



EXECUTIVE SUMMARY
Investigative Report
Ombudsman Complaint A2013-1560
Finding of Record and Closure
September 19, 2017

(The summary has been edited and redacted to remove information made confidential by Alaska Statute and to protect the privacy interests of the citizens involved.)

Summary of the Complaint

An inmate¹ filed a complaint with the Office of the Ombudsman alleging that on August 16, 2013, Spring Creek Correctional Center (SCCC) correctional officers took him and 11 other House 1 Bravo Module (Mod) inmates out of their cells “for no reason,”² shackled each of them in handcuffs, then took them to the House 1 recreational sally port area. The complainant alleged that, once there, the inmates were unshackled and ordered to strip naked in front of female staff.

The complainant said the correctional officers (COs) told him to submit again to handcuffs while he was naked or they would force him to submit. In addition to the handcuffs, he said the COs put him and the other 11 inmates on a “dog leash”³ and walked them naked to the House 1 Charlie Mod. He alleged that the COs ridiculed and laughed at all the inmates during “the parade.” He claimed that the Charlie Module cell, where he was placed naked and held for several hours without covering or clothing, was filled with debris, had blood on the cell walls and feces in the cells, and had no running water or working toilets. He also alleged that SCCC supervising COs ordered staff to turn off the prison’s surveillance cameras during this incident.

The complainant said he never received a disciplinary “write-up” for a precipitating incident (to his extraction from his cell and subsequent search), which is required by Department of Corrections (DOC) policy if an inmate commits a disciplinary infraction. He believes that the way SCCC staff carried out this cell extraction, search, and relocation constituted sexual harassment of him and the other inmates. He contended that SCCC staff were retaliating against him and the 11 other inmates for an earlier disruption at the institution, on the night of August 5-

¹ The inmate is referred to as the Complainant in the report.

² The Complainant said that on that day, another inmate in the Bravo Module, Inmate N, broke a shower head, flooding the cellblock, but he said neither he nor the other inmates housed in this area played any part in the shower damage.

³ The ombudsman determined during the investigation that the “dog leash” referenced by the complainant was a cuff retainer, an approved restraint device used by correctional officers to restrain prisoners who are considered aggressive or combative and who present a security/safety risk to officers.

6, 2013. He filed a grievance with DOC about the incident and alleged that the staff member assigned to investigate his grievance was the same CO who ordered the actions taken by staff on August 16.

Sequence of Events

Disturbance August 5-6, 2013

Late in the evening of Monday, August 5, 2013, fourteen inmates in the House 3 Juliet Mod of SCCC engaged in a “disturbance.” The *Seward Phoenix Log* reported that the inmates broke apart porcelain toilets in their cells and used the broken parts to smash windows.⁴ According to another article in the *Anchorage Daily News (ADN)*, the August 5 incident “was sparked by inmates upset over a directive to make their beds and clean their rooms.”⁵ The newspaper reported that the inmates broke not only the toilets in their cells, but also their sinks and flooded their cells. DOC moved the inmates one by one in ankle chains and handcuffs to another segregation unit. The incident ended the next morning on August 6, 2013, according to a media statement issued by DOC. The inmates who participated in the House 3 disturbance were subsequently removed from House 3 and placed in the Bravo Mod of House 1.

August 16, 2013 Incident

On August 16, 2013, another House 1 inmate, Inmate N, broke off a shower head, resulting in water flooding the Bravo Mod. A female DOC nurse was called to House 1 to examine Inmate N following his cell extraction by the staff. She noted that there was a disturbance in House 1 involving all the inmates housed in the Bravo module. She reportedly witnessed inmate N’s removal, as well as the other eleven inmates’ removal.

According to Spring Creek staff who documented the August 16 incident in House 1, the Bravo Mod inmates yelled and screamed support for Inmate N while he was in the shower, encouraging him to destroy state property. Additional officers were called to House 1 to assist with removing Inmate N from the shower. Maintenance staff shut off the water to House 1 to stop it from flowing uncontrollably throughout the housing unit. Initially, Inmate N refused to submit to restraints and was sprayed with oleoresin capsicum (OC, also known as “pepper spray”). Ultimately, he submitted to handcuffs and was removed from the shower. The staff took Inmate N to the House 1 recreational sally port where they removed his clothing and searched for contraband. After completing the search, they provided Inmate N with underwear and placed him in a different housing module, the Charlie Mod.

Inmate N received a disciplinary write-up for committing a C-15 infraction: “engaging in a group or individual demonstration or activity that involves throwing of objects, loud verbal confrontation or pushing, shoving or other physical contact that disrupts or interferes with the orderly administration of the facility.” He was given 40 days punitive segregation for the incident. He was the only inmate to receive a disciplinary write-up for the events occurring on August 16, 2013.

Shortly after inmate N’s removal from the shower, the officers who removed him were directed to report back to House 1 to remove the remaining inmates from the Bravo Mod. All accounts

⁴ “SCCC Inmates Trash Module” by Wolfgang Kurtz. The Seward Phoenix Log, August 8, 2013, Vo. 47. No. 51.

⁵ “Seward prison mayhem began over order to make beds” by Lisa Demer. Anchorage Daily News, August 8, 2013.

agree that the officers removed 12 inmates from the Bravo Mod, strip searched them, attached them to a cuff retainer or other restraints, and moved them naked to the Charlie Mod. The inmates were placed naked into different empty cells in the Charlie Mod, where they remained, naked, for up to 12 hours. The inmates did not receive a mattress or blanket until the following day (August 17) at 10:00 p.m., according to DOC's records.

Inmates' Grievances and DOC's Response

On August 23, 2013, the Complainant filed a grievance about the August 16 incident. The grievance indicated it was a staff misconduct grievance. The Complainant described being "subjected to sexual embarrassment or sexual harassment by several officers." He questioned why staff removed the inmates from their cells, strip searched them in front of female staff, and "put us on a dog leash for no reason . . ." He alleged he was placed in a cold cell "with blood and construction debris all over the room [and] no water or clothes for 16 hours. . ."

The SCCC Facility Standards Officer received the Complainant's grievance on August 28, 2013 and forwarded it to a SCCC lieutenant on September 19 for investigation — 22 days after the grievance was received. The lieutenant completed the grievance investigation on October 8, 2013. According to the lieutenant's investigation report, the complainant was involved in a group demonstration. The report states that the complainant was restrained and uncovered,

. . . for a period reasonably necessary to conduct a search, perform an exam by nursing staff, and to alleviate the security threat determined by staff posed by misuse of state clothing.

The lieutenant wrote that the complainant was provided with a blue safety smock/blanket to cover himself and received regular state clothing the next morning.

Several other House 1 inmates filed grievances that provided accounts similar to the Complainant's. DOC's responses were also similar in nature, noting that the inmates participated in a group disturbance requiring staff to move them to a different housing unit. DOC acknowledged that there was a female staff member present during their cell movement and strip search: a nurse whom staff asserted was on scene to treat any inmate injuries.

The inmates complained of being stripped and walked naked to the Charlie Mod on "dog leashes" in front of female staff and placed into unsanitary cells without anything, including clothing. Their written accounts varied on the time they were left naked in their cells, from a few hours to 12 or more hours.

One inmate reported that the cells were cold, "probably 50 degrees at the most." He also alleged that the incident was not videotaped, and that inmates were told by staff that they would be fired if they gave the inmates anything (i.e. clothes).

The same lieutenant investigated the other inmates' grievances and concluded that they all were involved with a group demonstration justifying the actions staff took on August 16. The Assistant Superintendent upheld the lieutenant's grievance investigation findings and denied the inmates' grievances. When the inmates appealed the matter to the DOC Director of Institutions, the Deputy Director denied their appeals and provided similar responses, "Denied, it states in the report that all 11 prisoners in the module were banging on their doors & shouting you were a participant in a disturbance and accountable for your actions."

When one inmate questioned why he and the other inmates were not written up for disciplinary infractions if they had been involved in a group disturbance, the Deputy Director concurred that they should have been, noting,

I agree you should have received a write-up for participating in a group disturbance. The report clearly stated that all 11 prisoners were banging & hollering & encouraging another inmate to resist lawful orders.

DOC Response to Ombudsman Complaint

Assistant Superintendent Response

During the Ombudsman's investigation, the Assistant Superintendent produced a copy of a September 6, 2013 memorandum prepared by the lieutenant, the same staff member who also investigated the House 1 inmates' grievances. The Assistant Superintendent asserted that the memorandum represented the August 16, 2013 incident report prepared by SCCC staff. However, the memorandum was not the typical report format required by DOC policy 809.03 Reporting Procedures for Rule Violations.⁶ The September 6 memorandum did not follow the requirements of DOC Policy 809.03 and 22 AAC 05.410. No information was provided to the Ombudsman explaining what action the Assistant Superintendent took in response to the incident report, once he received it.

According to the lieutenant's memo, on the evening of August 16, 2013, two staff members reported that Inmate N was part of a group demonstration in the Bravo Module "that included the possession of contraband-weapon stock, disobeying staff orders, breaking a sprinkler head causing flooding, the application of oleoresin capsicum, all prisoners screaming and banging loudly on the cell doors and tray slots, and the eventual response of the facility Tact [Tactical] Team." The lieutenant stated in the memo that he directed the staff to remove the prisoners from their cells in the Bravo Mod, search them, issue a blue smock or blanket, and move them to individual open cells in the Charlie Mod. Staff were directed to search the Bravo Mod for metal contraband after the inmates had been removed from their cells. On the morning of Saturday, August 17, according to the memo, the lieutenant returned to the facility and determined SCCC staff had completed a thorough search of the inmates and the Bravo Mod. He directed staff to exchange blue smocks for regular facility clothing. At 10 p.m. on August 17, inmates were allowed a mattress and a blanket.

When asked by the Ombudsman to explain how the complainant and other 11 inmates misused their state clothing on August 16 (as referenced by the lieutenant's grievance investigation responses), the Assistant Superintendent referred to the August 6 incident (10 days earlier) where the inmates in the House 3 Juliet Mod used state clothing to damage state property by wrapping the clothing around the plumbing and yanking fixtures from the wall. According to the Assistant Superintendent, on August 16 the same prisoners involved in the August 6 incident, including the complainant, "were beginning to exhibit the same behavior." Accordingly, "[t]he decision was made to take their state issued clothing as a preemptive move to minimize any further destruction to state property." However, his response did not articulate specifically how the complainant was misusing — or communicating an intent to misuse — his state-issued clothing on August 16.

⁶ DOC policy 809.03 was repealed by DOC on May 18, 2017 and replaced by DOC policy 809.04, Disciplinary Committee, Hearing Officers and Basic Operations.

None of the other officers' written accounts of the August 16 disturbance referenced the inmates misusing their state-issued clothing. Likewise, the lieutenant's September 6 memo did not include any description of misuse of state-issued clothing by these inmates.

Depositions and Interviews of DOC Staff

The ombudsman interviewed and/or deposed several DOC staff members who were present during the events of August 16 in the House 1 Bravo Mod, or who were determined by the Ombudsman to have knowledge of the incident.

The testimony of two sergeants and two correctional officers indicated that staff had been instructed by the lieutenant to remove the inmates from their cells, strip search them, escort them to their new cells, and to leave them in their cells naked with "absolutely nothing" until the following day. The lieutenant disputed that these were his instructions to staff.

Several officers confirmed that the inmates were walked naked from the recreation sally port attached to a cuff retainer or rope and other restraint devices. They confirmed that the inmates were then placed naked into different, empty cells where they remained, naked, for up to 12 hours.

The lieutenant asserted during his deposition that the House 1 inmates had misused their clothing on August 16 by tying the clothing around their hands and banging on the cell doors. However, he also acknowledged he was not at the institution at the time of the events in question, so he did not witness any inmates using their clothing in the manner he described.

Allegations Investigated and Ombudsman Findings

The purpose of the Ombudsman's investigation was to determine whether DOC's treatment of the Complainant and the other House 1 inmates was unlawful, contrary to policy, or otherwise objectionable. The Ombudsman investigated four allegations restating them to conform with the statutory guidelines for ombudsman investigations (AS 24.55.150) as follows:

Allegation 1:

Spring Creek Correctional Center staff stripped several inmates of their clothing, attached them to a "dog leash" and walked them through House 1 naked in front of female staff. Staff subsequently placed the inmates in cells without covering or clothing for several hours. This was **contrary to law**, violating the Fourth Amendment to the U.S.

Constitution, Alaska Statute 12.25.070, AS 11.80.220, AS 11.81.900(b)(27), and 22 AAC 05.060.

The Ombudsman determined that Allegation 1 is **JUSTIFIED**.⁷

The Ombudsman found by a preponderance of the evidence⁸ that the Complainant and 11 other inmates were subjected to a search and seizure by DOC staff on August 16, 2013 when staff

⁷ A complaint is *justified* if the investigation establishes that the administrative act complained of occurred and the Ombudsman determines that criticism of the administrative act is valid. See Ombudsman Policy 4060.03 Findings.

⁸ The standard used to evaluate all ombudsman complaints is *the preponderance of the evidence*: if the evidence indicates that, more likely than not, the administrative act took place and the criticism of it is valid, the allegation should be found justified.

removed the inmates from their cells, ordered them to strip off their clothing, attached them to a rope cuff retainer, and walked them through a housing module naked in front of female staff. The evidence reviewed indicated that DOC staff placed the inmates in cells without covering or clothing for several hours. These actions are contrary to federal and state law, as well as DOC policy.

Agency response: DOC did not dispute the Ombudsman's findings.

Allegation 2:

Spring Creek Correctional Center staff stripped several inmates of their clothing, attached them to a "dog leash" and walked them through House 1 naked in front of female staff. Staff placed the inmates in different cells without clothing, covering, or a mattress for several hours. These actions were **unreasonable**.

The Ombudsman determined that Allegation 2 is **JUSTIFIED**.

The Ombudsman found by a preponderance of the evidence that the complainant and other House 1 inmates were placed in cells in the Charlie Mod without clothing, a smock or blanket, or mattress. The Ombudsman also found that DOC staff did not provide covering, clothing, or a mattress within a reasonable time after the move.

DOC regulation 22 AAC 05.067 requires that prisoner searches by DOC staff be related to the security interests of the facility. If any contraband is found during a search, the officers should confiscate it. Once the search is completed, DOC policy requires staff to return an inmate's clothing. If no contraband is found, there is no justification for continued deprivation of an inmate's clothing.

None of the evidence reviewed indicates that contraband was found on the complainant or any of the Bravo Mod inmates, other than Inmate N. No SCCC employee testified that contraband was found during the August 16 search of the inmates or their cells.⁹ Therefore, under DOC policy, the inmates' clothing should have been returned to them before they were paced in Charlie Mod.

One staff member stated that it took time to round up enough suicide smocks or suicide blankets for the inmates. It is not reasonable that it took 12 hours to locate 12 smocks or blankets within the facility. Even if it were, it was unreasonable to leave the inmates naked in cold cells with only metal or concrete beds to sit on. That decision makes it clear to the Ombudsman that this was a punitive measure and not a security measure.

Agency response: DOC did not dispute the ombudsman's findings.

Allegation 3:

DOC **unreasonably** assigned a grievance investigation alleging misconduct to the staff member who was the subject of the grievance, in violation of DOC policy 808.03.

The Ombudsman determined that Allegation 3 is **JUSTIFIED**.

⁹ A CO testified that contraband was found in one of the inmate's cells days after they were moved to the Charlie Mod which led him to believe that no one searched the cells after the August 16 incident. But, no inmate was charged or received an incident report for possession of contraband.

The Ombudsman found by a preponderance of the evidence that SCCC assigned the grievances of the Complainant (and other Bravo Mod inmates) to the lieutenant who ordered the actions that the Complainant was grieving.

DOC policy 808.03.A.2.f requires that inmate grievances accepted for investigation must either be investigated by the Facility Standards Officer or be assigned to another staff member to investigate. The policy directs that the Facility Standards Officer “*shall assign an objective staff member that is not involved in the subject of the grievance*” to investigate the grievance and issue a recommendation.” [Emphasis added].

Further, the Complainant’s grievance about the August 16 incident should have been treated as a misconduct grievance against staff and processed under DOC policy 808.03.VII.C. That policy states that for allegations of staff misconduct, the Facility Standards Officer “shall record and forward the grievance directly to the facility manager.” That did not occur. The Complainant clearly marked the grievance as “misconduct” at the top of the document, but SCCC staff instead categorized the grievance as “miscellaneous.” That was a clear error. Not only was the grievance labeled “misconduct,” but the actions described by the Complainant — sexual harassment — in no way approximate a “miscellaneous” grievance.

Agency response: DOC did not dispute the Ombudsman’s findings.

Allegation 4:

DOC staff **unreasonably** failed to follow required departmental disciplinary policy and procedure 809.02.

The Ombudsman determined that allegation 4 is **JUSTIFIED**.

The stated purpose of DOC Policy 809.02 Prisoner Rules and Discipline is “to define prohibited conduct by offenders and establish penalties for violations of prohibited conduct.” Prisoner rules must be clear, uniform, reasonable, and applied fairly. According to this policy, “only a disciplinary committee/hearing officer may punish a prisoner after it convicts him or her of a disciplinary infraction.”

The Complainant was not written up for a disciplinary infraction for the events of August 16. Neither, it appears, were the several other inmates housed in the Bravo Mod at the time of the August 16 incident. Inmate N, the inmate responsible for breaking the shower head and flooding the Bravo Mod, was written up and received appropriate disciplinary sanctions for his conduct.

The CO who was responsible for preparing the write-ups for the August 16 incident insisted that he had prepared write-ups for all the House 1 inmates, not just Inmate N. His testimony was not credible and the investigation found no evidence to support his testimony. The evidence supports the conclusion that none of the inmates were written up for the noise disturbance on August 16.

The Deputy Director recognized that that the failure to write up any of the inmates who were moved after the Inmate N incident was contrary to DOC policy. Clearly, SCCC staff violated DOC policy by not writing up all the inmates for allegedly participating in a group disturbance. However, the Ombudsman is not suggesting that DOC create disciplinary write-ups after the fact.

Agency response: DOC did not dispute the Ombudsman’s findings.

Recommendations

The Ombudsman proposed four recommendations to DOC:

Recommendation 1:

[Redacted in accordance with Alaska confidentiality statutes]

DOC Response: DOC concurred with this recommendation.

Recommendation 2:

DOC should review and revise its policies and procedures concerning the use of restraint devices, and conduct department-wide training on any change in policy.

Restraint devices should not be applied as punishment and should be utilized only when a prisoner is a threat to him/herself or others or jeopardizes facility security. Moreover, current DOC policy on the use of restraint devices does not address the use of restraints on naked prisoners. A review of other correctional facilities' restraint policies suggests that best practices dictate that while restrained, prisoners should either be clothed or covered in a manner that maximizes prisoner privacy. DOC should revise current policy and conduct training to specify that clothing or covering should be provided to inmates during the use of restraint devices.

An earlier version of DOC policy 1208.08 provided that prisoner strip searches should be conducted "in a manner least offensive to the prisoner's dignity and in private, where possible." In December 2016, **DOC removed the requirement that strip searches be conducted in a manner that preserves the privacy and dignity of the inmate.** The Ombudsman recommended that DOC restore that provision and add a section addressing the use of restraint devices during inmate searches to clarify that while restrained, prisoners shall be either clothed or covered in a manner that maximizes prisoner privacy.

DOC Response: DOC noted that the December 2016 revisions to policy 1208.08 "specifically provides that these types of searches are to be performed by same sex officers and out of the view of other prisoners."

DOC declined to reincorporate previous wording that required strip searches be conducted in a manner that preserves the privacy and dignity of inmates, indicating that this language was considered too vague for both prisoners and staff. DOC contended that the current policy language was better defined and provided clearer instructions for staff.

With respect to department-wide training on policy changes, DOC noted that the department does not generally conduct formal training for policies that are not considered annual mandatory training policies. Instead, staff are required to read and provide written acknowledgment of the policy revision. DOC policy 1208.08 is not considered a mandatory training policy.

Ombudsman comment: DOC's 2016 policy revisions requiring that strip searches be conducted by staff members of the same sex and outside of other inmate's view partially satisfies the intent of the Ombudsman's recommendation, if staff ensure that the searches are conducted in private. While the Ombudsman agrees that it is helpful to have written acknowledgement by staff noting that they have read and understand a policy revision, to ensure that staff have a clear understanding of the changes and an opportunity to ask questions, the Ombudsman maintains that department-wide training on changes to DOC policy 1208.08 is warranted to prevent a similar incident from occurring in the future.

Recommendation 3:

DOC should review and revise 22 AAC 05.067 to reflect apparent changes in strip search and body cavity search policy.

DOC revised Policy 1208.08 in December of 2016 without also revising 22 AAC 05.067. Thus, the regulation still requires that body cavity searches be conducted by medical staff in the institution. This should be corrected.

DOC Response: DOC concurred with this recommendation and indicated that the Department is currently working on regulatory revisions to reflect consistency with revised DOC policy 1208.08.

Recommendation 4:

DOC should adopt a department-wide policy for recording corrections staff interactions with the inmate population, inclusive of a retention policy for recordings, for the protection of inmates and staff.

SCCC provided body cameras to its officers in 2015. The body cameras were issued in response to repeated unsubstantiated claims of abuse filed by one inmate. The former superintendent reported that the cameras were subsequently removed because corrections officers and their union representatives objected that the recordings would be used unfairly against the officers. The incident giving rise to this investigation shows the value of body cameras or other recording devices to DOC in the management of its facilities.

Body cameras, CCTV, and/or other audio-equipped video recording systems document daily interactions with the inmate population, as well as exigent and emergency situations. They are also a useful tool for prison officials to review incidents involving correctional officers and inmates, and could help to exonerate officers who inmates claim have engaged in excessive force or other inappropriate conduct.

The Bethel Police Department, the University of Alaska Police, and the Ketchikan Police Department currently equip officers with body cameras.¹⁰ Body cameras hold officers and suspects/inmates accountable for their behavior and can protect both sides from false accusations. The addition of audio and video coverage would aid DOC in making understandably dangerous and stressful work environments safer for everyone.

Video and audio recordings would be useful not just for performance evaluation, risk management, and investigating critical incidents. They would be a useful training tool for corrections officers and staff. However, their value is dependent on their retention. A department-wide policy for retention of recordings, particularly those related to incidents that would reasonably give rise to grievances, disciplinary action, criminal investigations, or civil actions is essential.

DOC Response: DOC concurred that the use of body cameras, particularly the audio recording feature, would be helpful to the department to document prisoner and staff interactions. However, the department also indicated that the current use of facility cameras has been adequate to document prisoner and staff activity. DOC acknowledged that if clear audio could be

¹⁰ *Ketchikan Police Will Begin Using Body Cameras*, Alaska Dispatch News, August 20, 2015, <http://www.adn.com/article/20150820/ketchikan-police-will-begin-using-body-cameras>;

obtained it would help staff to investigate inmate allegations. However, given DOC's current budgetary limitations, DOC concluded that the cost of purchasing body cameras and management of the systems would be cost prohibitive. Additionally, the commissioner's office noted that the department expected significant opposition from staff and their union representatives if DOC mandated the use of body cameras at all institutions. They declined to implement the recommendation at this time.

Ombudsman comment: Body cameras vary in cost depending on the model and features offered. On average, body cameras cost between \$30-300 per camera. Currently, only one institution, Lemon Creek Correctional Center, provides body cameras to its staff. According to DOC, the body cameras were purchased in 2013 for approximately \$300/per camera. A comparable 2017 model costs approximately \$450/per camera.

The Ombudsman is hopeful that DOC will reconsider implementing this recommendation when additional funds are available.

Conclusion

The Ombudsman recognizes that DOC is responsible for a population of individuals who are often violent, non-compliant, obstructive, and otherwise difficult to manage. The Ombudsman also recognizes that nearly half of the Alaskans in DOC custody experience a disability that impairs their cognitive and behavioral functioning.¹¹ DOC has policies and standards in place to preserve the safety of DOC staff and inmates, and to maintain the integrity of DOC facilities. These do not, and should not, allow for humiliation and degradation of people in custody.

The Ombudsman closed the investigation as **justified** and **partially rectified** based on DOC's concurrence with the investigation findings and acceptance of Ombudsman Recommendations 1 and 3.

¹¹ According to *Trust Beneficiaries in Alaska's Department of Corrections* (Hornby Zellar, 2014), 65% of the Alaska DOC population in a correctional facility on June 30, 2012 experienced a serious mental illness, chronic substance use disorder, developmental disability, or other cognitive disability that would qualify them as a beneficiary of the Alaska Mental Health Trust.