OVERVIEW AND POLICY ANALYSIS OF TETHERING IN LOS ANGELES COUNTY JAILS

June 2016

Introduction

On July 9, 2015, Sheriff Jim McDonnell was notified of a disturbing prisoner[1] complaint suggesting that a prisoner had been restrained for approximately thirty two hours without any food, only one cup of water, and no opportunity to use a restroom.

Sheriff McDonnell took action against the individuals responsible and relieved ten jail personnel of duty. The personnel included two lieutenants, one sergeant, one senior deputy, four deputies and two custody assistants. In addition, a number of other personnel were reassigned to other duties pending further investigation.

This event, however, is not an isolated incident. The Office of Inspector General (OIG) is aware of at least three other incidents involving similar conduct. In each, prisoners have been secured with a restraint device (i.e. waist chains, handcuffs, hobble etc.) to a fixed object for a prolonged period of time in a manner that subjected them to a substantial risk of mental and/or physical harm. All four of the incidents appear to involve possible violations of the Department's own policies, procedures and state laws. In fact, one of the incidents has since resulted in criminal misdemeanor filings by the Los Angeles County District Attorney's Office.[2] Of particular significance is that the incidents were known to or directed by supervisory personnel.

This report provides an overview of each of the four incidents including the Department's response to each incident through Corrective Action Plans and new directives. The OIG has not conducted an independent investigation of these incidents. The facts of each incident cited in this report are based on documents provided to the OIG by the Sheriff's Department, media reports, as well as the OIG's limited review of video surveillance of some, but not all, of the incidents. As a result of these incidents, the OIG has worked closely with the Department to

[1] The term "prisoner" used in Office of Inspector General (OIG) publications is used synonymously with "inmate" or "detained person." This term is used due to its growing acceptance in custody oversight and because Los Angeles County jails now function as prisons under recent changes to sentencing laws.

[2] See *People v. Hawkins et al.* Case no. 5NW02289 filed on September 4, 2015.

propose new policies and procedures regarding the tethering (hereinafter "fixed restraint") of prisoners. The goal of this collaboration has been to provide deputies reasonable tools to control prisoners while building in safeguards to ensure proper supervision that will limit potential abuse.

Analysis of Four Incidents

Twin Towers Correctional Facility (TTCF) Incident

On August 26, 2014, members of the Emergency Response Teams (ERT) were conducting a scheduled module search at the Twin Towers Correctional Facility (TTCF). All the prisoners were escorted to the recreation area for a strip search.[3] One of the prisoners, however, refused to be searched. Given his refusal, the prisoner was escorted to the module visiting area. On the way, the prisoner became resistive, and several deputies placed him in a control hold against the wall. Once at the visiting area, the prisoner was handcuffed to a stool. When he started kicking his legs, the deputies placed a hobble[4] on his feet and tethered the hobble to a handcuff ring on the counter of a visiting cubicle.[5] Deputies then stripped the prisoner naked and conducted a search. The prisoner remained in that position, naked and restrained, for at least ninety minutes[6] in an area visible to the public where he was seen by the public. He received treatment following the incident after complaining of pain to his right wrist and right foot. The incident was then referred to the Department's Internal Affairs unit for further investigation.

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[3] LASD policy provides that prisoners housed in modules at TTCF during the time the area is scheduled to be searched may be subject to searches of the person. *See* Custody Division, TTCF Unit Order 3-09-300/310. Prisoners who have been arraigned may be subject to a strip search or visual body cavity search. *See also,* California Penal Code Section 4030.

[4] A person is hobbled when he is handcuffed and his ankles are held together with a "Ripp Hobble" restraint device. The clip end of that device is not connected to the handcuffs. See Manual of Policy and Procedure (MPP), Section 3-01/1110.21

[5] Observations based on the OIG's review of video footage on March 23, 2015.

[6] Time reported to the OIG by the Department on March 23, 2015.

Conducting the search in the visiting room where the prisoner could be subjected to the view of individuals not participating in the search appears to have been contrary[7] to California Penal Code section 4030, which states:

> All strip, visual and physical body cavity searches shall be conducted in an area of privacy so that the search cannot be observed by persons not participating in the search.[8]

The prisoner's prolonged restraint also appears to be contrary to the Division's general policy on search procedures. According to the Division's general policy:

> Searches are not to be used to inflict physical stress or punishment on prisoners. Prisoners shall not be required to remain in any search position for more time than is reasonable and necessary to complete a search.[9]

During this incident, the prisoner was left naked and restrained for at least ninety minutes, seemingly exceeding a reasonable and necessary time to complete a search.

The following measures were taken as a Corrective Action Plan (CAP) in response to this incident: (1) a total of ten sergeants were ordered to attend ethics classes; (2) training bulletins were distributed Division-wide formalizing search protocols to be taught to all new sergeants; and (3) squad tactics classes were updated to include dorm search scenarios and were also incorporated in all future Custody Orientations for Supervisors.[10] Corrective actions are non-disciplinary and this report will not address disciplinary action which involves personnel records not publically disclosable under California law.[11] This incident also resulted in an Internal Affairs

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[7] Opinions expressed in this report are not meant to be legal conclusions regarding the applicability of criminal sanctions or discipline. This Office is tasked with providing common sense analysis of incidents for the purpose of improved policymaking and offers this analysis for that purpose only.
[8] California Penal Code section 4030(m).
[9] *See* Custody Division Manual, Section 5-08/010.00: Searches.
[10] Part of the corrective action plan included determining the best method to assist in identifying deputies and sergeants as members of ERT teams. OIG spoke to Sgt. Brad Gray on August 12, 2015, who explained that during the video review of this incident, it was difficult to identify which of the deputies and sergeants involved were members of ERT teams, so a corrective action plan was needed.
[11] The vast majority of the work done on this report was done during a period where the Office of Inspector General had limited access to personnel records.

Bureau (IAB) investigation. The IAB investigation has since been completed and both line staff and supervisors were disciplined.[12]

North County Correctional Facility (NCCF) Incident

On September 4, 2014, a week after the incident at TTCF, a prisoner detained in the North County Correctional Facility (NCCF) was suspected of concealing contraband in his rectum and was placed on the then-existing NCCF contraband watch. As a result, the prisoner was restrained and a "pull over"[13] detention was initiated, isolating him from other prisoners. The prisoner remained restrained for "an extended period of time,"[14] while Department personnel waited for him to use the toilet so they could retrieve potential contraband. According to a spokesperson for the Los Angeles County District Attorney's Office, as a result of the prolonged application of restraints, the prisoner "suffered injuries to his waist and midsection."[15]

The then-existing NCCF unit order for prisoner detentions regarding suspected contraband had been initiated only four months prior to this incident. The order allowed for restraints to be placed on a prisoner who refused to comply but was written in a vague manner that gave no clear guidelines on avoiding substantial risk of mental and/or physical harm to prisoners. With no provisions for either constant supervision or medical intervention, this unit order allowed for a prisoner to be tethered with handcuffs, a black box (also known as a "high security handcuff cover" restraint system)[16] and a waist chain to a metal bracket on the wall for a "reasonable period of time,"[17] wearing only a pair of boxers and shorts.[18]

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[12] State law prevents the public disclosure of discipline decisions.
[13] The term "pull over" is used by NCCF deputies to describe a prisoner that is isolated from other prisoners during the visual cavity search process when it is believed the prisoner may possess narcotics/contraband in their anal cavity.
[14] Reported by the Los Angeles Times, published on January 10, 2016, by reporter Cindy Chang.
[15] *Id.*
[16] A "high security handcuff cover" restraint system consists of a Master brand padlock, a length of chain, a black plastic handcuff cover, and leg chains. *See Custody Division Manual (CDM) section 5-05/120.00*
[17] Defined as no more than six hours. See IPA Detection for Suspected Contraband, Unit Order 07-105/03, effective April 8, 2014.
[18] *Id.*

As a result of this incident, the then-existing NCCF unit order was found to be nonconforming to Department policy. It does not appear to have been approved by Custody Support Services prior to its implementation. The unit order was immediately rescinded and replaced with a new and extensive Department-wide Custody Division directive for contraband watch procedures which was approved on February 20, 2015.[19] In addition, a new section was added to the Custody Division manual requiring that all changes to unit orders be reviewed by Custody Support Services to ensure compliance with Department policy.

The February 2015 Custody Division directive for contraband watch procedures appeared to address many of the deficiencies in the prior NCCF unit order. It required more supervision, medical assessments, no fixed restraints, no waist chains while unclothed, videotaping of an uncooperative prisoner and detailed documentation.[20] However, an even more extensive Department-wide Custody Division directive for contraband watch procedures was implemented on January 1, 2016.

The January 2016 directive outlines a set of pre-placement procedures that the facilities' watch commander must ensure are followed before a prisoner is placed on contraband watch. The pre-placement procedures include medical and mental health assessments, video recording of the prisoner's segregation, and notification to the Custody Investigation Services (CIS) on-call supervisor to assign an investigator to oversee the operation. [21]

Prisoners can now only be restrained with approved contraband watch restraint equipment and/or waist-chained, and ankles secured with either medical tape or Velcro straps. Unlike the previous order, no black box handcuff may be used, nor can the prisoner be tethered to a fixed object. As part of the Department's

[19] A temporary IPA Detentions for Suspected Contraband order was put in place on February 13, 2015, which was replaced by the new contraband watch procedures directive. The temporary order required a supervisor, sergeant or above to be present in the IPA during any search or "pull over" detention. The unit order also required deputy personnel to conduct fifteen-minute checks instead of thirty-minute checks every hour. In addition, the order required a sergeant to visually inspect the detained prisoner and sign the detention log every two hours.
[20] *See* Custody Division Directive: 15-001, Contraband Watch Procedures, effective February 20, 2015.
[21] *See* Custody Division Directive: 16-001, Contraband Watch Procedures, effective January 1, 2016.

corrective action plan, the metal brackets affixed to the wall (known as eye rings) which were being used to tether prisoners were removed from all holding cells.

Male prisoners must now be dressed in a pair of briefs, a t-shirt, socks, and a pair of county issued blue top and pants,[22] ensuring no prisoners are restrained unclothed. In order to provide range of motion to a restrained extremity, the new directive requires the prisoner be allowed free movement of each arm at least once every two hours, for a period of at least five minutes.

After pre-placement procedures have been completed, the CIS supervisor must contact the CIS Commander to seek approval for placement on Contraband Watch. Once approved, the prisoner is placed in a "dry cell"[23] for up to seventy-two hours. During each eight hour period, the CIS supervisor must provide status updates to the CIS Commander throughout the operation.

Throughout the duration of the prisoner's contraband watch, a deputy or custody assistant must keep constant visual contact of the prisoner and document safety checks every fifteen minutes. The assigned shift sergeant must conduct visual checks of the prisoner every two hours to assess the prisoner's well-being and ensure the staff's adherence to the contraband watch procedures. Drinking water must be placed in the cell and made available to the prisoner, along with regularly scheduled meals. Additional medical assessments must also be conducted every two hours by a registered nurse. Continuous video recording of the prisoner while on contraband watch is now required.

After the initial seventy-two hour hold, retention of a prisoner for a second seventy-two hour hold must be approved by the respective Custody Services Division Chief. Additional medical assessments must also be performed to support the continued need for retention. To continue the contraband watch beyond six days (144 hours),

[22] Female prisoners are issued the following clothing: one pair of underwear, one brassiere, one t-shirt, one pair of socks and a pair of county issued blue top and pants. *See* Custody Division Directive: 15-009, Contraband Watch Procedures, effective January 1, 2016.

[23] As defined, a dry cell has a toilet and sinks with the capability to shut off the flow of water to ensure any concealed contraband is not discarded. The dry cell shall be a cell that can provide the necessary security precautions of the facility and large enough to accommodate a fully extended sleeping mattress. The dry cell lights should be dimmed during normal hours of darkness. The dimming of lights should not adversely impact staff's ability to observe and monitor the prisoner. The setting may be in a general population area or in a segregated housing area of the facility.

approval of the Custody Operations Assistant Sheriff is required. All Contraband Watch operations continuing beyond six days must be approved by the Assistant Sheriff on a daily basis.

To assure compliance with the new contraband watch procedures, multiple levels of documentation are required. A contraband watch checklist must be completed throughout the operation to show compliance with pre-placement procedures, placement on contraband watch, placement in a dry cell and actions taken at the conclusion of the contraband watch. To document the safety and medical monitoring of the prisoner, a contraband watch activity log must also be completed which includes watch commander and supervising sergeant checks, fifteen-minute safety checks, as well as various medical assessments. At the conclusion of the Contraband Watch, a Chief's memorandum must be submitted for each contraband watch incident by the CIS supervisor summarizing the incident and indicating the circumstances that led to the request for a contraband watch.

As a result of the September 4, 2014, incident at NCCF, fourteen NCCF personnel, including the head of the facility, were reassigned and transferred to positions in which they no longer have contact with prisoners.[24] In addition, the Los Angeles County District Attorney's Office filed misdemeanor charges against three Department personnel for the crime of cruel punishment or treatment impairing health, in violation of Penal Code section 673. One of the three individuals charged was also charged with the crime of assault by a public officer, a misdemeanor, in violation of Penal Code section 149. The case is currently pending in the Santa Clarita Courthouse. The next scheduled court date is June 24, 2016.[25]

High Observation Intake Housing (HOH) Incident

While the issues of the August 26, 2014, incident at TTCF and the September 4, 2014, incident at NCCF were being examined by the Department, a third incident

[24] Reported by the Los Angeles Times, published on January 8, 2016, by reporter, Cindy Chang.
[25] See *People v. Hawkins et al.*, case no. 5NW02289.

occurred at the High Observation Intake Housing (HOH)[26] at TTCF in which a prisoner subsequently died. Similar to the two prior incidents, the prisoner had been tethered by his handcuffs to a fixed object, his cell door, for a prolonged period of time.

On January 12, 2015, the prisoner went to court and upon his return to the Inmate Reception Center (IRC) began displaying bizarre behavior. At 11:00 p.m. that evening he was handcuffed to a bench and vitals were taken. At approximately 1:00 a.m. on January 13, 2015, the prisoner was seen by a psychiatrist, placed in line for a mental health evaluation, and cleared for high observation housing (HOH). At 9:37 a.m. the prisoner was brought into HOH in a safety chair[27] wearing a spit mask. When he refused to remove his undergarment in exchange for a safety garment, the prisoner was placed in a cell, tethered with his left wrist handcuffed to a waist chain that traveled through the cell door's tray slot and secured to the door handle on the outside of the cell door. The prisoner was kept in this position for approximately 10 hours and 25 minutes. On multiple occasions, deputies failed to recognize that the prisoner was in medical distress. At 10:16 p.m. deputies made entry into his cell and found the prisoner unresponsive. Rescue efforts were made, but the prisoner was pronounced dead shortly thereafter. The autopsy revealed that the prisoner had ingested methamphetamine which had generated toxins in his system.

Two days after this incident, on January 15, 2015, the Department issued a new unit order regarding HOH prisoner intake procedures. The purpose of the order was to establish procedures for properly housing mental health prisoners in a cell at HOH and confiscating their clothes. Now, a prisoner who refuses to exchange his clothing for a safety garment must be placed in an individual Therapeutic Treatment Module (TTM). The floor sergeant must be notified to work with mental health and

[26] Prisoners who do not need inpatient care to address a mental illness but who require an intensive level of observation are assigned to High Observation Housing (HOH) by Department of Mental Health personnel to maintain prisoner safety and security.

[27] A safety chair is a security restraint device. It is intended to be used for short term security, temporary control and transportation of an inmate who has been identified as violent, self-destructive, or a high security risk. *See* Custody Division Manual Section 5-03/130.05: Safety Chair

medical staff to gain the prisoner's cooperation. Title 15 safety checks[28] are initiated at fifteen-minute intervals in which the prisoner must be observed at all times and the observations documented on the HOH Prisoner Secured to a Fixed Object Observation Log. If within thirty minutes the prisoner is still noncompliant, the floor sergeant must notify the watch commander. If the situation is still not resolved within sixty minutes, the watch commander must respond and attempt to gain compliance or direct the sergeant to form a plan to remove the prisoner's clothing.

Once a prisoner is in a suicide prevention gown, the new unit order appears to allow for only momentary use of fixed restraints while placing the prisoner inside a cell. Specifically, when the prisoner is placed in the cell, his waist chain is released and placed through the opened tray slot. To maintain control of the prisoner after the door is closed, the waist chain is then secured to the exterior door handle. One hand is then removed from the cuff, leaving one hand secured until the waist chain is completely removed. The unit order clearly states "At no time will a prisoner be left secured to the exterior door handle."[29]

The January 13, 2015, incident revealed several untimely safety checks on the prisoner, as well as the denial of a meal during a scheduled food delivery.[30] When the prisoner stopped moving at 7:30 p.m. no checks were conducted. At 7:45 p.m., during an apparent safety check, the deputy appeared not to look into the prisoner's cell or to recognize that the prisoner was in medical distress.[31]

The LASD personnels' delay in recognizing the prisoner's medical distress triggered the Department to require that each facility conduct "man down" drills using mannequins. The drills were mandated by Custody in coordination with Medical

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[28] The California Code of Regulations (CCR) is the codification of the general and permanent rules and regulations mandated by California state agencies. The CCR consists of 28 titles and contains the regulations of approximately 200 regulatory agencies. Title 15 of the CCR regulates the California Department of Corrections and Rehabilitations. Within Title 15, 'safety checks' are defined as "direct, visual observation performed at random intervals within timeframes prescribed …to provide for the health and welfare of inmates." 1006 CCR 15: Definitions.

[29] Custody Division Twin Towers Correctional Facility, High Observation Housing Prisoner Intake Procedure, Unit Order 5-08-340, effective January 15, 2015.

[30] OIG's review of the video footage showed that at 4:02pm meals where distributed although no meal was provided to this prisoner.

[31] Times and observations are based on the OIG's viewing of the video footage.

Services Bureau line staff, and emphasized scenarios involving prisoners in medical distress. This incident also resulted in an Internal Affairs Bureau (IAB) investigation. The IAB investigation has since been completed and both line staff and supervisors were disciplined.[32]

Inmate Reception Center (IRC) Incident

The most recent incident, which caused the Department to relieve thirteen personnel of duty and four to be temporarily reassigned to other units pending investigation, occurred at the Inmate Reception Center (IRC) on June 19, 2015. The prisoner, who was booked on an arson charge, was restrained after he "ripped his T-shirt into shreds, told a jail deputy he was going to hurt himself and then head-butted her, giving her a concussion."[33] According to Chief Eric Parra who is in charge of the general population of the Custody Service Division, the prisoner was then placed in a chair with his hands cuffed behind his back and his ankles bound together.[34] Approximately three hours later, the prisoner's ankles were untied, but he remained on the chair in waist chains attached to a bench with his hands cuffed to the chains. The restraints were loose enough that the prisoner could lie on the bench, according to Chief Parra.[35] However, the prisoner remained restrained for approximately thirty two hours and received no meals, only one cup of water and no access to a restroom. Chief Parra added that without access to a toilet, the prisoner may have relieved himself on the floor of the cell.[36]

As part of the corrective action plan, on July 9, 2015, (the same day Sherriff McDonnell learned of the incident), an email was sent out by the IRC Operations Lieutenant containing the Custody Division Manual (CDM) policies on handcuffing prisoners and use of isolation cells. The policies were required to be briefed. In addition, changes requiring watch commanders to personally check on prisoners in

[32] State law prevents the public disclosure of discipline decisions
[33] Reported by the Los Angeles Times, published on July 13, 2015, by reporter Cindy Chang.
[34] Chief Eric Parra's statement made to the Los Angeles Times, published on July 13, 2015, reporter Cindy Chang.
[35] *Id.*
[36] *Id.*

isolation cells prior to approving any extensions to their detention were made and ordered effective immediately.

On July 15, 2015, additional revisions to the IRC unit order went into effect requiring a sergeant to conduct hourly checks on recalcitrant prisoners who are restrained inside a temporary isolation cell. During the hourly check, the sergeant must also evaluate whether the continued use of handcuffs or waist chains is necessary. In addition, multiple new IRC unit orders were created that went into effect on July 15, 2015, and July 19, 2015. These orders included new procedures on changing prisoners into suicide gowns and the creation of Medical Housing Expedite Deputies.

Relative to the issue of restraints, a new IRC unit order took effect at the same time establishing the proper use of the medical transportation chairs. The order makes clear that a transportation chair can only be used for transporting prisoners within a custodial facility and never as a safety chair as was done in this incident. The order goes on to read:

> At no time should an inmate be handcuffed, strapped to, hobbled or otherwise secured to a medical transport chair or tethered with a restraint device (i.e. waist chains, handcuffs, hobble, etc.) to a fixed object while in a Medical Transport Chair.[37]

The order states that when using the medical transportation chair, Custody Service Division personnel shall only handcuff a prisoner if it is reasonably necessary and in compliance with the Department Manual of Policy and Procedures sections regarding handcuffing.[38]

This incident was presented to both the Los Angeles County District Attorney's Office as well as the Los Angeles City Attorney's Office for review. Both prosecutorial agencies declined to file criminal charges.[39]

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[37] IRC Unit Order: 5-28/000.00
[38] *Id.*
[39] Reported to the OIG by the Department on April 28, 2016.

Policy Analysis

The need for a correctional facility to maintain safety and order is undeniable. However, search procedures and prisoner restraints must strike a reasonable balance between a prisoner's safety and the needs of the institution. Clearly, a correctional officer may intrude on a prisoner's rights more than is allowed in other non-custodial circumstances. However, an intrusion must be done in a manner that respects human dignity, is not intended to punish or humiliate a prisoner, and does not create a substantial risk of physical or mental harm.

The four incidents discussed in this report demonstrate that a prisoner may need to be restrained for a variety of different reasons: the August 26, 2014, incident at TTCF stemmed from the prisoner's refusal to adhere to a random strip search; the September 4, 2014, incident at NCCF resulted from a prisoner being detained after suspicion of concealing contraband in his rectum; the January 12, 2015, incident was initiated after the prisoner displayed signs of a mental illness and refused to remove his undergarment in exchange for a safety gown at HOH; and on June 19, 2015, the prisoner assaulted a deputy at IRC which led to the prisoner's isolation and extensive restraints.[40]

Each incident occurred in a separate jail facility within Los Angeles County and within various areas of each facility under different and challenging circumstances. In each incident supervisory personnel were involved in decisions that resulted in health risks to prisoners. These circumstances suggest a pattern of behavior within the Los Angeles County jails that likely cannot be attributed to individual malfeasance alone. The improved policies the LASD has already put in place appear to be an excellent start to a systemic solution.

However, the Department's efforts to remedy each of these incidents have been a series of corrective action plans and policies aimed at each specific incident. Within months of each other, four separate incidents all sharing a common link occurred –

[40] The prisoner was convicted of this assault in felony case no. BA437748 on February 17, 2016.

the prisoner was left tethered to a fixed object for an extensive period of time without proper care and supervision.

This common link, although acknowledged within each incident, was never addressed by a general fixed restraints policy. While each of the corrective action plans put in place is excellent, without implementation of a general fixed restraint policy, the Department would not be able to address the most serious problem: the possibility that the same damaging conduct will occur under slightly different circumstances that cause it to fall outside one of the corrective action plans. The Inspector General believes that an effective policy on fixed restraints must apply regardless of the reason for the use of fixed restraints, must have effective centralized notification under circumstances likely to result in abuse, and must include increased monitoring of the prisoner to limit the increased risk to health.

When a prisoner is "tethered," an already attached restraint device (i.e. handcuffs, waist chains, hobble etc.) is secured to a fixed object, significantly limiting the prisoner's range of motion. When kept in this restricted position of confinement for an extended period of time without proper care, the potential risk of harm is greatly heightened.

The elimination of all fixed restraint practices would ignore the reality of a correctional facility's need to occasionally utilize these restraints to maintain safety and order. Recognizing this need, the Department has spent the last several months working closely with the OIG, *Rosas*[41] monitors[42] and the Department of Justice (DOJ), to implement new Department-wide policies regarding the fixed restraint of prisoners.

[41] *Rosas, et. al. v. Baca* Case No. CV 12-00428 DDP: federal class action law suit that alleged that Los Angeles County Sherriff Lee Baca and his staff allowed for a pattern of abuse against prisoners to occur in the jails. An agreement was approved in April 2015, that the Sheriff's Department reform Department policies and practices on use of force. One of the key mandates in the agreement includes the implementation of policies to prevent abuse of prisoners.

[42] Court monitors appointed by United States District Judge Dean Pregerson in the matter of *Rosas, et. al. v. Baca* to assure compliance by the Los Angeles County Sheriff's Department with the settlement agreement approved in April 2015.

Proposed Fixed Restraint Policies

The proposed fixed restraint polices have been divided into four sections to account for the unique circumstances under which a prisoner may need to be tethered throughout the Los Angeles County jails.

CDM 7-01/000.00: General Principles of Security Restraints and Handcuffing Inmates

Section 7-01/000.00 of the Custody Division Manual (CDM) addresses the general principles of security restraints and handcuffing inmates. Along with other general principles, the policy reinforces that restraints should never be used to punish prisoners, and must only be used on a prisoner when there is a potential threat of physical harm, destruction of property, escape, or to escort or transport a prisoner. Adopting language from the *Rosas* agreement, the policy also states that prisoners should not be restrained to fixed objects unless the object is designed or is commonly used for that purpose, and only used for the shortest period of time necessary.[43] Furthermore, the policy recognizes that the longer restraints are applied, the greater the risk of medical distress to a prisoner. Therefore, the policy requires Department personnel to immediately summons medical assistance whenever a prisoner appears to be experiencing medical distress or complains of difficulty breathing.

CDM 7-01/000.15: Security Restraints in Mental Health Housing

Separated from the general population, prisoners who suffer from mental illness are commonly housed in High Observation Housing (HOH)[44] or Moderate Observation

[43] *Rosas* Agreement: Use of Restraints: Section 17.1(8) prisoners should not be restrained to fixed objects unless the object is designed for that purpose, and only for the shortest period of time.
[44] Prisoners who do not need inpatient care to address a mental illness but who require an intensive level of observation are assigned to High Observation Housing (HOH) by Department of Mental Health personnel to maintain prisoner safety and security.

Housing (MOH).[45] Addressing the unique circumstances surrounding this population, CDM 7-01/000.15 makes clear that security restraints in HOH and MOH cannot be used as an alternative to mental health treatment. Rather, utilizing the least restrictive option, for the least amount of time, security restraints must only be used when necessary to ensure safety.

CDM 7-01/000.05: Fixed Restraints And Handcuffing Inmates

CDM 7-01/000.05 is the Department's general fixed restraint policy enforced throughout the county in every facility.[46]

The policy defines fixed restraints as:

> The application of any handcuffs, shackles or transportation chain, permanently or temporarily, affixed to an immovable object (e.g. tables, chairs, benches, stools, rails, ring or bolt, etc.) which are designed to limit the movement of an inmate within a custodial environment.

The policy requires that prisoners in fixed restraints be placed in a location where they are in direct and unobstructed visual observation of custody personnel. If unobstructed visual observation is not feasible, then the prisoner is considered to be separated or isolated from the general population and therefore must be monitored by the additional requirements proposed in CDM 7-03/000.10, security restraints and separation/isolation of inmates, explained below.

When possible, the application of fixed restraints is required to occur in areas where a fixed video surveillance (CCTV) is available for purposes of documentation. When

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[45] Prisoners who have a broad range of mental health diagnoses and functioning and whose health needs can be cared for in less intensive and more open setting than the high observation areas are assigned to Moderate Observation Housing (MOH) by Department of Mental Health (DMH) personnel.
[46] Exceptions to the notification/approval process outlined in this policy may be made when fixed restraints are utilized during routine procedures such as IRC clinic and inmate visiting, or when used in HOH, MOH or for inmates awaiting housing in the Correctional Treatment Center (CTC).

a CCTV is unavailable, a video camera must then be used to document the fixed restraint protocols once a prisoner is restrained in excess of three hours.

Once a prisoner is placed in fixed restraints, a supervising sergeant for that location must promptly be notified. The sergeant must be provided with the location and reason why the prisoner was placed in fixed restraints. The sergeant is responsible for evaluating the application of the fixed restraints and approving its continued use, if reasonable. At least once every hour, the sergeant must conduct a prisoner safety check of all prisoners in fixed restraints in areas under his/her supervision and reassess whether or not a prisoner needs to remain in fixed restraints. During the check, the sergeant must also ensure each prisoner is provided access to toilet facilities, drinking water and regularly scheduled meals.

At least once every two hours, the sergeant must ensure that a medical evaluation is conducted by medical personnel. Any refusals by the prisoner for a medical evaluation must be made directly to medical personnel and documented.

If after four hours the prisoner is still restrained, the watch commander must be notified and must respond to the location where the prisoner is restrained to evaluate the application of the fixed restraint and approve their continued use. If continued use is approved, the watch commander must then conduct prisoner safety checks, similar to the sergeant, at least once every four hours.

If a prisoner remains in fixed restraints in excess of six hours, the facility's Captain[47] must be notified and consulted to approve any continued use. After eight hours, notification and consultation is required with the facility's division commander.[48] All notification and consultation must be documented in the Watch Commander's Log.

[47] The facility's Captain is also referred to as the facility's unit commander.
[48] The facility's Division Commander is also referred to as the facility's commander

CDM 7-03/000.10: Security Restraints And Separation/Isolation Of Inmates

If a prisoner is temporarily separated/isolated or cannot be placed in the unobstructed visual observation of custody personnel, while in fixed restraints, the procedures listed in CDM 7-03/000.10, Security Restraints and Separation/Isolation of Inmates**,** must be followed *in addition* to the requirements outlined in the general fixed restraint policy, CDM 7-01/000.05, Fixed Restraints and Handcuffing Inmates.

In addition to the hourly checks required by the sergeant under the general fixed restraint policy, CDM 7-03/000.10 requires the handling sergeant to also direct custody personnel to conduct and document inmate safety checks on the restrained prisoner every fifteen minutes. The custody personnel conducting the inmate safety checks every fifteen minutes must look at the prisoner to determine if he/she is in any type of physical distress (e.g., not breathing, skin discoloration, abrasions or bleeding around any area where the restraints were applied, or any other symptom which require medical assistance). Medical personnel must be summoned immediately if the prisoner displays any signs of medical distress.

Under this policy, notification to the watch commander by the sergeant must be made before the four hour mark required under the general fixed restraint policy. Once the sergeant has completed his/her initial assessment of the restrained prisoner, the sergeant must place the watch commander on notice of the incident. If after one hour of notifying the watch commander the sergeant determines the prisoner should remain restrained, the sergeant must consult with the watch commander. The watch commander must then personally evaluate the behavior of the prisoner and determine the next course of action.

If the watch commander determines that the restraints should not be removed, the watch commander must ensure the following inmate safety checks are completed: fifteen-minute checks by custody personnel; hourly checks by the supervising sergeant; and safety checks every four hours by the watch commander. During all safety checks, Department personnel must ensure the prisoner is given the opportunity to use toilet facilities and consume scheduled meals and water.

Furthermore, to ensure compliance, all supervisory safety checks must be documented with a portable video camera.

Since this policy is to be followed in conjunction with the general fixed restraint policy, the facility Captain must be notified and consulted if the prisoner is restrained in excess of six hours. If the prisoner is restrained in excess of eight hours, the facility's division commander must be notified and consulted.

Conclusion

On April 27, 2016, the *Rosas* monitors approved all four of the new proposed policies. Still pending is the approval of DOJ. Once all approvals have been given, custody personnel should be thoroughly trained on the new fixed restraint policies procedures to assure uniform compliance across all facilities. Adoption of the proposed policies will help ensure that the appropriate balance between the constitutional rights of the prisoners and the increased need for security and order in jail facilities is maintained while minimizing danger of harm to both the prisoner as well as jail personnel.