward Powers – September 28, 1995
- 3 21. Internal Affairs Case Assignment: Case no. N-PBSP-199-02 – October 16, 2002
- 4 22. Office of Investigative Services Investigative Plan re: Case no. N-PBSP-199-02 – October
- 5 16, 2002
- 6 23. Internal Affairs Investigation Request re: Case no. N-PBSP-199-02 – October 8, 2002
- 7 24. Internal Affairs Northern Region Investigation Worksheet re: Case no. N-PBSP-199-02 –
- 8 October 15, 2002
- 9 25. CDC Special Service Unit Supplemental Report re: Case no. 03-018-95(S) – July 25, 1995
- 10 26. PBSP Internal Affairs Transcript of Interview with Officer Owen Tuttle – March 8, 1995
- 11 27. PBSP Internal Affairs Transcript of Interview with Officer Greg Devos – March 8, 1995
- 12 28. PBSP Internal Affairs Transcript of Interview with Officer Ronald Parker – March 27, 1995
- 13 29. PBSP Internal Affairs Transcript of Interview with Officer Norman Whitley – March 8, 1995
- 14 30. FBI Investigation Report 282A-SF-116046 – September 18, 1998
- 15 31. Internal Affairs Investigation Request re: Case no. N-PBSP-200-02 – October 8, 2002
- 16 32. Internal Affairs Northern Region Investigation Worksheet re: Case no. N-PBSP-200-02 –
- 17 October 15, 2002
- 18 33. Internal Affairs Case Assignment: Case no. N-PBSP-200-02 – October 16, 2002
- 19 34. Office of Investigative Services Investigative Plan re: Case no. N-PBSP-200-02 – October
- 20 16, 2002
- 21 35. PBSP Internal Affairs Transcript of Interview with Officer Charles Matlock – February 25,
- 22 1991
- 23 36. PBSP Internal Affairs Transcript of Interview with Officer M.D. Maxwell – February 26,
- 24 1991
- 25 37. CDC 989: Subjects E. Powers and M. Payne re: Employee Misconduct; Reference no. 005/91
- 26 – March 19, 1991
- 27 38. Pelican Bay State Prison Incident Report re: Case no. PBP-BYD-91-02-0088 – February 14,
- 28 1991
39. Memorandum to Associate Warden C.J. Johnson from Program Administrator D.J. Helsel re:
The Incident of February 14, 1991, Involving the Assault of Officer J. Mather by Inmate
Perez D-46240 – February 15, 1991

- 1 40. Internal Affairs Northern Region Investigation Worksheet re: Case no. NC-PBSP-036-03 –
2 October 15, 2002
- 3 41. Internal Affairs Case Assignment: Case no. NC-PBSP-036-03 – October 16, 2002
- 4 42. Internal Affairs Investigation Request re: Case no. NC-PBSP-036-03 – October 8, 2002
- 5 43. Memorandum to Thomas Moore, Assistant Director OIS from John Chen, Chief Deputy
6 Inspector General re: Internal Affairs Investigation Phase II Reviews Case #: CC-PVSP-082-
7 02 and C-PVSP-143-02 – May 20, 2002
- 8 44. Memorandum to Special Agents in Charge: Office of Investigative Services Headquarters –
9 Internal Affairs Regional Offices from Thomas Moore, Assistant Director OIS re: Office of
10 the Inspector General’s Review – August 1, 2003
- 11 45. All Pleadings Filed in the Case of Charles Alexander and Richard Newton vs. State of
12 California et. al. Case no. 98-AS-03598
- 13 46. Memorandum to All CDC Employees from Edward Alameida, Director re: Potential Budget
14 Reductions – June 12, 2003
- 15 47. All Documents Provided to State Senators Jackie Speier and Gloria Romero Per Their
16 Request from Edward Alameida re: Senatorial Committee Hearings Commencing on July 10,
17 2003.
- 18 a. Copies of leases for all CDC offices in Rancho Cucamonga.
 - 19 b. Copy of lease agreement that requires CDC to pay for office space utilized by all the
20 State Personnel Board in the Southern Region.
 - 21 c. Number of Category I investigations conducted by the Office of Investigative Services
22 (OIS) Northern, Central, and Southern Regional Offices for the past five years.
 - 23 d. Written explanation of higher OIS Central Regional office/equipment costs as
24 compared to Northern and Southern Regional Offices.
 - 25 e. Overtime expenditures for the OIS Northern, Central, and Southern Regional Offices
26 for each for the past five years.
 - 27 f. Documentation outlining temporary assignment and current status of Correctional
28 Officer Shane Ziska.
 - g. Can CDC retain the Discrimination Investigations Unit (DIU) at the same lease cost if
the OIS is dropped from the lease.
 - h. Headquarters Office expenditures, staffing and workload.
 - i. Clarification of total OIS workload as provided in the June 24th report.
 - j. Decision to close the Southern Region Office.
48. Agenda re: Senate Select Committees on Government Oversight and the California
Correctional System Joint Hearing on the California Department of Corrections – July 10,
2003
49. Letter to Senators Jackie Speier and Gloria Romero from Peter Siggins, Chief Deputy
Attorney General, Legal Affairs re: Attorney General’s Investigation of Incident at California
Institution for Men in Chino – July 9, 2003
50. Memorandum to Edward Alameida, Director, Department of Corrections from Frank
Renwick, Deputy Director, Administrative Services Division re: Office of Investigative
Services Classification Alternatives – April 14, 2003

- 1 51. Memorandum to Edward Alameida from Jerry Negrete, Special Agent in Charge, Office of
2 Internal Affairs re: Reclassification of OIS/LEIU Special Agent Series to Correctional
Lieutenant – March 14, 2003
- 3 52. Confidential Talking Points re: Proposed Special Agent Reclas
- 4 53. Memorandum to C.A. Terhune Director, Department of Corrections from Richard Ehle,
5 Assistant Director, Office of Internal Affairs re: Acceptance of Dillard Case by Attorney
General’s Office – July 10, 1998
- 6 54. Office of Investigative Services Policies and Procedures
 - 7 a. Weapons Inventory
 - 8 b. Weapons Storage Policy
 - 9 c. Storage of Firearms, Ammunition and Valuable Equipment
 - 10 d. Weapons Issuance and Return Policy
 - 11 e. Ammunition and Chemical Agents Issuance and Return Policy
 - 12 f. Incident Reporting
 - 13 g. Field Incident Report “CDC Form 1662,” Part A, B, and C-1
 - 14 h. Sex Crimes Investigations
 - 15 i. Transfer of Inmate Witnesses
 - 16 j. Office of Investigative Services Computer Policy
 - 17 k. Intake Report
 - l. Employee Access to Videotape Recordings, re: Personnel Investigations
 - 18 m. Collection of Videotape Evidence
 - 19 n. Mailing Instructions Video and Audio Evidence
 - 20 o. Delivery Instructions for Audio Evidence
 - 21 p. Audio Processing Case Log
 - 22 q. Audio Processing Item Log
 - 23 r. Transfer of Office of Internal Affairs Investigations
 - 24 s. Informant Fund
 - 25 t. Pre-Interrogation Discovery
 - 26 u. Notification of Persons Under Investigation
- 27 55. Department of Corrections Mission Statement
- 28 56. Department of Corrections Organizational Chart
57. Department of Corrections Operations Manual (DOM) Including Various CDC
Memorandum
58. Senate Select Committees on Government Oversight and the California Correctional System
Joint Hearing on the California Department of Corrections Transcripts – July 10, 2003
59. Senate Select Committees on Government Oversight and the California Correctional System
Joint Hearing on Department of Corrections: Impact of Closing Southern Region of
Investigative Services, Utilization of Retired Annuitants, and, Paid Leave Issue from the
Committees’ May 8 Hearing Transcripts – June 5, 2003
60. *U.S. v. David Gene Lewis* (CR-99-0186-MMC) Transcripts of Preliminary Hearings –
January 7, 2003; February 5, 2003

- 1 61. *U.S. v. David Gene Lewis* (CR-99-0186-MMC) Excerpts of Criminal Trial Transcript
- 2 62. Declaration of Gregory Schwartz re: *Long v. Gomez* - Case no. C-98-2679-SBA (MEJ)
- 3 63. Memorandum to Steve Cambra, Regional Administrator North Institutions Division from
- 4 Arthur Diaz, Chief, Investigative Services Unit re: Shooting Review Board Close Out # 033-
PBSP-94 – July 28, 1994
- 5 64. CDC Special Service Unit Sacramento Personnel Investigation Report no. 41-003-96 re:
- 6 David Lewis – February 28, 1996

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1 **Appendix 5**

2 **GLOSSARY OF ACRONYMS**

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4 **BCP** — Budget Change Proposals

5 **BIR** — Bureau of Investigative Services

6 **CAP** — Corrective Action Plan

7 **CCPOA** — California Correctional Peace Officers Association

8 **CDC** — California Department of Corrections

9 **CPOST** — California Peace Officer Standards for Training

10 **D.A.** — District Attorney

11 **DFRB** — Deadly Force Review Board

12 **DOM** — Department of Corrections Department Operation Manual

13 **ELU** — Department of Corrections Employment Law Unit

14 **ERC** — Executive Review Committee

15 **FBI** — Federal Bureau of Investigation

16 **GAR** — Governor’s Action Request

17 **IA or IAD** — Internal Affairs Division

18 **LEIU** — California Department of Corrections Law Enforcement Investigation Unit

19 **MOU** — California Correctional Peace Officers Association Memorandum of
20 Understanding

21 **MTA** — Medical Technical Assistant

22 **OIG** — Office of the Inspector General

23 **OIS** — Office of Investigative Services

24 **PERB** — Public Employment Relations Board

25 **PBSP** — Pelican Bay State Prison

26 **POBAR** — California Peace Officer Bill of Rights

27 **POST** — Police Office Standards of Training

- 1 **SPB** — State Personnel Board
- 2 **SRB** — Shooting Review Board
- 3 **SRT** — Shooting Review Team
- 4 **SSU** — Special Services Unit
- 5 **YACA** — Youth and Adult Correctional Agency

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1 **PROOF OF SERVICE BY MAIL**

2 I, Kristina Hector, declare:

3 I am a resident of the County of Alameda, California; that I am over the age of eighteen (18)
4 years of age and not a party to the within titled cause of action. I am licensed to practice law in
5 the State of California and employed as the Assistant to the Special Master in *Madrid v.*
Woodford et al. in the County of San Francisco, California.

6 On June 24, 2004 I arranged for the service of a copy of the attached documents described as
7 the SPECIAL MASTER'S FINAL REPORT RE DEPARTMENT OF CORRECTIONS "POST
8 POWERS" INVESTIGATIONS AND EMPLOYEE DISCIPLINE on the parties of record in said
9 cause by sending a true and correct copy thereof by United States Mail and addressed as follows:

10 MIKE JORGENSON/SARA TURNER
11 Deputy Attorney Generals
12 455 Golden Gate Ave., Suite 11000
13 San Francisco, CA 94102

14 STEVEN FAMA
15 Prison Law Office
16 General Delivery
17 San Quentin, CA 94964-0001

18 MADRID UNIT (2 copies)
19 Pelican Bay State Prison
20 P.O. Box 7000
21 Crescent City, CA 95532

22 KATHLEEN KEESHEN
23 Deputy Director
24 Legal Affairs Division
25 California Department of Corrections
26 P.O. Box 942883
27 Sacramento, CA 94283

28 BRUCE SLAVIN
YACA
1100 11th Street, Suite 400
Sacramento, CA 95814

MATTHEW CATE
Inspector General
Office of the Inspector General
P.O. Box 348780
Sacramento, CA 95834-8780

1 MILDRED K. O'LINN
Manning & Marder
2 Kass, Ellrod, Ramirez, LLP
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3 660 S. Figueroa Street
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8 11344 Coloma Road, Suite 145
Gold River, CA 95670

9 RONALD YANK
10 Carroll, Burdick & McDonough
44 Montgomery, Suite 400
11 San Francisco, CA 94104-4606

12 I declare under penalty of perjury under the laws of the State of California that the foregoing
13 is true and correct. Executed on June 24, 2004 at San Francisco, California.

14

15 Kristina Hector

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