

Investigation of Restraint Device Use in Iowa's County Jails



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Iowa Citizens' Aide/On
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Executive Summary

The use of full-body restraint devices is a widespread practice in Iowa's county jails. Full-body restraints come in the form of restraint chairs, boards, and beds, including two such devices manufactured in Iowa. Iowa law, which refers to these as four- and five-point restraints, states they are only to be used when an inmate is a threat to self, others, or jail security. However, the Ombudsman found they were also used on inmates who caused minor disruptions or in response to an inmate's verbal abuse. In some cases, the restraints were used on inmates with known mental illness who were acting out, though no attempts were made to seek medical or mental health reviews for those inmates while restrained, leading to extended use of the restraint device.

The Ombudsman believes restraint devices can be a useful tool to safely control an inmate, but concerns arise when the devices are not used in accordance with manufacturer policies or used for reasons other than those allowed by Iowa law. The Ombudsman also has concerns about the devices' effect on inmate life and safety, given the cases of inmate deaths associated with their use outside of Iowa. These cases have often been followed by civil suits with verdicts reaching millions of dollars.

In January 2006 the Ombudsman received a complaint from Lillian Slater, who claimed abusive treatment by Scott County Jail staff during its use of a restraint chair. That investigation resulted in a critical report issued in June 2007. Since receiving Ms. Slater's complaint, the Ombudsman has reviewed additional complaints of restraint device use by county jails. These cases provide examples of jail staff failing to follow Iowa law, jail policy, or recommended standards set forth by professional organizations in the corrections field. The cases also highlight some of the major shortcomings in Iowa law and county jail policies as it relates to the mentally-ill offender and the use of restraints.

Iowa law gives little guidance on the screening and treatment of mentally-ill jail inmates or on the use of restraint devices. For guidance on these issues, the Ombudsman reviewed standards and publications from professional organizations dealing with correctional health care, including the American Correctional Association and the National Commission on Correctional Health Care. The Ombudsman also relied on research articles, guidelines, and publications from the Centers for Medicare and Medicaid, American Psychiatric Association, the Federal Bureau of Prisons, the National Institute of Corrections, the National GAINS Center, and the U.S. Department of Justice – Civil Rights Division.

Relying on these resources, the Ombudsman identified a number of issues to address in this report. These include: (1) mental health intake screening of new inmates; (2) follow up mental health assessment for inmates who screen positive for mental illness; (3) when to use restraint devices; (4) what type of restraints are appropriate; (5) monitoring restrained inmates; (6) medical and mental health reviews of inmates; (7) documentation of restraint use; and (8) time limits for restraint use. The Ombudsman reached a number of conclusions for each of the five county jails examined in this report, based on the

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minimum standards that should be employed in all cases of inmate mental health and restraint use, as described below:

Mental Health Screening. During the Ombudsman’s investigations, the Iowa Department of Corrections adopted administrative rules requiring a mental health screen for all inmates entering a county jail. However, the rules provide little guidance on what questions should be included in the screening tool and provide little guidance on what staff should do with the collected information. The Ombudsman reviewed the Brief Jail Mental Health Screen endorsed by the National GAINS Center, a federal agency that focuses on developing services for adults in the justice system who have mental illness and substance use disorders. The screen is an eight-question form that takes two to three minutes to complete. Depending on the responses from the inmate, the tool can identify offenders requiring a mental health referral for further assessment. Jail staff only require brief informal training in order to administer the screen. Based on the research and testing of the screen, the Ombudsman encourages Iowa’s county jails to use this screen, or another health-authority-approved form.

Mental Health Assessment. Iowa law is silent on seeking treatment for inmates who screen positive for mental illness. It only states that a jail must have a “plan” for treatment, but does not require the jail to initiate the plan. Federal courts have found that under the Eighth Amendment, a correctional facility cannot ignore the mental health care needs of inmates. The Ombudsman believes that every inmate who screens positive for a potential mental illness should be assessed by a mental health professional. The requirement is consistent with national organizations’ professional standards.

A standing relationship with a mental health professional enables the professional to know the scope and limitations of the jail and further determine if the holding facility cannot meet the mental health needs of the offender requiring a transfer. A county jail should work with its county central point of coordination to find psychiatrists, psychologists, psychiatric nurses, or psychiatric social workers who may provide services for the jail. Such services may be provided via telemedicine in the event the county jail lacks those services in its own community.

Types of Restraint Devices. The Ombudsman reviewed medical articles and lectures relating to different types of restraints and the adverse medical conditions associated with them. Positional asphyxiation is one of the leading causes of death from restraint use. Of primary concern are restraint devices that immobilize the inmate in the prone position. This can affect breathing by restricting movement of the inmate’s chest and abdomen. In addition, any restraint device that uses straps across the inmate’s chest can restrict breathing. Devices that place the inmate in the supine position may result in aspiration if the inmate has a reduced level of consciousness, commonly caused by the use of drugs or alcohol.

Restraint devices that reduce the risk of asphyxiation include a restraint chair with shoulder straps to control the upper torso that do not cross the chest or abdomen. The

upright position of the chair also reduces the risk of aspiration, where an inmate might choke on vomit.

When to Use Restraints. Iowa law provides only three situations when four- and five-point restraints can be used: When the inmate is (1) a threat to self, (2) a threat to others, or (3) a jeopardy to security. However, the Ombudsman reviewed cases where jail staff placed inmates in restraints when only minor damage to a cell occurred, the inmate posed no other threat to jail staff other than verbal abuse, or when the immediate threat to safety or security had already passed. The Ombudsman concludes the use of restraints in these instances violated federal constitutional law, Iowa law, and jail policy. Restraint devices must only be used when the inmate is an immediate and ongoing threat to themselves or others, or is jeopardizing jail security. Use of restraints after a need has passed indicates the restraint is being used for punitive reasons contrary to Iowa law.

Monitoring. Iowa law requires 15-minute personal visual observation of the inmate and the restraint application. In several cases, jails could not provide evidence the required 15-minute checks were conducted. In one case, the 15-minute check consisted only of viewing the inmate through a cell door. The Ombudsman interprets Iowa law as requiring jail staff to not only check whether the inmate is alive and breathing, but also check the application of the restraints, which includes circulation checks. The Ombudsman questions whether such checks can be effectively done by looking at an inmate through a cell door window.

While Iowa law states that restraints can only be used for the amount of time necessary to alleviate the condition causing the restraint, it does not require periodic reviews to determine if an inmate can be released. A majority of the jails the Ombudsman investigated could not provide documentation an inmate was periodically reviewed to determine if the continued need for restraints was warranted. In accordance with federal case law, the Ombudsman concludes that jails must provide documentation an inmate continues to be a threat to self, others, or jeopardizes jail security to justify the restraint. The most effective way to make this determination is to conduct periodic reviews of the inmate and note the inmate's actions and disposition.

Medical Reviews. Iowa law does not require medical reviews of the inmate, regardless of how long an inmate is restrained. With no medical review requirement, the Ombudsman found occasions when medical consultations were not done at any time during restraint use, even when the restraint lasted 12 hours. Others attempted consultation over the phone, though the manufacturer of the restraint chair used frequently in Iowa recommends "direct medical supervision" of any inmate left in the restraint chair for more than two hours.

The Ombudsman has concerns about a lack of medical oversight because of inmate deaths in other states that resulted from adverse medical conditions such as pulmonary embolisms and dehydration. Following manufacturer recommendations and relying on professional correctional standards, the Ombudsman believes a jail should have an inmate

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reviewed in-person by a medical professional every two hours. The in-person medical review is necessary for the medical staff to check the inmate's vital signs. Jails should at least notify their medical authority immediately when restraints are applied.

Mental Health Reviews. Whether reported by the inmate or discovered during the investigation, the Ombudsman found in each case where restraints were used for six or more hours, the inmate had a history of mental illness. The Ombudsman has concerns that the extended use of restraints could be attributed to the mental illness. In each case of extended restraint use, a mental health professional was never consulted. The Ombudsman concludes when an inmate has a known or suspected mental illness, jail staff should contact a mental health professional to determine if the cause of the violent behavior is related to a mental illness and whether immediate mental health intervention may be necessary.

An existing mental illness may be determined by relying on the mental health screen conducted when the inmate is admitted to the jail. It could also be determined based on statements by the inmate after admission or observation of unusual behavior by jail staff. The Ombudsman also believes that extensive use of the restraint device for periods of six or more hours should raise concerns of mental illness even if the inmate reported no prior mental illness.

Documentation. Iowa law requires that all decisions and actions be documented when a jail inmate is placed in four- and five-point restraints. The Ombudsman believes this includes the initial decision to place the inmate in restraints, each 15-minute check, the decision to release or keep an inmate in restraint during a periodic review, and any medical or mental health observations of the inmate. The cases reviewed in the Ombudsman's report provide examples of when a jail failed to document one or more of these actions or decisions. The Ombudsman believes that if a jail cannot provide documentation of an action or decision, the action was not taken or the decision was not made.

In addition to written documentation, the Ombudsman believes a jail should video record the placement, use, and release of the inmate in the restraint device. Video documentation enables supervisors to review actions and procedures jail staff took or failed to take to determine if a change in procedure is needed or if staff need additional training. It can also effectively rebut accusations that jail staff physically abused an inmate or used the restraint device improperly. The Ombudsman was able to use video documentation in one investigative case to conclude the inmate's allegations were not true. In another case where a jail disputed an inmate's account of events, the Ombudsman could not reach the same conclusion because the jail had erased the recording that could have supported its position.

The Ombudsman recommends jails retain video copies of restraint device use for a period of at least two years, consistent with the statute of limitations for tort claims.

Time Limits. The Ombudsman analyzed case law and professional standards to determine what, if any, time limits should apply to restraint device use. The Ombudsman concludes that for the safety of the inmate and staff, a specific time limit should not be set. Releasing an inmate who still has violent or suicidal tendencies could result in the serious injury or death of the inmate or jail staff. In the absence of a time limit, the Ombudsman emphasizes the need for the 15-minute checks, periodic reviews of the inmate, medical and mental health reviews of the inmate, as well as the documentation of each decision and action.

Systemic Mental Health Challenges. The Ombudsman recognizes the difficult situation jails face when housing mentally-ill inmates. During the investigations, jail officials expressed frustration with the revolving door of the mentally ill who come into the jail, enter the correctional system, and then are released with little or no oversight or services available after their release. This results in the inmate committing additional crimes and beginning the incarceration process over. The higher recidivism rate for inmates with mental illness compared to those without mental illness is well-documented throughout the country and in Iowa. This requires a review of the quality of mental health treatment in Iowa outside the walls of the county jails.

The Ombudsman reviewed the recommendations of a recent report funded by the Iowa Department of Corrections. The report found a need to address inmates' mental health needs upon release from prison in order to stop the cycle of continuous inmate incarceration. The report recommended dividing the parole docket so certain counselors only handle parolees with mental health needs. These parole officers would receive specialized training on mental health issues to address the unique needs of these inmates. The report also made reference to re-entry coordinators in each of Iowa's judicial districts whose task would include finding community services for offenders with mental health needs.

The Ombudsman reviewed the concept of mental health courts that would have jurisdiction over misdemeanor offenders. Mental health courts have proven effective when intervening after a minor crime has been committed. The mental health court brings together community resources to offer services and treatment to the offender as an alternative to going to jail. The overall goal of the court is reducing recidivism and preventing the inmate from escalating to more violent crimes. While this is a growing trend in the country, only one such court exists in Iowa. However, that court has reported impressive statistics since its inception in 2001 in terms of reducing recidivism and the time the inmates spent in its county jail.

Addressing the needs of the mentally-ill inmate in county jails requires a change both by the jail as well as the culture of community-based services in Iowa. There is little doubt jails have seen an increase in the numbers of inmates with mental health needs, due in large part to the lack of community funding and resources. This leaves jails which lack expertise in mental health care as the de facto caretakers for these individuals. However,

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ignoring the special needs of these inmates while the state struggles with mental health management can lead to dire consequences for the inmate, the jail, and staff.

Recommendations. The Ombudsman makes the following recommendations regarding inmate screening and restraint device use for all jail facilities:

1. A jail should incorporate a health-authority-approved mental health screen to be used on all newly admitted inmates soon after entering the jail. A screen should possess the following qualities:
 - The screen has been vetted and approved by a mental health organization for its accuracy in identifying mental health conditions;
 - The screen is brief and easy to administer;
 - Limited training is needed for a screening officer to use the form;
 - The screen notifies an officer when to refer an inmate for further mental health assessment based on the responses of the inmate.
2. Inmates who screen positive for a mental illness must receive further assessment by a mental health professional. Assessments for referred inmates may require a jail to enter a formal relationship with a mental health professional who can become knowledgeable of the jail's services and limitations, and can accurately determine if the inmate needs to be transferred to another facility.
3. Restraint devices must only be used when an inmate is an imminent risk to the inmate's self or others, or is jeopardizing jail security. Verbal abuse alone is not sufficient reason to place an inmate in a restraint device. Use of a restraint device should cease immediately when the condition causing the need for the restraint is no longer present. Jail policy should detail the conditions when an inmate may be restrained and when an inmate should be released.
4. When the circumstances allow for it, jail staff must consider using less restrictive alternatives to restraint devices, which ensures the safety of the inmate and others. When a less restrictive alternative is not used, jail policy should require staff to report what alternatives were considered and the reason for not employing them.
5. When a jail uses video for continuous monitoring of the inmates, the video must provide a clear and accurate view of the inmate's body, including torso, extremities, and face. Staff must be able to identify emergency conditions on the video immediately when they arise.
6. Personal, visual observation of the inmate and the restraint application every 15 minutes is required under Iowa law. This should include checking the inmate up-close and face-to-face for adverse medical conditions.

7. Jails should conduct periodic reviews of the inmate for the purpose of determining whether the inmate can be released from the restraint device. After each review, staff should document whether the inmate was released and if not, the reason for keeping the inmate in the restraint device. Periodic reviews should be conducted at least every hour.
8. A jail's restraint chair policy should, as a minimum standard, incorporate the recommended procedures for use found in the manufacturer's instruction manual. That policy should also include recommended medical reviews of the inmate placed in the restraint device.
9. Absent specific manufacturer recommendations, a jail should incorporate medical review procedures in its policy that require direct, in-person medical reviews of a restrained inmate by a physician, nurse, physician's assistant, nurse practitioner, or other appropriate licensed medical professional.
10. The person conducting the medical reviews should be a medical professional who is employed or contracted by the jail for the purpose of conducting medical reviews and assessments of the inmates. Medical reviews of an inmate should not be conducted by a person employed as an officer or administrator of the jail, even if the officer or administrator is a licensed medical professional.
11. A jail should incorporate in its policy a requirement to contact a mental health professional whenever an inmate with a known or suspected mental health condition is placed in a restraint device. In the event any inmate is required to be held for longer than a few hours, a mental health professional should be contacted. To accommodate facilities that may not have a mental health professional in their immediate area, mental health reviews of an inmate may be conducted by telemedicine, enabling the mental health professional to view and talk to the inmate through video from an off-grounds location.
12. Jail staff must document all decisions and actions when an inmate is placed in four- and five-point restraints. This includes the reason the inmate was placed in restraints, who ordered the inmate to be placed in the restraints, observations during 15-minute checks, observations of medical reviews conducted on the inmate, and the decision to release the inmate or keep the inmate in restraints after periodic reviews. Such documentation should be as detailed as possible.
13. All facets of restraint device use should be videotaped, including placement, duration of use, and release. Jails should retain video copies of restraint device use for a period of at least two years.

The Ombudsman also directs some of these recommendations to the five specific jails whose incidents and issues were investigated.

Role of the Ombudsman

The Office of Citizens' Aide/Ombudsman (Ombudsman) is an independent and impartial investigative agency located in the legislative branch of Iowa state government. Its powers and duties are defined in Iowa Code chapter 2C.

The Ombudsman investigates complaints against Iowa state and local government agencies. The Ombudsman can investigate to determine whether agency action is unlawful, contrary to policy, unreasonable, unfair, oppressive, or otherwise objectionable. The Ombudsman may also decide to publish the report of the findings and conclusions, as well as any recommendations for improving agency law, policy, or practice. If the report is critical of the agency, the agency is given the opportunity to reply to the report, and the reply is attached to the published report.

The investigations of each county jail cited in this report were initiated by contacts from jail inmates who raised allegations of abuse involving a restraint chair or board. The investigations were conducted by a lead investigator and assistant ombudsman. For purpose of this report, all investigative actions are ascribed to the Ombudsman. The Ombudsman based his findings and conclusions on the original allegations from the inmates, written and video documentation from the jails, and interviews and interrogatories from jail staff. This report is the result of those investigations as well as interviews with professionals in the fields of medicine and corrections, reviews of professional standards of practice from medical and correctional organizations, and analysis of research articles from the fields of mental health, medicine and corrections. The Ombudsman also interviewed the owner of E.R.C. Inc., Tom Hogan, which manufactured the restraint chair that is the primary, though not exclusive, focus of this report. Mr. Hogan provided valuable insight into the intended use of his restraint chair and his concerns about its potential for abuse.

During the investigation, the Ombudsman addressed the Iowa Board of Corrections and the Iowa Legislature's Administrative Rules Review Committee when additional administrative rules were being promulgated that could affect county jails' use of restraint devices. The Ombudsman took the opportunity to raise additional rules for consideration that he believed were essential to address mental health needs of inmates and basic procedures to follow when restraint devices are required. While the suggested rules were not adopted at that time, each has been incorporated as recommendations in this report.

This report is meant to serve several purposes. Along with its attempt to provide comprehensive minimum standards for screening inmates for potential mental illness, guidelines for restraint device use, and actions to take for recognizing when to seek outside placement of inmates, this report will address the specific actions taken in each case and the unique circumstances that accompany them. Many of the jails have cooperated with our investigation. Our purpose is not to single-out certain jails and our discussion is not aimed to be punitive. These cases provide valuable insight of the issues faced by each jail that others can learn from, not just the jail that is the focus of the

recommendations. The jails mentioned in this report have a right to know the findings and conclusions from our investigations.

Overview: Complaint Allegations

The Ombudsman received a letter from T.H. on May 22, 2007. In his letter, T.H. introduced himself and made some extraordinary claims. He listed his IQ at 190 and claimed he had completed most of a master's degree program in the Science of Creative Intelligence at Maharishi University. He provided the subjects of four books he had written or will soon write, including *Caught in a Dream: Visions of Robin Hood*, relating his experience of robbing a bank and giving the money to the poor. He described himself as working for the past 40 years as "an undercover, real life investigative reporter." His complaint against the Jefferson County Jail included experiencing four heart attacks due to bipolar medication prescribed by the University of Iowa Hospitals and Clinics, which was further aggravated by the "exotic cooking oil" used by the local hospital kitchen that provides meals for the jail. He also complained that despite his solicitation to provide jail staff free counseling, he had been subjected to constant harassment.

The issue that stood out to the Ombudsman was T.H.'s description of being placed in a restraint chair, which he referred to as a "Torture Chair," on four separate occasions in late April 2007 for time periods of 2½ hours, 6½ hours, 12½ hours, and 10½ hours, respectively.

There is little doubt that T.H. is very intelligent. This is evident from his writing samples as well as acknowledgments from the sheriff and jail administrator. There is also little doubt that T.H. suffers from severe mental illness, as was evident from these same sources.

* * *

G.A. entered the Woodbury County Jail on June 25, 2006, "self-medicating" with methamphetamine and marijuana for his diagnosed bipolar disorder, paranoid schizophrenia, and conduct disorder. When G.A. entered the jail, it took two months before mental health professionals evaluated him and prescribed Seroquel, a mood-altering drug commonly used for bipolar disorder and schizophrenia. That two-month delay may have been too late. The day after G.A. began taking Seroquel, he broke a light fixture in his cell, threatened officers with a sharpened tooth brush, injured an officer who was trying to subdue him, and was placed in a restraint chair. The day after that, a special law enforcement team was called to extract G.A. from his cell when an officer noticed padding torn from the cell window. He was placed in a restraint chair for seven hours. No medical reviews were done while G.A. was in the restraint chair for those seven hours and no doctors were consulted. The jail could provide no video documentation of G.A. in the restraint or provide an explanation how G.A. remained a threat for those seven hours. For the next two months, mental health professionals continued to adjust G.A.'s medication.

* * *

T.F. wrote the Ombudsman on February 3, 2007. She claimed her rights were violated by the Centerville Police Department, but admitted she did not remember the arrest due to “mental disorders” and drinking while on medication. However, she could recount her experience at the Appanoose County Jail, when officers placed her in a restraint chair for ten hours soon after her arrest. She could also recall hollering for someone to let her out of the chair so she could use the bathroom, and an officer threatening to “Taser” her if she did not shut up. She remembers defecating soon after while still restrained in the chair.

* * *

J.L. contacted the Ombudsman in May 2007 claiming the Wapello County Jail did not respond to his reported breathing condition. J.L. had been arrested for public intoxication when he got in an argument and yelled at a mother and daughter he saw on the street. After reviewing security tapes and officer incident reports, the Ombudsman had reservations about J.L.’s credibility on his breathing claim. However, based on this same documentation, the Ombudsman raised serious concerns on J.L.’s second claim: that an officer struck him while he was in the restraint chair.

* * *

M.B. wrote to the Ombudsman in February 2008 claiming a correctional officer at Polk County Jail strapped him to a chair, strangled him, and told him he was going to beat him all day. M.B. further claimed the officer pushed bamboo sticks under his fingernails and said he was going to kill M.B. The Ombudsman reviewed the security video capturing the placement and use of the restraint chair and could not substantiate any of the actions M.B. described, other than being strapped to a restraint chair. The Ombudsman did note problems with required monitoring and checks during the restraint, including the failure to conduct periodic checks during much of M.B.’s restraint lasting 4 hours and 40 minutes.

Getting Started: Identifying Issues of Restraint Use

Iowa law provides little guidance on the use of restraint devices in the jail setting. The use of the restraint chair, and other forms of restraints such as boards and beds, is largely unregulated in both their form and function.¹ While these devices vary widely in their form and design, they serve the same purpose of preventing aggressive inmates from hurting themselves, others, or causing a security threat. They also share the same common characteristics of securing a person's legs, arms, and torso to the device, often with nylon straps.²

There are no standards for what type of restraint is acceptable, and state law does not provide manufacturer regulations on the shape and design of restraint devices. As a result, jails often refer to the manufacturer's guidelines to develop their own policies, but there is no requirement to adopt the manufacturer's recommended use. Manufacturers of restraint devices used in Iowa include both in-state and out-of-state companies, so guidelines can vary even on similar devices depending on where the device was purchased. This places much of the discretion of policy language in the hands of the sheriff and/or jail administrator, the county officials in charge of the jail.

The Ombudsman has received complaints in the last two years from inmates claiming abuse by jail officers who placed them in restraint chairs and on restraint boards and who were physically abused while restrained in these devices. With the use of restraints largely unregulated by Iowa law or policy, questions arose early in the Ombudsman's investigations, including:

- Under what circumstances can correctional staff place an inmate in restraints?
- What is the maximum amount of time an inmate can remain in a restraint device?
- What medical concerns arise for someone restrained for an extended period of time longer than two hours?
- How are restroom breaks and food and water breaks facilitated, if at all, during time spent in restraints?
- What medical or mental health concerns arise when an inmate with a mental illness is placed in restraints?
- Should inmates with mental illnesses be handled differently than inmates with no known mental illness?

The Ombudsman recognizes jails of different sizes, staffing, and funding resources may experience unique challenges. An overarching concern with the restraint devices is the use of medical supervision when an inmate requires an extended confinement in the restraint. A small county jail will struggle to have medical personnel in-house or on

¹ Restraint devices often include metal and plastic handcuffs and leg irons, various electrical and chemical devices, and full body restraints such as chairs, boards, and beds. Throughout this report, the terms "restraints" and "restraint devices" are intended to refer to restraint chairs, restraint boards, and restraint beds, unless otherwise denoted. The term "four- and five-point restraints" includes restraint chairs, restraint boards, and restraint beds.

² See *Appendix A* for an example of a restraint chair used in Iowa and reviewed in this report.

location at the jail to observe an inmate compared to a larger urban facility that will typically have medical staff available during each shift. For this reason, the Ombudsman will address restraint guidelines that have universal application despite the size of the facility.

Because Iowa law does not address for many of the concerns raised by this office, the Ombudsman reviewed state and federal case law; researched publications from correctional, medical and mental health fields; analyzed county policies from across Iowa and from other states; and interviewed experts working in the fields of corrections, medicine, and mental health.

This report will examine these resources, the complaints received by the Ombudsman's office about restraint device use, and what changes, if any, in jail procedures need to be made in each case. This report will also address current dilemmas facing the correctional and mental health situation in Iowa and programs the Ombudsman believes can address these problems.

A. Trying to Find a Policy

In limited circumstances, the need for restraints and the potential benefit it has on violent inmates and staff trying to control those inmates is recognized by this office. The question is not whether the use of restraints should be available to correctional personnel. If used correctly, restraints can be a safe and effective tool to prevent inmates and patients from harming themselves and others. Rather, the question is what restrictions and regulations should accompany their use.

The use of restraint devices in county jails is briefly addressed in the Iowa Administrative Code rule 201 – 50.13(2)(f). This provision places the following requirements on restraint device use:

- Restraint devices will be used only when the inmate is a threat to self or others, or jeopardizes jail security.
- A restraint device is not to be used as a means of punishment.
- Approval for restraint use must come from a facility supervisor.
- The inmate must be clothed or covered to maintain privacy.
- The inmate will be restrained for only the amount of time it takes to alleviate the condition causing the restraint.
- Four- and five-point restraint shall be used only when other types of restraints have proven ineffective.³

If placed in a four- or five-point restraints, which includes most restraint chairs, boards, and beds, correctional staff must:

³ IOWA ADMIN. CODE r. 201 – 50.13(2)(f) (2008).

- (1) Observe the inmate continuously (a CCTV system may be used),
- (2) Conduct personal visual (non-CCTV) observation of the prisoner and the restraint device application at least every 15 minutes,
- (3) Include consideration of an individual's physical and health condition, such as body weight, in the restraint guidelines, and
- (4) Document all decisions and actions.⁴

Some jails go beyond the basic requirements of Iowa law. Jefferson County Jail, which has one of the more detailed written policies reviewed by this office, lists the classes of inmates that correctional officers cannot place in their Emergency Restraint Chair (restraint chair or ERC). The list includes pregnant women, small children, people with obvious neuromuscular disorders, and inmates with open or sutured wounds. Many larger county jails, such as Scott, Woodbury, and Polk, do not provide for such restrictions. Jefferson County's policy also makes it clear that only those members of the Jefferson County Sheriff's Office/Correctional Facility who are trained in the restraint chair's application are authorized to use the restraint chair. Iowa law, as well as other county policies included in this report, is silent on who is authorized to use the chair.

Though not required under Iowa law, jail policies also frequently place a maximum time limit on the use of the restraint device, usually between two and four hours. For continued use beyond the designated time limit, supervisor approval is required, and in some cases a medical professional must supervise its use. However, since no requirement exists, jails are not consistent with what maximum time frame is required or if one is required at all.

B. Correctional Standards

Private, national accreditation organizations, such as the American Correctional Association (ACA) and the National Commission on Correctional Health Care (NCCHC), provide guidelines for facilities seeking accreditation. They do not act as a governing body that can force compliance on non-member facilities, and the policies are not geared specifically toward Iowa counties by taking into consideration Iowa's laws, policies, and judicial system. The policies also do not address the specific use of restraint chairs, boards, or beds; however, they do provide useful instructions for restraint device use.

The Iowa Law Enforcement Academy (ILEA) provides training to Iowa law enforcement officers with services ranging from psychological testing of law enforcement applicants to providing education to officers. The ILEA provides training to correctional officers through its "Jail School," coordinated by Willis Roberts. The Jail School offers several courses annually on a wide range of topics faced by jails. However, one training topic ILEA does not cover is the use of restraint chairs, boards, and beds. According to Mr. Roberts, ILEA does not provide operational or procedural training of these devices since

⁴ *Id.*

manufacturers provide most of the training. In addition, ILEA providing restraint device training could potentially result in their involvement in legal actions.

To determine the basic legal standards for restraints in the jail setting – beyond the very limited requirements provided by the Iowa Administrative Code – one must turn to the courts. State and federal courts have used varying standards for the “use of force” question to determine whether placement in a restraint device violated a detainee’s rights. Even the courts are not consistent on what standard to apply.⁵ The U.S. District Court for the Northern District of Iowa used an “objective reasonableness” test in *Ogden v. Johnson and Sanders v. Zeller* when determining whether correctional officers’ actions constituted excessive force.⁶ However, the same court in *Roger v. Dunn* used an Eighth Amendment “malicious and sadistic” test to determine excessive force.⁷ In circumstances involving jail disturbances, the “malicious and sadistic” test requires the court to look at whether the officials’ actions were taken “‘in a good faith effort to maintain or restore discipline’ or whether they acted ‘maliciously and sadistically for the very purpose of causing harm.’”⁸

Regardless of the standard used in a particular case, courts have found the restricted use of a restraint device does not violate a detainee’s constitutional rights under both the “objectively reasonable” and “sadistic and malicious” standard. In *Sanders*, using the “objective reasonableness” standard, the court concluded the use of a restraint board in that case was reasonable “as long as it is only used for the amount of time necessary to restore order.”⁹ The court weighed the inmate’s injury of being placed on the restraint board against the jail’s administrative interests in safety, security, and efficiency.¹⁰ In *Ogden*, the same federal district court determined placement to be reasonable on an inmate who became disruptive, belligerent, and assaultive during his processing.¹¹

⁵ One factor in this disagreement is a dispute over what provision of the Constitution applies. As the Eighth Circuit Court of Appeals pointed out in *Wilson v. Spain*, 209 F.3d 713, 715 (8th Cir. 2000), “[b]etween arrest and sentencing lies something of a legal twilight zone. The Supreme Court has left open the question of how to analyze a claim concerning the use of excessive force by law enforcement ‘beyond the point at which arrest ends and pretrial detention begins,’ and the circuits are split.” (quoting *Graham v. Connor*, 490 U.S. 386, 395 n.10) (1989).

⁶ *Ogden v. Johnson*, No. C00-0034, 2002 WL 32172301, at *2 (N.D. Iowa Sept. 5, 2002), *Sanders v. Zeller*, No. C04-0067, 2006 WL 1192924, *4 (N.D. Iowa April 28, 2006).

⁷ *Rogers v. Dunn*, No. C00-0188-PAZ, 2001 U.S. Dist. LEXIS 22710 (N.D. Iowa Nov. 27, 2001). See also *Fuentes v. Wagner*, 206 F.3d 335 (3d Cir. 2000) (court used a “malicious and sadistic” standard for a pretrial detainee placed in restraint chair).

⁸ *Rogers*, No. 00-0188-PAZ, 2001 U.S. Dist. LEXIS 22710, at *8 (citing *Starbeck v. Linn County Jail*, 871 F.Supp. 1129, 1147 (N.D. Iowa 1994)). The U.S. District Court for the District of Nebraska used a “reasonably related” test when it reviewed a “use of force” claim involving a restraint chair in *Birdine v. Gray*, 375 F.Supp.2d 874 (D. Neb. 2005). An article in the CORRECTIONAL LAW REPORTER pointed out this may have been the incorrect test, compared to other courts that used the “malicious and sadistic” test established in *Hudson v. McMillian*, 503 U.S. 1 (1992). William C. Collins, *Judge Finds Stun Gun Preferable to Other Force Techniques*, 18 CORRECTIONAL L. REP. 54, 64 (2007).

⁹ *Sanders*, No. C04-0067, 2006 WL 1192924, at *4.

¹⁰ *Id.*

¹¹ *Ogden*, No. C00-0034, 2002 WL 32182301, at *2. In THE MENTALLY DISORDERED INMATE AND THE LAW, author Fred Cohen believes the distinction between standards used by the court(s) is an important one

The court did not address the issue of an objective maximum time limit for restraint use in *Ogden* or *Sanders*.¹² However, in *Ogden*, the court upheld a jury verdict that found the arrestee's five-hour placement on a restraint board by Linn County Jail staff was unreasonable. The arrestee showed he was held on the board long after the need for restraint had ended, and the jury found this constituted excessive force. In approving the jury award, the court determined the board was "more than just uncomfortable. It is a restraint that should be used only for the amount of time necessary to restore order."¹³ In a similar case against the Linn County Jail, the same court found the jail could not justify the continued restraint of an inmate that lasted for eight hours and violated the inmate's Eighth Amendment rights.¹⁴

C. Medical Standards

Iowa law does not require medical reviews of detainees placed in restraint devices, and it is silent on any review requirement regardless of the length of time an inmate is placed in restraints. The Ombudsman contacted the Iowa Board of Medicine (IBOM) about the standards for medical professionals' involvement in the use of restraints.¹⁵ In response, the IBOM said it did not possess "the necessary expertise regarding proper procedures for medical approval of the use of restraint devices in the jail setting."¹⁶ Despite the fact that some county jails across the state use medical professionals to evaluate an inmate's placement and continued use of a restraint device, the IBOM, which has authority to review the actions of those same medical professionals, declined to provide guidance on this issue.

Even absent a legal requirement under Iowa law, some jails incorporate in their policy a medical review process by qualified medical personnel for inmates placed in restraints. Jefferson County Jail's policy has incorporated such a process if an inmate is to remain in restraints for more than two hours:

when concerning "deliberate indifference" for inmates with mental illness, compared to "willful, wanton and malicious" when restraints are used on "an unruly prisoner." "For a prisoner with mental illness, there must be some involvement by a mental health professional who should early assess the impact on the prisoner's course of treatment. This could not be required in the straight use of force on disruptive prisoner." FRED COHEN, *THE MENTALLY DISORDERED INMATE AND THE LAW* ¶ 12.4[3] (1998). This report will address the need for medical and mental health reviews of inmates depending on their needs, regardless of the legal standard courts apply in these circumstances.

¹² In *Sanders*, the inmate was placed in the restraint for only 25 minutes. No. C04-0067, 2006 WL 1192924, at *2.

¹³ *Ogden*, No. C00-0034, WL 32172301, at *3.

¹⁴ *Rogers*, No. 00-0188-PAZ, 2001 U.S. Dist. LEXIS 22710, at *14.

¹⁵ The IBOM's response, and the case from which the Ombudsman request was made, is discussed in greater detail during the Jefferson County Jail discussion later in this report.

¹⁶ E-mail from Kent M. Nebel, Dir. of Legal Affairs, Iowa Bd. of Med., to Andy Teas, Assistant Ombudsman, Iowa Citizens' Aide/Ombudsman (Jan. 7, 2008, 16:00 CST) (on file with author).

Inmates may be held in the ERC no more than 2 hours without direct medical supervision, doctor or nurse while doing range of motion exercises.¹⁷

Separately, under the “Medical Concerns” section, Jefferson County’s policy states:

Inmates may be held in the ERC for no more than 2 hours without the direct supervision of medical personnel (Doctor/Nurse).¹⁸

As part of its restraint chair placement, Scott County Jail requires medical staff be notified of a pending restraint use and must inspect the restraints when they are applied. A supervisor may be used if medical staff is not available.

Secondary resources provide insightful guidelines for the use of isolation and restraints in the correctional setting, but these resources often do not require compliance from their target audience. Instead, the sources reflect the acceptable trend practitioners should follow in a particular field. The American Psychiatric Association (APA) published a resource document titled *Use of Restraint and Seclusion in Correctional Mental Health Care* (Resource Document), which analyzed the use of restraints for mental health intervention in jails and prisons and provided a guideline on the medical review of patients placed in restraints.¹⁹

The National Commission on Correctional Health Care (NCCHC) provides standards a jail must follow for its accreditation, as well as for jails wanting to comply with national standards in the field of health services in corrections. While private organizations such as these do not require legal compliance under Iowa law, the Ombudsman identifies the importance of these guidelines for determining the proper procedures a jail should follow for inmate intake screening and restraint use later in this report.

D. Mental Health Standards

At least three cases the Ombudsman investigated dealt with inmates who were previously diagnosed with severe mental illness. The decision to use restraints becomes more difficult when an inmate has a mental illness and exhibits aggressive behavior because of the illness. Questions arise whether such inmates should be treated in the same manner as other inmates who do not have a mental illness. What was the cause that triggered the inmate’s aggressive behavior? Will the restraint only agitate the inmate further and require extensive restraint use, unlike an inmate with no mental illness? What

¹⁷ JEFFERSON COUNTY JAIL POLICY AND PROCEDURE I-10A at 6, Supervision (2007) (emphasis omitted).

¹⁸ *Id.*

¹⁹ JEFFERY L. METZNER ET AL., COUNCIL ON PSYCHIATRY AND LAW, *THE USE OF RESTRAINT AND SECLUSION IN CORRECTIONAL MENTAL HEALTH CARE* (2006). The Resource Document deals with situations in the correctional setting to maintain safety for the period of time an inmate waits to be transferred to a psychiatric setting. Extended stays in restraints can be caused by administrative delays in the transfer.

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psychological effect will the restraints have on the inmate? Is there an alternative to placing an inmate in restraints, such as possibly preventing the aggressive behavior from arising in the first place?

The population of mentally-ill inmates in state and federal jails and prisons has long exceeded the number of patients housed in psychiatric hospitals. Nationally, the number of psychiatric beds has decreased dramatically from 500,000 in 1955 to only 59,000 in 2000.²⁰ During approximately this same time period, from 1955 to 2005, Iowa went from having 198 public psychiatric beds for every 100,000 residents to only 8 beds.²¹ The closing of mental-health institutions was due to the development of psychotropic medications during the 1950s, which was accompanied by a national movement to downsize psychiatric hospitals in favor of community-based services.²² However, state and federal budgets did not provide adequate funding for community-based programs, resulting in people with mental illness becoming homeless and/or incarcerated.²³

The closing of mental hospitals and the underfunding of supplementary community-based programs turned jails and prisons into the primary treatment facilities for individuals with mental illness. It is estimated the rate of mental illness inside prison populations is three times higher than in the general U.S. population.²⁴ In December 2006 there were 3,535 Iowa inmates out of a total of 8,600 who were diagnosed with a mental illness.²⁵

While the number of mentally-ill individuals in jails and prisons is increasing in Iowa, the number of mental health institution beds is decreasing. According to the Iowa Department of Human Services, the largest state mental health institution held 90 patients in 2005.²⁶ That same year, the Critical Care Unit at Iowa State Penitentiary held 143 offenders with mental illness, making it the largest mental health facility in the state.²⁷ Despite these increased numbers in mentally-ill inmates entering jails and prison, corrections officials are left to be the de facto caretakers of mentally-ill inmates.

²⁰ MARY BETH PFEIFFER, *CRAZY IN AMERICA* 38-39 (2007) (based on statistics compiled by the U.S. Substance Abuse and Mental Health Services Admin, U.S. Dept. of Health and Human Services).

²¹ Statistics provided by Christine Krause, Director of Behavioral Health Services, Mary Greeley Medical Center. According to information provided by Ms. Krause, Iowa had 239 public psychiatric beds in 2005, when the State's population was approximately 2,950,000.

²² CORRECTIONAL MENTAL HEALTH HANDBOOK 5 (Thomas J. Fagan & Robert K. Ax eds., 2003).

²³ *Id.*

²⁴ John G. Peters & Teri Himebaugh, *Sudden Death, "Excited" Delirium, and Issues of Force: Jail Suicide*, 12 CORRECTIONAL MANAGERS' REP. 91, 94 (2007).

²⁵ DURRANT GROUP INC. ET AL, STATE OF IOWA SYSTEMIC STUDY FOR THE STATE CORRECTIONAL SYSTEM, PHASE I 50 (2007). According to Phase I of the systemic report on the Iowa correctional system, the number of inmates with mental illness increased by 9 percent from the prior year, to 40 percent of all inmates. This was due, in part, by earlier and more accurate identification of inmates. Phase II, released the following year, reported the number of seriously, persistently mentally ill offenders at 2,640, representing 30.4 percent of the population. DURRANT GROUP INC. ET AL, STATE OF IOWA SYSTEMIC STUDY FOR THE STATE CORRECTIONAL SYSTEM, PHASE II 68-69 (2008).

²⁶ DURRANT GROUP, PHASE I at 214.

²⁷ *Id.*

Compounding the effects of fewer psychiatric beds and underfunded community-based mental health programs is the dearth of mental health professionals in Iowa. According to a U.S. Department of Health and Human Services, Health Resources and Services Administration report, Iowa ranked forty-seventh in the nation for psychiatrists per capita and forty-sixth in psychologists.²⁸ To make the matter even more dire, of the 24 major health professions surveyed in Iowa in 2005, those servicing mental health represented the highest percentage of licensees age 55 or older.²⁹ “These percentages indicate the probability that services to Iowa’s mental health consumers will decline substantially during the next decade.”³⁰

The U.S. District Court for the Northern District of Iowa did not address the issues of underlying mental health for the individuals placed in the restraints in either *Sanders* or *Ogden*. In *Ogden*, after learning of her husband’s arrest, the arrestee’s wife contacted the county jail to inform staff her husband suffers from panic attacks and takes medication to control the attacks. The court did not mention a need for medical or mental health staff to review the status of an inmate to determine the potential medical basis of the aggressive behavior and what medication, if any, should be prescribed to someone in restraints. In *Norris v. Engles*, the Eighth Circuit Court of Appeals did not find handcuffing an inmate with diagnosed manic bipolar disorder to a floor grate shocked the conscience.³¹

While no distinction has yet been made between those inmates with mental illness and those without when placed in restraints, the Eighth Circuit has recognized that isolation on inmates may have adverse effects on inmates with mental illness, where the same techniques will not have any effect on an inmate with no mental illness. In *Buckley v. Rogerson*, the Eighth Circuit cited the expert testimony regarding the effects of isolation on someone with a mental illness similar to the plaintiff’s in that case.³² The court cited Dr. Herbert Notch as testifying “while an average inmate might be isolated in a quiet room and not suffer any harm, a person with [the plaintiff’s] illness would tend to suffer exacerbation of his already serious symptoms.”³³

²⁸ MARY KELLY, IOWA’S MENTAL HEALTH WORKFORCE 5 (2006), available at http://www.idph.state.ia.us/hpcdp/common/pdf/workforce/mentalhealth_0306.pdf

²⁹ *Id.* at 4.

³⁰ *Id.*

³¹ *Norris v. Engles*, 494 F.3d 634 (8th Cir. 2007). In *Norris*, an inmate diagnosed with manic bipolar depression would self-mutilate as part of her symptoms. She was taken to jail under protective custody and handcuffed to a floor grate after she threatened to pull a peripherally inserted central catheter out. Staff determined being handcuffed behind the inmate’s back was not sufficient restraint to prevent the inmate from pulling out the intravenous line. The court found that the length of time “while not insubstantial, was not so lengthy as to warrant a finding that it was conscience-shocking.” *Norris*, 494 F.3d at 639.

³² *Buckley v. Rogerson*, 133 F.3d 1125 (8th Cir. 1998). Eddie O. Buckley, Jr. was an inmate at Iowa Medical and Classification Center, under the direction of Dr. Paul Loeffelholz, and was diagnosed with chronic schizophrenia or schizophrenia-like psychosis. Treatment plans for his mental illness included isolation and restraints.

³³ *Id.* at 1128.

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Publications authored by professionals with extensive experience in mental health and corrections have been helpful with the Ombudsman's investigation concerning mental health in jails and the placement of mentally ill inmates in restraints. The Ombudsman also relied on federal government findings and standards and certification policies from the APA, the NCCHC, and the ACA as a guide for this report's conclusions and recommendations.

Current National Trends on Restraint Device Use

A. Inmate Deaths and Monetary Judgments

While restraint devices are still commonly used in Iowa jails, the Maricopa County Sheriff in Arizona stopped using restraint chairs in 2006 after at least three inmate deaths in ten years and replaced them with “safe beds.” The sheriff’s office had used a version of the restraint chair since the late 1970s. One of the primary motivating factors for discontinuing the restraint chair was a jury award for \$9 million in March 2006. Prior to the jury award, the county settled a lawsuit for \$8.25 million stemming from an inmate’s death in 1999. Though Sheriff Joe Arpaio cited drugs for triggering the inmate’s death, he said it was “time to move in the direction of what many hospitals and psychiatric wards do to restrain combative people.”³⁴

According to a news story by CBS affiliate KPHO in Phoenix, Arizona, a consultant for the Maricopa County Jail hired in 1997 wrote, “[t]he best recommendation I can professionally make in respect to the restraint chair is to remove it from any use associated with the Maricopa County Sheriff’s Office jail.”³⁵ According to the same report, though the county’s insurance company covered \$18 million in jury awards due to the restraint chair, the county’s deductible after the last death rose from \$1 million to \$5 million per case for any subsequent deaths.

On May 7, 1998, Michael Oliver Lewis died after being placed on a restraint board for three hours at El Paso County Jail in Colorado.³⁶ The county coroner concluded Mr. Lewis died from a combination of heart disease, medication, and the restraint board, though he could not say which had a dominant role in the death.³⁷ Mr. Lewis’ mother later sued the county jail, who settled in 2001 for \$116,000.³⁸ The county also settled a lawsuit the previous year brought by the ACLU concerning the county’s use of the restraint board for \$50,000.³⁹ The county put a moratorium on the restraint board use, and in its place began using a restraint chair.⁴⁰

In March 1997 inmate Michael Valent died after spending 16 hours in a restraint chair in a Utah state prison.⁴¹ The cause of death was determined by a medical examiner to be a pulmonary embolism; bloods clots that traveled to his lungs caused by the extended use

³⁴ Lindsay Collom, *Jails Stop Restraint Chair Use*, ARIZ. REPUBLIC, Aug. 22, 2006.

³⁵ *5 Investigates Jails’ Use of Restraint Chairs*, available at <http://www.kpho.com/iteam/9454105/detail.html> (last visited June 16, 2008).

³⁶ Patricia Callahan, *Restraining Inmates ‘Sadistic’ ACLU Sues El Paso Sheriff*, DENVER POST, May 22, 1998, at B-07. According to the plaintiff’s complaint filed by the ACLU after the inmate’s death, the restraint board was manufactured by Zeller Enterprises, based out of Iowa.

³⁷ *Id.*

³⁸ Pam Zubeck, *County Settles Lawsuit/Family of Inmate Who Died After Restraint Will Get \$116,000*, GAZETTE (Colorado Springs, Colo.), April 27, 2001, at Metro 1.

³⁹ *Id.*

⁴⁰ *Id.*

⁴¹ Sheila R. McCann, *Utah Settles Lawsuit Over Inmate’s Death; State Settles Inmate-Death Suit For \$200,000*, SALT LAKE TRIBUNE (Utah), July 31, 1998, at A1.

of the restraint chair. The county settled a lawsuit brought by the family against the Utah state prison for \$200,000 in 1998.⁴² The state ceased use of the restraint chair, even though halting its use was not part of the settlement.

The circumstances involved in the Maricopa County, El Paso County, and Utah state cases should sound alarms for Iowa county jails, if for no other reason than the financial liability it raises. Liability may come in the form of failing to follow Iowa law, failing to follow a jail's own policy, or failing to follow national standards recommended by professional organizations.⁴³ At the time of this report, the Ombudsman knows of no deaths caused by placement in a restraint chair in Iowa.

B. Restraint Devices as Torture

In addition to adverse financial verdicts handed down by courts, one federal court found the punitive use of restraints equated to torture.⁴⁴ The 2006 case involved a Michigan state prisoner who was placed in "soft restraints" after disobeying custodial orders and then placed on a restraint bed when he flooded his sink.⁴⁵ The U.S. District Court for the Western District of Michigan described the top of the bed restraint in the following manner:

In practice, "top of the bed restraints" is a euphemism for chaining an inmate's hands and feet to a concrete slab. T.S.'s "bed" was composed of a concrete slab with four metal, arc-shaped handles emanating from the slab for the purpose of receiving the locking restraints A small mattress pad was provided, but was not used for much of the restraint because T.S. removed it and/or because he urinated on the bed.⁴⁶

According to the district court, the inmate spent five days in two segregation cells, locked in four-point restraints. He was seen by an outpatient social worker after the first day, who determined T.S. exhibited symptoms consistent with his description of manic episodes prior to incarceration.⁴⁷ His documented mental health history included bipolar disorder, depression, hyperactivity disorder, and suicide attempts. T.S. was referred for a transfer to a prison psychiatric hospital, but while awaiting the transfer, he did not receive any effective access to medical or psychiatric care.⁴⁸ He was told by staff he would be kept in the restraints until he was cooperative.

⁴² *Id.*

⁴³ According to CLINICAL PRACTICE IN CORRECTIONAL MEDICINE, (Rolla Couchman ed., 2d ed. 2006), the most widely referenced guidelines and standards are those published by the American Psychiatric Association and the National Commission on Correctional Health Care.

⁴⁴ *Hadix v. Caruso*, 461 F.Supp.2d 574 (W.D. Mich. 2006).

⁴⁵ *Id.* at 577.

⁴⁶ *Id.*

⁴⁷ *Id.* at 578.

⁴⁸ *Id.*

On the last day, T.S. was removed from restraints after prolonged sleeping and fell face-first on the concrete floor.⁴⁹ A nurse only reported T.S.'s vital sign readings as being faint, but he heard them. Two hours later, T.S. was pronounced dead.⁵⁰

The court spent the next five pages of the decision extensively reviewing the history of torture as reviewed in judicial proceedings from pre-colonial English practice to present-day court interpretations of Eighth Amendment standards of review.⁵¹ The court then reviewed the Michigan prison system's punitive use of the restraint bed and concluded its use violated the Eighth Amendment.⁵² The court relied on the expert testimony of a medical monitor and the plaintiff's expert witness, who testified restraints expose a person to known risks of heart attack, dehydration, and asphyxiation.⁵³ The court found the use of punitive restraint constituted torture, and that its cessation was immediately required "to prevent further loss of life, loss of dignity and damage to both inmates and correctional officers."⁵⁴

The restraint chair has been referred by some organizations as a "devil's chair" and a "torture chair."⁵⁵ It has been at the center of controversy throughout the country, and even for its use by U.S. officials outside the country. Media began reporting in 2006 accounts of the U.S. government using the restraint chair to force feed detainees at Guantanamo Bay, Cuba, who had begun hunger strikes.⁵⁶ The chairs were purchased by the U.S. government from E.R.C. Inc, based in Denison, Iowa.⁵⁷ This company is also the primary source for restraint chairs used by Iowa county jails.

⁴⁹ *Id.* at 579.

⁵⁰ *Id.* at 580.

⁵¹ *Id.* at 590-95.

⁵² It must be noted the court reviewed the use of restraints under its stated purpose of punishment. The court noted the defendants asserted the restraint was useful "(1) to discourage prisoners who are not overtly mentally ill, but engaged in self-destructive behaviors such as cutting themselves or inserting foreign objects into bodily cavities; and (2) to discourage disruptive prisoners who present a threat to others and/or a threat of property damage." *Id.* at 581. In Iowa county jails, the intended purpose is not to punish, but to prevent harm to an inmate's self or others, and destruction of property.

⁵³ *Id.* at 595.

⁵⁴ *Id.* at 596. Fred Cohen argues the court could have concluded the prison's actions amounted to cruel and unusual punishment without a finding of torture. Mr. Cohen recognized the situation involved T.S. as being exceptional in its duration, inherent punitiveness, and unadulterated stupidity, but the actions should have been analyzed under deliberate indifference, not torture. Fred Cohen, *Restraints as Torture? A Consent Decree Is Reopened*, 18 CORRECTIONAL L. REP. 66, 77, 79 (2007).

⁵⁵ Anne-Marie Cusac, *The Devil's Chair*, THE PROGRESSIVE, April 1, 2000, available at http://www.progressive.org/mag_cusacchair.

⁵⁶ Tim Golden, *Hunger Strike Breaks Out at Guantanamo*, N.Y. TIMES, April 8, 2007, available at <http://www.nytimes.com/2007/04/08/us/08cnd-hunger.html?pagewanted=print>; Ben Fox, *Guantanamo Hunger Strikers Stay Defiant*, USA TODAY, July 20, 2007, available at http://www.usatoday.com/news/topstories/2007-07-20-558769473_x.htm.

⁵⁷ Kevin Dobbs, *Strapped in for Safety*, DES MOINES REG., March 6, 2006, at 1A.

C. Use of Restraints in MHIs and Nursing Homes

Along with jails and prisons, physical restraints such as chairs, beds, and boards have long been used by mental health institutes (MHIs) and nursing homes on patients who are exhibiting aggressive behavior to themselves and others. There is a movement in these facilities, primarily due to federal law and the Centers for Medicare and Medicaid Services (CMS) regulations, to limit the use of restraints that is not widely mirrored in the jail setting. The federal requirements have shown a pattern of reduced restraint use while maintaining a level number of assaults on staff working in these facilities.

1. Reduction of Restraint Use in MHIs

A report written by several administrators at Mary Greeley Medical Center (Mary Greeley) in Ames, Iowa, discussed the implementation of CMS requirements that restricted the use of restraint and seclusion on patients.⁵⁸ It described how staff would have to change from an environment of authorized discretion to one where restraint and seclusion would only be used as a last resort after other interventions had been tried.⁵⁹ One primary concern that administrators had was the potential increase in numbers and severity of assaults on staff by patients.⁶⁰

Mary Greeley implemented changes to its procedures to accommodate the new restraint and seclusion standards that included mandatory de-escalations and violent patient management training for staff, use of therapeutic interventions, and receiving input from the local mental health advocate group. Mary Greeley reported restraint and seclusion use declined over 50 percent between 2001 – when it implemented the process improvements – and the article’s publication in 2007.⁶¹ “More remarkable is the near elimination of restraint use.”⁶² At the same time, assaults and assaults with injuries had not increased.⁶³ The authors revealed:

What was clearly an assumption, that assaults would increase if restraint and seclusion decreased, was proven wrong. If we had continued to embrace this assumption we would not have made the changes that improved this outcome for our patients.⁶⁴

⁵⁸ Judy Rabinowits et al, *Maintaining Staff Safety While Reducing the Use of Seclusion and Restraints*, in TRANSFORMING NURSING DATA INTO QUALITY CARE: PROFILES OF QUALITY IMPROVEMENT IN U.S. HEALTHCARE FACILITIES 23 (Isis Montalvo & Nancy Dunton eds., 2007).

⁵⁹ *Id.* at 24.

⁶⁰ *Id.*

⁶¹ *Id.*

⁶² *Id.*

⁶³ *Id.* at 25.

⁶⁴ *Id.* at 26.

The *Nursing Spectrum* published an article in 2007 about the successful reduction of isolation and restraint in a Massachusetts MHI.⁶⁵ The initiative to reduce restraints on patients experiencing acute psychotic episodes at Anna Jaques Hospital came in response to a Massachusetts state law mandating restraint reduction. According to the article, the hospital incorporated practices to identify signs of impending crisis and practices to diffuse situations, such as having patients “ride on exercise bicycles, work on puzzles, or partake in warm footbaths.”⁶⁶ The hospital conceded the efforts take more work, “but the outcome is 100 times better.”⁶⁷

2. Reduction of Restraint Use in Nursing Homes

Restraints were formerly a common practice in nursing homes and considered a necessity to improve safety. However, according to an article published in the *Globe Gazette* (Mason City), emphasis by federal and state governments and the nursing home industry to eliminate the use of restraints resulted in a nearly 40 percent drop nationally in their use in recent years.⁶⁸ The article cited a decrease from 9.7 percent of the nation’s 1.5 million nursing home patients restrained in 2002, to 5.9 percent in 2006.⁶⁹

One factor in the decrease was a 1987 change in federal law that made it illegal to physically restrain patients for discipline or as a matter of convenience.⁷⁰ Until the change, restraints were common practice in nursing homes, but now can only be used for medical purposes. According to Mary Jean Koren, Assistant Vice President of The Common Wealth Fund, the typical effects of restraint use include depression, pressure sores, and dehydration. At a nursing home in South Dakota, the need for restraints had been curbed, in part, by hiring trained personnel to work with specific patients. Anticipating patient needs is one process that acts as a substitute for restraints. The same staff work with the same group of patients, allowing them to know the patients’ habits, routines, and behaviors.⁷¹

The goal to reduce the use of restraints is aided by the efforts of the Advancing Excellence in America’s Nursing Homes campaign, a coalition of long-term care providers, caregivers, government agencies, and consumers.⁷² Compared to September 2006, the coalition wanted to reduce the number of restraints used on residents by 30,000

⁶⁵ Heather World, *Mental Health Care’s New Model Shuns Restraint and Seclusion*, NURSING SPECTRUM, Aug. 10, 2007, available at <http://include.nurse.com/apps/pbcs.dll/article?AID=2007308100011>.

⁶⁶ *Id.*

⁶⁷ *Id.*

⁶⁸ *Use of Physical Restraint on Patients in Nursing Homes Declines*, GLOBE GAZETTE (Mason City, Iowa), March 27, 2008, available at <http://www.globegazette.com/articles/2008/03/27/news/latest/doc47eb37e12a66e381245705.txt>

⁶⁹ *Id.*

⁷⁰ *Id.* This provision of law is part of the Federal Nursing Home Reform Act, included in the Omnibus Budget Reconciliation Act of 1987.

⁷¹ *Id.*

⁷² <http://www.nhqualitycampaign.org/> (last visited Oct. 30, 2008).

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by September 2008.⁷³ According to the organization's data progress report, that national goal was met.⁷⁴

⁷³ ADVANCING EXCELLENCE IN AMERICA'S NURSING HOMES CAMPAIGN GOALS & OBJECTIVES, *available at* <http://www.nhqualitycampaign.org/files/NHQualityCampaignGoals-Technical.pdf> (last visited Oct. 30, 2008).

⁷⁴ <http://www.nhqualitycampaign.org/files/reports/results/CampaignResultsSummary.pdf> (last visited Oct. 30, 2008).

Law, Policies, Standards, and Guidelines

The Ombudsman reviewed several correctional resources to determine industry standards for new inmate intake screening, mental health assessments and treatment, use of restraint devices, and time limits for restraint device use. The Ombudsman relied heavily on the American Correctional Association's (ACA) jail standards, the National Commission on Correctional Health Care (NCCHC) jail standards, the United States Department of Justice's investigations of correctional facilities under CRIPA, the Federal Bureau of Prisons policies, and the Centers for Medicare and Medicaid Services rules and regulations on restraint use in facilities under its jurisdiction.⁷⁵ The ACA and NCCHC are national organizations that provide accreditation to jails, but membership is voluntary and the standards do not demand legal compliance from Iowa jails. However, these sources, along with publications on correctional health care, provided a solid base upon which the Ombudsman reached his conclusions.

A. Intake Screening for Mental Health

Iowa law requires jails to comply with emergency hospitalization procedures if an inmate who is believed to be mentally ill is criminally charged with a simple misdemeanor, and due to the mental illness, is likely to injure the person's self or others.⁷⁶ Regardless of the underlying criminal charge, "[t]he jail shall have a written plan to provide prisoners access to services for the detection, diagnosis and treatment of mental illness."⁷⁷

Recently, the Iowa Department of Corrections enacted an administrative rule that requires a jail to initiate a mental health intake screening process upon admission: "The plan shall include a mental health screening process at admission."⁷⁸ However, the new rule does not provide guidelines on what the mental health screen must contain or what information must be gathered.

The accuracy of the inmate's responses to the questions and its usefulness to the jail relies on the truthfulness and honesty of the inmate. Absent an admission by the detainee, a medical condition or mental illness can go undiscovered by jail staff at intake. This situation can arise particularly when someone is bipolar and experiencing a mania cycle. A person in mania can experience a "high" and an increase in energy. Often, the person will not want to seek treatment during this period because they feel good due to their euphoric feelings, as opposed to the depression that often follows a session of mania, and may not report the condition. An inmate can remain at a jail without staff recognizing a specific mental illness.

⁷⁵ See *Appendix B* for a comparison of policies between the organizations on each topic.

⁷⁶ IOWA ADMIN. CODE r. 201—50.15(6)(d) (2008).

⁷⁷ *Id.*

⁷⁸ *Id.* The Iowa Department of Corrections is charged under Iowa law with making periodic inspections of each jail and municipal holding facility. IOWA CODE § 356.43 (2008). The Department, in consultation with the Iowa state sheriff's association, the Iowa association of chiefs of police and peace officers, the Iowa league of cities, and the Iowa board of supervisors association, draws up minimum standards for the regulation of jails. IOWA CODE § 356.36 (2008).

1. Federal CRIPA Investigations

Beginning in 1998, the U.S. Department of Justice (DOJ), through its Civil Rights Division, initiated an investigation of the Black Hawk County Jail's conditions of confinement, pursuant to their authority under the Civil Rights of Institutionalized Persons Act (CRIPA), 42 U.S.C. § 1997.⁷⁹ On January 4, 1999, the DOJ issued a letter of written findings to the Black Hawk County Board of Supervisors, criticizing the jail's intake and screening of new detainees, its use of restraints and isolation, and post-admission health assessments for treatment of all inmates who stayed at the jail for extended periods of time, including those with mental illness.⁸⁰

The DOJ's concerns about intake arose particularly from the possibility inmates were not disclosing their medical conditions during the initial intake process.⁸¹ Relying on an inmate to provide medical information was exacerbated by the lack of a thorough exam by the jail's medical staff. Nurses did not perform physical examinations or take vital signs. Instead, an exam would consist of staff asking the inmate questions and calling their physician or family members to obtain medications.⁸²

These same deficiencies existed for intake and screening of mental health. Inmates at Black Hawk County Jail were reluctant to relay medical and mental health information due to the lack of privacy at the jail.⁸³ This led to undocumented medical problems at the jail, even in cases where the DOJ expert concluded some inmates showed signs of obvious mental illness. There existed no routine mental health assessment of new inmates who did not self-report or were identified by staff having mental illness. The DOJ report described the case of one inmate whose mother notified the jail of her son's history of paranoid schizophrenia. The jail's nurse reviewed the medical sheet, but the inmate was never interviewed or evaluated by mental health personnel or the nurse and received no treatment for mental illness. The report concluded the nursing staff lacked an understanding of relevant psychiatric issues with the inmate.⁸⁴

As part of its minimum remedial measures, the DOJ directed the jail to develop a standard nursing form for nurses to take and record complete vital signs on all inmates identified as having a medical problem.⁸⁵ A complete health assessment by a physician should be provided for all inmates within 14 days of admission. For mental illness, the jail's screening process should not rely on an inmate self-reporting his or her mental

⁷⁹ Letter from Bill Lann Lee, Acting Assistant Att'y Gen., Civil Rights Div., to Brian S. Quirk, Chair, Black Hawk County Bd. of Supervisors (Jan. 4, 1999), *available at* <http://www.usdoj.gov/crt/spilt/documents/bhfind.htm>.

⁸⁰ *Id.*

⁸¹ *Id.* at "Inadequate Medical Care, Intake/Screening".

⁸² *Id.*

⁸³ *Id.*

⁸⁴ *Id.*

⁸⁵ *Id.* at "Minimal Remedial Measures, Medical Care."

illness in a group setting, but should instead “establish a system of collecting mental health-related information that will ensure confidentiality.”⁸⁶

A more recent investigation by the DOJ involved the Dallas County Jail in Texas. The DOJ investigated and entered an “Agreed Order” settlement with Dallas County Jail on November 6, 2007, that included a review of the intake screening process. The settlement states the county shall implement and comply with policies to provide adequate medical and mental health intake screening to all inmates.⁸⁷ Newly admitted inmates who present “current risk of acute mental health needs will be immediately referred for a mental health evaluation by a mental health professional.”⁸⁸

The DOJ also recently filed suit against Terrell County Jail, Georgia, where a federal court granted the DOJ’s motion for summary judgment, finding no genuine issue of material fact concerning whether the conditions at the jail were unconstitutional.⁸⁹ On December 21, 2007, the federal district court adopted the DOJ’s “Proposed Order,” which required in part:

The defendants shall appropriately screen all inmates upon arrival at the Jail to identify individuals with serious medical or mental health conditions, including . . . mental illness, suicide risk, and drug and/or alcohol withdrawal. **Inmates who screen positively for any of these items shall be referred for immediate or prioritized screening by the HSA or other qualified health care staff.**⁹⁰ (emphasis added).

The initial screening would also record the inmate’s mental health history, including mental health treatment, medication, and hospitalization.⁹¹ Terrell County Jail was also required to ensure a qualified mental health professional provide timely, adequate, and appropriate screening for inmates who enter the jail with serious mental health needs or develop serious mental health needs while incarcerated.⁹²

2. NCCHC Publications and Standards

The NCCHC is a not-for-profit organization that provides standards for health services in prisons, juvenile facilities, and jails seeking accreditation as well as those institutions only seeking to comply with national health care standards. “NCCHC also provides

⁸⁶ *Id.* at “Minimal Remedial Measures, Mental Health Care.”

⁸⁷ Agreed Order at 5, *United States v. Dallas County, Texas*, Civil No. 307 CV 1559-N (N.D. Tex. Nov. 6, 2007), http://www.usdoj.gov/crt/split/documents/dallas_county_order_11-06-07.pdf.

⁸⁸ *Id.* at 5-6.

⁸⁹ Order granting Summ. J., *United States v. Terrell County, Georgia*, 1:04-CV-76-WLS (M.D. Ga. Sept. 29, 2006).

⁹⁰ Order accepting Pl.’s Proposed Order at 10, *United States v. Terrell County, Georgia*, 1:04-CV-76-WLS (M.D. Ga. Dec. 21, 2007).

⁹¹ *Id.* at 11.

⁹² *Id.* at 15-16.

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technical assistance and quality improvement reviews on correctional health care management and policy issues, and develops and publishes research on the correctional health care field.”⁹³ The NCCHC claims compliance with its standards can help reduce the risk of adverse legal judgments. Black Hawk County Jail is the only jail in Iowa accredited by the NCCHC.

According to the *Clinical Practice in Correctional Medicine, Second Edition*, published by the NCCHC, the establishment of a functional and effective medical and mental health intake screening process for inmates is vital and absolutely elemental to a correctional facility’s health care system.⁹⁴ “The NCCHC has formally stated that ‘receiving screening’ is the most important of all standards in the NCCHC jail and prison manuals.”⁹⁵ Screening, to be done by a qualified health care professional or at least a health-trained correctional staff member, ensures inmates are placed in appropriate housing and identifies problems that need immediate attention.⁹⁶ A physical examination is used to establish a baseline health status so that further health care needs can be identified and care can be provided.

The NCCHC’s *Standards for Health Services in Jails* requires “receiving screening” to be performed on all inmates immediately upon arrival at the intake facility.⁹⁷ Persons who are mentally unstable are immediately referred for care. Reception personnel, using a health-authority-approved form, must inquire about past and current mental illness, including hospitalizations.⁹⁸ The standards state inmates with mental disorders are often unable to give complete or accurate information in response to health status inquiries.⁹⁹ For this reason, it recommends in addition to the receiving screening, all inmates receive a mental health screen and evaluation. The mental health screen should take place within 14 days of admission, conducted by qualified mental health professionals or mental health staff.¹⁰⁰

The purpose of the mental health screen is to prevent a suicidal inmate from causing self harm and to provide psychiatric services to an inmate who requires it before a crisis arises.¹⁰¹ The initial mental health screen includes inquiries into psychiatric hospitalization and outpatient treatment, violent behavior, and the current status of psychotropic medications.¹⁰² An inmate with a positive screen for mental health

⁹³ STANDARDS FOR HEALTH SERVS. IN JAILS vii (Nat’l Comm’n on Corr. Health Care 2003).

⁹⁴ John M. Raba, *Intake Screenings and Periodic Health Evaluations*, in CLINICAL PRACTICE IN CORRECTIONAL MEDICINE. 41, 41 (Rolla Couchman ed., 2d ed. 2006).

⁹⁵ *Id.* (citing Judith A. Stanley, *The Most Important Standard: Receiving Screening*, CORRECTCARE, Fall 2004, at 21).

⁹⁶ *Id.*

⁹⁷ STANDARDS FOR HEALTH SERVS. IN JAILS J-E-02, Compliance Indicators.

⁹⁸ *Id.*

⁹⁹ *Id.* at Recommendations.

¹⁰⁰ *Id.* at J-E-05, Compliance Indicators.

¹⁰¹ Erin M. Spier et al, *Psychiatric Intake Screening*, in CLINICAL PRACTICE IN CORRECTIONAL MEDICINE 285, 286 (Rolla Couchman ed., 2d ed. 2006).

¹⁰² STANDARDS FOR HEALTH SERVS. IN JAILS J-E-05, Compliance Indicators.

problems should be referred to a qualified mental health professional for further evaluation, and inmates who require acute mental health services beyond those available at the facility are transferred to an appropriate facility.¹⁰³ These standards intend to ensure that the serious mental health needs are identified.¹⁰⁴

According to *Clinical Practice*, many facilities face budgetary and staffing constraints that preclude the use of mental health professionals for screening purposes.¹⁰⁵ Both the APA and the NCCHC allow for initial intake screening to be performed by correctional or nursing personnel, as long as they have received adequate training on the intake screening tools and where to refer inmates in need of service by mental health staff.¹⁰⁶ Because inmates with mental illness may be unwilling or unable to provide complete or accurate health history information, it is important that receiving staff are trained in interviewing and observation.¹⁰⁷

3. ACA Standards

The ACA's *Performance-Based Standards for Adult Local Detention Facilities* provides some guidelines on intake and screening, but does not go into great detail on policy rationale for the requirements. The standards provide that the admission process for newly admitted inmates includes medical, dental, and mental health screenings, and inmates are assigned to holding settings according to their immediate security needs and physical and mental conditions.¹⁰⁸

All inmates also receive an initial mental health screening at the time of admission to the facility by mental health-trained or qualified mental health care personnel.¹⁰⁹ The screening includes inquiries into the inmate's present medications, current mental health complaints, current treatment, and history of psychiatric treatment and substance abuse. The screening also includes observations of general appearance and behavior, and current symptoms of psychosis, depression, anxiety, and/or aggression.¹¹⁰ Based on the mental health screen, the inmate will be (1) cleared for general population, (2) cleared for general population with appropriate referral to mental-health care service, or (3) referred to an appropriate mental-health care service for emergency treatment.¹¹¹

¹⁰³ *Id.*

¹⁰⁴ *Id.* at Discussion.

¹⁰⁵ Spier, *supra* note 101, at 286.

¹⁰⁶ *Id.* See also STANDARDS FOR HEALTH SERVS. IN JAILS J-E-05, Discussion.

¹⁰⁷ *Id.* at 287.

¹⁰⁸ PERFORMANCE-BASED STANDARDS FOR ADULT LOCAL DET. FACILITIES 4-ALDF-2A-21, 4-ALDF-2A-22 (Am. Corr. Ass'n, 4th ed. 2004) (amended 2007).

¹⁰⁹ *Id.* at 4-ALDF-4C-29.

¹¹⁰ *Id.*

¹¹¹ *Id.*

B. Mental Health Assessment and Treatment

1. Federal CRIPA Investigations

During its investigation of Black Hawk County Jail, the DOJ found faults with the jail's mental health care staffing. While finding many of the systemic deficiencies that affected the delivery of medical care also affect mental health care, the DOJ criticized the jail's contract with a private mental health provider. The private provider did not include a psychiatrist, which inhibited the jail from providing a full range of mental health services.¹¹² This led the jail's nursing staff to rely on outside psychiatrists or physicians who had no formal relationship with the jail.¹¹³ This was usually done over the phone with no face-to-face contact between the psychiatrist and the inmate. There would also be few follow-up visits or monitoring by the psychiatrist.

The DOJ's report cited one case in which an inmate requested to see mental health personnel. A nurse responded that the jail did not routinely have mental health personnel come out to the jail and advised the inmate to read, exercise, and talk to others.¹¹⁴ Other than calling to determine if the inmate was on medication, the nurse ordered no further follow-up or evaluation. Two days later, the inmate hung himself from the window bars in his cell.¹¹⁵

The DOJ's report recommended Black Hawk County Jail develop a quality assurance plan to ensure the level of staffing provided sufficient mental health services to identify and treat inmates suffering from serious mental disorders. It recommended the jail provide an adequate and timely health evaluation by qualified and appropriately trained health professionals of inmates who screen positive for possible mental illness at intake and of inmates who exhibit symptoms of mental illness at any time during their incarceration.¹¹⁶ The jail should ensure inmates who request mental health care are seen and evaluated by a qualified and appropriately trained mental health professional, and reviews of mental health-related sick calls should go to the jail's psychiatrist.¹¹⁷

Similar deficiencies and requirements were set forth as a result of the DOJ's review of Dallas County Jail in Texas and Terrell County Jail in Georgia. With the enforcement of a federal court, the DOJ provided recommendations for mental health assessment and treatment. The "Agreed Order" for Dallas County Jail required, in part, the following:

- Defendants shall ensure timely access to a qualified mental health professional when presenting symptoms of mental illness require such care.

¹¹² See Letter from Bill Lann Lee to Brian S. Quirk, *supra* note 79, at "Inadequate Mental Health Care, Inadequate Mental Health Staffing."

¹¹³ *Id.*

¹¹⁴ *Id.* at "Inadequate Mental Health Care, Sick Call/Treatment."

¹¹⁵ *Id.*

¹¹⁶ *Id.* at "Minimum Remedial Measures."

¹¹⁷ *Id.*

- Defendants shall ensure adequate and timely treatment for inmates whose assessment reveal serious mental illness, including timely and appropriate referrals for specialty care and regularly scheduled visits with a qualified mental health professional.
- Defendant shall ensure that treatment plans adequately address inmates' serious mental health needs and that the plans contain interventions specifically tailored to the inmates' diagnoses.
- Defendants shall provide adequate on-site psychiatric coverage for inmates' serious mental health needs and ensure that psychiatrists see inmates in a timely manner.¹¹⁸

The federal court in *Terrell County* adopted the DOJ's "Proposed Order," which provided:

Mental Health Assessment and Referral. The Defendants shall develop and implement adequate policies, procedures, and practices consistent with generally accepted professional standards to ensure timely and appropriate mental health assessments by a qualified mental health professional for any inmate who becomes suicidal and those inmates with mental health histories, whose responses to initial screening questions, or whose behavior indicate a need for such an assessment.¹¹⁹

The "Proposed Order" also required Terrell County Jail to enter a written contractual relationship with an individual with a minimum of a master-level education and training in psychiatry, psychology, counseling, social work or psychiatric nursing, and licensed to coordinate and deliver mental health services to jail inmates. Duties for this person included providing on-call consultations and phone orders, obtaining prescriptions, and evaluating and coordinating treatment for inmates in response to mental health referrals.¹²⁰

2. NCCHC Standards and Recommendations

The NCCHC standards state a jail's written policy and procedures should address post-admission mental health screening and evaluation.¹²¹ Within 14 days of admission, qualified mental health professionals or mental health staff should conduct initial mental health screening with inquiries into a history of psychological hospitalization and outpatient treatment, suicidal behavior and violent behavior, and the current status of

¹¹⁸ Agreed Order at 12-13, *United States v. Dallas County, Texas*, Civil No. 307 CV 1559-N (N.D. Tex. Nov. 6, 2007), http://www.usdoj.gov/crt/split/documents/dallas_county_order_11-06-07.pdf.

¹¹⁹ Order accepting Pl.'s Proposed Order at 16, *United States v. Terrell County, Georgia*, 1:04-CV-76-WLS (M.D. Ga. Dec. 21, 2007).

¹²⁰ *Id.* at 9.

¹²¹ STANDARDS FOR HEALTH SERVS. IN JAILS J-E-05, Compliance Indicators (Nat'l Comm'n on Corr. Health Care 2003).

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psychotropic medication. Inmates who screen positive for mental health problems are to be referred to a qualified mental health professional for further evaluation.¹²²

The purpose of identifying mentally-ill inmates during the post-admission screening is to prevent deterioration of their functioning level and to receive necessary treatment. The standards also require mental health services be available to inmates who require them.¹²³ The immediate objective of mental health treatment in the correctional setting is to alleviate symptoms of serious mental disorders and prevent relapses to enable the patient to function safely in their environment.¹²⁴ Patients who require acute mental health services beyond those available at the facility are to be transferred to an appropriate facility.¹²⁵

3. ACA Standards

The ACA standards are similar to the NCCHC's, though they give less detail or explanation behind the policies. After the new inmate intake, the ACA standards require those inmates who were referred to receive a mental health appraisal during the health services screen receive the appraisal by a qualified mental health person within 14 days of admission.¹²⁶ A mental health examination includes, in part:

- 1) Assessment of current mental status and condition.
- 2) Assessment of current suicide potential.
- 3) Assessment of violence potential.
- 4) Review of historical records of psychiatric treatment.
- 5) Review of treatment with psychotropic medication.
- 6) Review of history of drug and alcohol addiction and treatment.
- 7) Referral to treatment.
- 8) Development and implementation of treatment plan.¹²⁷

Inmates referred for mental health treatment receive a comprehensive evaluation by a licensed mental health professional, which includes a review of the mental health screen, direct observation of behavior, collection and review of individual diagnostic interviews and tests, compilation of the individual's mental health history, and development of an overall treatment plan with referral to include transfer to mental health facility for inmates whose psychiatric needs exceed the treatment capability of the facility.¹²⁸

¹²² "Mental health staff" includes qualified health care professionals who have received instruction and supervision in identifying and interacting with individuals in need of mental health services. "Qualified mental health professionals" includes psychiatrists, psychologists, psychiatric social workers, psychiatric nurses, and others who by virtue of their education, credentials, and experience are permitted by law to evaluate and care for the mental health needs of patients." *Id.* at Definitions.

¹²³ *Id.* at J-G-04, Standard.

¹²⁴ *Id.* at Discussion.

¹²⁵ *Id.* at J-E-05, Compliance Indicators.

¹²⁶ PERFORMANCE-BASED STANDARDS FOR ADULT LOCAL DET. FACILITIES 4-ALDF-4C-30 (Am. Corr. Ass'n, 4th ed. 2004) (amended 2005).

¹²⁷ *Id.*

¹²⁸ *Id.* at 4-ALDF-4C-31.

C. Use of Restraints

1. Federal CRIPA Investigations

The Civil Rights DOJ's review of Black Hawk County Jail concluded the lack of psychiatric involvement at the jail contributed to deficiencies in medication management for an inmate who was taking Haldol for his mental illness.¹²⁹ The inmate claimed the medication caused a heart attack, which the nurse dismissed with no thorough medical examination or psychiatric input. The inmate thereafter refused to take the medication, causing his mental health condition to deteriorate. This led to the inmate being placed in restraints several times during the week. The investigation found "[h]is chart did not contain an adequate treatment plan, and he was not receiving treatment for his serious mental illness."¹³⁰

The DOJ focused on inmates who had been placed in the restraint chair due to symptoms associated with their mental illnesses. Neither medical nor mental health personnel appeared to be involved in the decision to place the inmates in the chair, or in monitoring the inmates while they were restrained.¹³¹ The DOJ also reviewed two inmates with serious mental illness in the "special housing unit," (SHU) a maximum security area for inmates in disciplinary or administrative segregation.¹³² A female inmate had been placed in SHU because of actions associated with her mental illness, including assaultive behavior. However, there was inadequate documentation in her chart regarding her mental health history and treatment plan. A psychiatrist had given telephone orders to administer psychotropic medication, but the inmate had not undergone a face-to-face evaluation and was not receiving an adequate level of mental health care.¹³³

The DOJ found the jail's practice of placing inmates with mental illness in the restraint chair created a serious risk for those inmates. The DOJ recommended the jail ensure its on-call psychiatrist is consulted in the event of a mental health emergency.¹³⁴ It also recommended the jail develop a comprehensive policy on the use of restraints on inmates with serious mental illnesses. When restraints must be used, the jail must ensure that mental health personnel are involved in the decision to restrain mentally-ill inmates and the monitoring of such inmates while restrained.¹³⁵ The DOJ concluded, "[a]cutely mentally ill persons who cannot function in the jail's general population must be transferred to a treatment facility as expeditiously as possible."¹³⁶

¹²⁹ See Letter from Bill Lann Lee to Brian S. Quirk, *supra* note 79, at "Inadequate Mental Health Care, Medication Management."

¹³⁰ *Id.*

¹³¹ *Id.* at "Inadequate Mental Health Care, Improper Restraint and Seclusion of Mentally Ill Inmates."

¹³² *Id.*

¹³³ *Id.*

¹³⁴ *Id.* at "Minimal Remedial Measures, Mental Health Care."

¹³⁵ *Id.*

¹³⁶ *Id.* at "Inadequate Mental Health Care, Improper Restraint and Seclusion of Mentally Ill Inmates."

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In the event any inmate is placed in restraints, regardless of mental health status, the DOJ recommended a supervisor be present when the inmate is first placed in a restraint chair.¹³⁷ Inmates must be checked by appropriately trained personnel every 15 minutes and by medical and mental health staff at “appropriate intervals.”¹³⁸ Limb exercises should be done to avoid circulation problems, and attention must be given to food, hydration, and bodily functions.

In 2001 the DOJ issued a “Findings Letter” to Shelby County Jail in Tennessee, similar to the one issued to Black Hawk County Jail.¹³⁹ The Findings Letter was the precursor to a Settlement Agreement entered between the United States and Shelby County in 2002, which addressed issues relating to mental health and restraint chair use in its jail facility. The Settlement Agreement required the county to revise its policies to ensure that “mental health professionals are consulted before any planned use of force or non-routine use of restraints on any inmate with a diagnosis of mental illness.”¹⁴⁰ The county also had to revise its policy on the use of its restraint chair to require pre-authorization and supervision by mental health staff for any non-emergency use of the restraint chair involving inmates with mental illness. The county must require all security staff to attend annual in-service training on the use of force and de-escalation techniques.¹⁴¹

2. The Federal Bureau of Prisons Policies

The Federal Bureau of Prisons (Bureau), an agency of the U.S. Department of Justice, has written policies governing the use of four-point restraints at its 114 institutions. According to its website, the Bureau employs approximately 36,000 personnel and is responsible for the custody and care of more than 201,000 federal offenders.¹⁴²

a. Placement and use of four-point restraint

In federal institutions, four-point restraints are to be used when they are the only means available to obtain and maintain control over an inmate.¹⁴³ Prison staff is to use the process of progressive restraints, where the least restrictive restraint method is used to control the inmate based on the circumstances, and more restrictive restraints may be used based on the inmate’s behavior.¹⁴⁴ The Bureau’s policy states ambulatory restraints should initially be used to restrain an inmate if deemed appropriate for the situation.¹⁴⁵

¹³⁷ *Id.* at “Minimal Remedial Measures, Use of Restraint.”

¹³⁸ The DOJ Letter does not say what constitutes “appropriate intervals.”

¹³⁹ Letter from William R. Yoemans, Acting Assistant Att’y Gen., Civil Rights Div., to Jim Rout, Mayor, Shelby County, Tennessee (June 27, 2001), *available at* <http://www.usdoj.gov/crt/split/documents/shelbyfind.htm>.

¹⁴⁰ Settlement Agreement Between the United States and Shelby County, Tennessee (Aug. 15, 2002), *available at* http://www.usdoj.gov/crt/split/documents/shelby_settleagmt.htm.

¹⁴¹ *Id.*

¹⁴² www.bop.gov/about/index.jsp (last visited Oct. 30, 2008).

¹⁴³ FEDERAL BUREAU OF PRISONS, PROGRAM STATEMENT P5566.06(10) (2005), *available at* http://www.bop.gov/policy/progstat/5566_006.pdf.

¹⁴⁴ PROGRAM STATEMENT P5566.06(9).

¹⁴⁵ *Id.*

Such situations include an assault that occurs and ends quickly, and the inmate is no longer displaying signs of violence or aggression.¹⁴⁶ The ambulatory restraints are those which allow an inmate to eat, drink, and take care of basic human needs without staff intervention.

When four-point restraints are necessary, the policy requires staff to check the inmate at least every 15 minutes to ensure the restraints are not hampering circulation and for the general welfare of the inmate.¹⁴⁷ Every two hours, a lieutenant must review the inmate to determine if the use of the restraints achieved the required calming effect, allowing staff to remove the inmate from the restraints.¹⁴⁸ During this two-hour review, the inmate will be afforded the opportunity to use the toilet, unless the inmate is actively resisting or becomes violent while being released.¹⁴⁹ The lieutenant must determine how many staff are needed for the bathroom break and what protective equipment is needed.

The goal of the two-hour review is to determine as soon as possible if the inmate has regained self-control and can be placed in lesser restraints. If the inmate is temporarily released from the four-point restraints for any reason, and there is no continued disruption or aggression, the lieutenant must consider authorizing lesser restraints or removing the restraints altogether. If the inmate is returned to the restraint after this non-disruptive break, the lieutenant must document the reasons for this action.

b. Medical and mental health reviews

The policy states a qualified health personnel must initially assess the inmate when the inmate is placed in four-point restraints to ensure appropriate breathing and physical and verbal response.¹⁵⁰ The health personnel should visit with the inmate at least twice during each eight-hour shift, and if the inmate is to remain in the restraint longer than eight hours, supervision must be conducted by the health personnel. In the event an institution does not have 24-hour medical coverage, medical staff must report to the institution twice during each eight-hour shift.¹⁵¹

Medical staff must examine and document the following:

- Date and time of examination;
- Examining staff member;
- Body position;
- Restraints (adequate circulation);
- Vital signs (blood pressure, pulse, respiration, and temperature);
- Medication;

¹⁴⁶ *Id.*

¹⁴⁷ PROGRAM STATEMENT P5566.06(10)(d).

¹⁴⁸ PROGRAM STATEMENT P5566.06(10)(e).

¹⁴⁹ *Id.*

¹⁵⁰ PROGRAM STATEMENT P5566.06(10)(f).

¹⁵¹ *Id.*

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- Injuries;
- The inmate's intake, output, hydration, etc.;
- Possible medical reasons for behavior;
- Deterioration of inmate's health; and
- Any other significant findings and comments.¹⁵²

After the inmate is removed from the restraints, medical staff must examine the inmate and treat any noted injuries.¹⁵³ Psychological services staff must examine an inmate who is restrained once during every 24-hour period.

c. Documentation

Federal prison staff must document, in writing, the use of restraints on an inmate who becomes violent or displays signs of immediate violence.¹⁵⁴ The report must identify all those who were involved in the incident and “must provide a vivid, detailed description of the incident.”¹⁵⁵ In addition, staff must document the 15-minute check, the two-hour lieutenant check, the health services staff review, and the psychology check.¹⁵⁶

Staff must immediately obtain a video camera to record any use of force incident, unless a delay would endanger the inmate, staff, or others or would result in major disturbance or serious property damage.¹⁵⁷ The prison must maintain all documentation, including the videotape, for a minimum of 2½ years.¹⁵⁸ According to the policy requiring the careful documentation of restraint applications, the incidents must be reported and investigated to protect staff from unfounded allegations and eliminate the unwarranted use of force.¹⁵⁹

3. NCCHC Standards and Recommendations

According to the NCCHC standards, health services staff are to be notified immediately when a restraint is used so that they can review the health record for any required contraindications or accommodations and initiate health monitoring which continues as long as the inmate is restrained.¹⁶⁰ Health services staff are required to notify correctional administration if they determine that an individual is being restrained in an unnatural position or one that could jeopardize his or her health.¹⁶¹ If health services staff note

¹⁵² *Id.*

¹⁵³ PROGRAM STATEMENT P5566.06(12)(b).

¹⁵⁴ PROGRAM STATEMENT P5566.06(14).

¹⁵⁵ PROGRAM STATEMENT P5566.06(14)(a).

¹⁵⁶ PROGRAM STATEMENT P5566.06(14)(b).

¹⁵⁷ PROGRAM STATEMENT P5566.06(14)(c).

¹⁵⁸ PROGRAM STATEMENT P5566.06(14)(d).

¹⁵⁹ PROGRAM STATEMENT P5566.06 (6)(j).

¹⁶⁰ STANDARDS FOR HEALTH SERVS. IN JAILS J-I-01, Compliance Indicators (Nat'l Comm'n on Corr. Health Care 2003).

¹⁶¹ B. Jay Anno & Steven S. Spencer, *Medical Ethics and Correctional Health Care*, in CLINICAL PRACTICE IN CORRECTIONAL MEDICINE 19, 25 (Rolla Couchman ed., 2d ed. 2006) (referencing NCCHC standards).

improper use of restraint that is jeopardizing the inmate's health, staff should communicate their concerns as soon as possible to appropriate custody staff. The standards state exercising each limb for at least ten minutes every two hours to prevent blood clots is recommended.¹⁶²

In the event an inmate has a medical or mental health condition, the physician is notified immediately so that appropriate orders can be given.¹⁶³ Except for monitoring an inmate's health status, health services staff does not participate in the restraint of inmates ordered by custody staff.¹⁶⁴

4. ACA Standards

Similar to its requirements for intake screening and assessment, the ACA standards do not provide exhaustive detail on restraint use. However, they do state four- and five-point restraints are used only in extreme instances and only when other types of restraint have proven ineffective.¹⁶⁵ Advanced approval must be obtained from the jail administrator or designee before placement, and the health authority must be notified to assess the inmate's medical and mental health condition. The health authority will also determine if the inmate should be in a medical or mental health unit for emergency involuntary treatment with sedation or medical management.

If the inmate remains in the facility, and four- and five-point restraints are used, the following minimum procedures are to be used:

- direct visual observation by staff is continuous prior to obtaining approval from the health authority or designee;
- subsequent visual observation is made at least every 15 minutes;
- restraint procedures are in accordance with guidelines approved by the designated health authority;
- all decisions and actions are documented.¹⁶⁶

These requirements closely resemble those incorporated by the ACA for adult detention facilities housing convicted inmates, such as prisons. Advanced approval must be obtained from the warden or designee, and the health authority must be notified to assess the inmate's medical and mental health condition to determine if the inmate must receive emergency involuntary medical or mental health treatment.¹⁶⁷

¹⁶² STANDARDS J-I-01, Recommendations.

¹⁶³ *Id.* at Compliance Indicators.

¹⁶⁴ *Id.* at Standard.

¹⁶⁵ PERFORMANCE-BASED STANDARDS FOR ADULT LOCAL DET. FACILITIES 4-ALDF-2B-03 (Am. Corr. Ass'n, 4th ed. 2004).

¹⁶⁶ *Id.*

¹⁶⁷ STANDARDS FOR ADULT CORR. INSTS. 4-4191 (Am. Corr. Ass'n, 4th ed. 2003).

5. CMS Regulations

The Centers for Medicare & Medicaid Services (CMS) promulgates rules for institutions that participate in the federal Medicare and Medicaid programs. Facilities that are commonly affected by CMS rules include medical facilities such as hospitals and mental health institutions. While county jails are not directly affected by the rules, according to one corrections expert, “these rules may properly be looked at in the same fashion as Standards or even Model rules; that is, persuasive but not binding authority.”¹⁶⁸ This is due in part to the similar circumstances that give rise to restraint use in hospitals and county jails: patient is an immediate threat to themselves or others.

The CMS recently incorporated rules in the Code of Federal Regulations (Regulations) that govern the use of restraints and seclusions in hospitals, including on patients who pose a physical threat of harm to themselves or others.¹⁶⁹ The Regulations allow for the use of restraints and seclusion only when “less restrictive interventions have been determined to be ineffective to protect the patient, a staff member, or others from harm.”¹⁷⁰ Also, the type or technique of restraint used must be the least restrictive intervention that will effectively protect the patient, staff, and others.¹⁷¹

If restraints are required, the attending physician must be consulted “as soon as possible” if the physician did not order the restraint.¹⁷² The patient’s condition must be monitored by a physician, other licensed independent practitioner (LIP), or trained staff that have completed training criteria required in the Regulations.¹⁷³ These individuals must have a working knowledge of hospital policy regarding the use of restraints and seclusion. Patients must be seen face-to-face within one hour after placement by a physician or other licensed independent practitioner, a registered nurse, or a physician’s assistant to evaluate:

¹⁶⁸ *Patients’ Rights: CMS’s Rules on Seclusion and Restraints*, 9 CORRECTIONAL MENTAL HEALTH REP. 51 (Fred Cohen ed., 2007).

¹⁶⁹ Condition of Participation: Patients’ Rights, 42 C.F.R. § 482.13 (2007).

¹⁷⁰ *Id.* at § 482.13(e)(2).

¹⁷¹ *Id.* at § 482.13(e)(3).

¹⁷² *Id.* at § 482.13(e)(7). According to the CMS, many facilities raised concerns during the public comment period before the regulations were codified, arguing that physicians are not always available to order restraints. The CMS responded,

[w]e understand that physicians are not always onsite when an emergency occurs. . . . We do not expect staff to stand by and let the patient injure himself or others without intervening simply because a physician is not present. The hospital may develop emergency procedures that staff follow before obtaining the order for restraint or seclusion; however, an order must be obtained as soon as possible.

Medicare and Medicaid Programs; Hospital Conditions of Participation: Patients’ Rights, 71 Fed. Reg. 71,378, 71,396 (Dec. 8, 2006) (to be codified at 42 C.F.R. pt. 482).

¹⁷³ The CMS defined “Licensed Independent Practitioner” as “any individual permitted by State law and hospital policy to order restraints and seclusion for patients independently, with the scope of the individual’s license and consistent with the individually granted clinical privileges.” *Id.* at 71,394.

- The patient’s immediate situation;
- The patient’s reaction to the intervention;
- The patient’s medical and behavioral condition; and
- The need to continue or terminate the restraint or seclusion.¹⁷⁴

If the evaluation is conducted by a registered nurse or physician’s assistant, the attending physician or other LIP must be consulted as soon as possible after the completion of the one-hour face-to-face evaluation. The Regulations allow orders for restraint and seclusion to be written by a physician or LIP for a maximum of four-hour periods for adults. Each four-hour order must be approved by a physician or LIP for a maximum of 24 hours total. At the 24-hour point, a physician or LIP must see and assess the patient before a new order can be written.¹⁷⁵ While an order may be written for up to four hours, restraints must be discontinued at the earliest possible time “regardless of the length of time identified in the order.”¹⁷⁶

The Regulations do not provide for periodic reviews other than one for the first hour and in conjunction with the order renewal every four hours. The Regulations leave additional monitoring and checks to the hospital when it requires the patient’s condition to be monitored “at an interval determined by hospital policy.”¹⁷⁷ This is in part due to the wide variety of restraints available to a hospital and the impracticality of the Regulations to provide guidelines for each situation. As explained in the *Federal Register*, mental health and vital sign checks are important, along with breaks for toileting, hydration, and eating, even if not addressed in the Regulations:

We cannot provide an exhaustive list of the items to be monitored because they will vary with the type of intervention used and the patient’s condition. For example, the use of a restraint that keeps the patient immobilized would require a check of the patient’s skin integrity and steps to prevent skin breakdown. Depending on the duration of the intervention, range of motion exercise might be necessary. The patient’s mental status, as well as vital signs, should be assessed, particularly when the restraint is initiated to manage self-destructive or violent behavior that jeopardizes the immediate physical safety of the patient, a staff member, or others. The patient should be provided the opportunity for toileting, hydration, and eating if the interventions used impedes these activities.¹⁷⁸

In addition, the CMS explained the absence of specific periodic checks codified in the Regulations does not indicate staff should not attempt to address the underlying cause for agitation:

¹⁷⁴ 42 C.F.R. § 482.13(e)(12)(ii).

¹⁷⁵ Medicare and Medicaid Programs; Hospital Conditions of Participation: Patients’ Rights, 71 Fed. Reg. at 71,412.

¹⁷⁶ 42 C.F.R. § 482.13(e)(9).

¹⁷⁷ *Id.* at §482.13(e)(10).

¹⁷⁸ Medicare and Medicaid Programs; Hospital Conditions of Participation: Patients’ Rights, 71 Fed. Reg. at 71,400.

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The use of these interventions must not end efforts to treat the underlying cause of the behavior; nor is it expected that treatment will come to a complete halt. . . . Certainly, trained staff should work with the patient toward release as quickly as possible and use other interventions to de-escalate the crisis behavior.¹⁷⁹

The Regulations also provide requirements for circumstances where hospital staff use simultaneous seclusion and restraint. This is only permitted if the patient is continually monitored (1) face-to-face by an assigned, trained staff member, or (2) by trained staff using both video and audio equipment. The audio and video monitoring must be in close proximity to the patient. The *Federal Register* explained these requirements as follows:

If restraint and seclusion are used simultaneously to manage self-destructive or violent patient behavior that jeopardizes the immediate physical safety of the patient, a staff member, or others, the patient must be continually monitored, face-to-face, by an assigned, trained staff member; or continually monitored by trained staff using both video and audio equipment . . . “continually” means ongoing without interruption.¹⁸⁰

When restraints or seclusion are used, staff must document each of the following:

1. The 1-hour face-to-face medical and behavioral evaluation if restraint or seclusion is used to manage violent or self-destructive behavior;
2. A description of the patient’s behavior and the intervention used;
3. Alternatives or other less restrictive interventions attempted (as applicable);
4. The patient’s condition or symptom(s) that warranted the use of the restraint or seclusion; and
5. The patient’s response to the intervention(s) used, including the rationale for continued use of the intervention.¹⁸¹

Commenters to the Regulations suggested requiring restraints logs and elements that should be included in the log such as time initiated and discontinued, time physician was contacted, and documentation of physical exams. The CMS replied that it agreed with such practices and believed tracking and monitoring would be appropriate for the hospital, but declined to require such documentation because it would be unnecessarily burdensome.¹⁸²

¹⁷⁹ *Id.* at 71,413.

¹⁸⁰ *Id.* at 71,400.

¹⁸¹ 42 C.F.R. § 482.13(e)(16).

¹⁸² Medicare and Medicaid Programs; Hospital Conditions of Participation: Patients’ Rights, 71 Fed. Reg. at 71,415.

6. Other Resources

In *The Mentally Disordered Inmate and the Law*, Fred Cohen provides a list of essential points that every facility must cover in its policy and procedures governing restraint device placement, monitoring, and duration. Those points include:

- 1) *Clarity on the rationale (or criteria) for the intervention.* There are always emergencies that will require the prevention or reduction of harm and damage. The nature of emergencies that trigger therapeutic restraint or seclusion must be spelled out.
- 2) *Authorization.* In an emergency (and these situations always are emergencies) it may not always be possible to have a doctor or a psychiatrist perform an initial authorization. However, the regulations should clarify (1) who may then authorize [restraint application], (2) how soon thereafter clinical authorization is required, and (3) whether or when personal observation must precede clinical authorization.
- 3) *Monitoring.* The policy should specify who will do the monitoring, at what intervals monitoring shall occur, and whether it is for medical, psychiatric, or comfort purposes.
- 4) *Bodily function factors.* The policy should provide for details on provision of food, relief of bodily wastes and fluids, water intake, nonimpairment of blood circulation, and the like.
- 5) *Duration.* The policy must state how long a single restraining episode will last and the time frames for monitoring, recordkeeping, and the like.¹⁸³

Kenneth L. Faiver, in his book, *Health Care Management Issues in Corrections*, published by the ACA, states that in the case of a person with a diagnosed or suspected mental illness, “the officer should notify mental health personnel as soon as possible and be guided by competent clinical advice as to the continuation of any form of restraint.”¹⁸⁴ The warden or jail administrator delegates authority for the use of restraints on mentally ill inmates, but correctional personnel should only employ them while consulting with mental health staff.¹⁸⁵

Mr. Faiver sets proposed requirements that should accompany policies governing restraints used by mental health professional on mentally ill prisoners. A policy should address:

- who may order the restraints,
- what type of restraints should be used,
- the length of time for which an order for restraint is valid,
- alternative measures which must be considered prior to employment of restraints,

¹⁸³ FRED COHEN, *THE MENTALLY DISORDERED INMATE AND THE LAW* ¶ 12-5[2] (1998).

¹⁸⁴ KENNETH L. FAIVER, *HEALTH CARE MANAGEMENT ISSUES IN CORRECTIONS* 152 (1998).

¹⁸⁵ *Id.* at 153.

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- a requirement for periodic inspection of the restraint patient by a qualified mental health and/or medical staff,
- a requirement for visitation of the restrained patient by a mental health professional who is qualified to order restraints, and
- adequate documentation.¹⁸⁶

Mr. Faiver states that the principle of “least restrictive environment” should be observed in all cases of restraint use. This means restraints should be applied only when less restrictive devices are judged to be insufficient, and the type of restraint used must be the least restrictive restraint that is effective.¹⁸⁷ Mr. Faiver also describes in his book the restraint chair that is now popularly incorporated in small jails was used in the early 1900s in mental hospitals, “but was long ago discarded as an inappropriate and unacceptable treatment for mentally ill persons.”¹⁸⁸

The American Psychiatric Association’s Resource Document, addressing the use of seclusion and restraint in the correctional health care system, states when four-point restraints are used, observation should be continuous and documentation of the observations should be contemporaneous.¹⁸⁹ A nurse should check each extremity every 15 minutes for at least the first 2 hours of restraint.¹⁹⁰ “Every two hours, nursing staff should perform an assessment of the patient, including condition of the skin and circulation, need for toileting, personal hygiene procedures, and proper application of the restraint.”¹⁹¹ Evaluations should summarize the patient’s overall physical condition, general behavior, and response to counseling/interviews. Vital signs should be taken every eight hours.

The Resource Document suggests range of motion exercises should be performed every two hours unless the patient is too agitated or assaultive to safely remove the restraints. For exercise, restraints on each extremity shall be removed one at a time.¹⁹² Toileting should be provided at least every four hours, and if security concerns do not allow the inmate to exit a room for these facilities, a urinal or bed pan should be used. Fluids and nourishment should also be provided every two hours except during hours of sleep.¹⁹³

¹⁸⁶ *Id.*

¹⁸⁷ *Id.*

¹⁸⁸ *Id.* at 154. The Ombudsman recognizes, however, that the restraint chair is not being used to treat mentally ill inmates, but to prevent injury by the inmates. Correctional officers are not trained mental health professionals, and their primary functions lies with maintaining security.

¹⁸⁹ JEFFERY L. METZNER ET AL., COUNCIL ON PSYCHIATRY AND LAW, THE USE OF RESTRAINT AND SECLUSION IN CORRECTIONAL MENTAL HEALTH CARE 5 (2006).

¹⁹⁰ *Id.* at 6.

¹⁹¹ *Id.*

¹⁹² *Id.*

¹⁹³ *Id.*

D. Time Limits

1. E.R.C. Inc. Policy

Over the past several years, E.R.C. Inc. has changed the language and substance of its policy manual; some of which appears to be contradictory. According to an older version of E.R.C. Inc.'s *Instructions*, whose publication date is unknown, "detainees should not be left in the Emergency Restraint Chair for more than two hours at a time."¹⁹⁴ This policy is echoed on the E.R.C. Inc. website.¹⁹⁵ A letter from President Tom Hogan to customers, (Customer Letter), dated January 17, 2001, states:

We recommend that detainees not remain in the Emergency Restraint Chair for more than two hours at a time. This time limit was established to allow for the detainee to calm down or sober up, and if needed it allows for the correctional officer to seek medical or psychological (sic) help for the detainee. This two-hour limit may be extended, but only under direct MEDICAL SUPERVISION (Doctor/Nurses) while performing range of motion exercises. **This extended time period should not exceed eight hours; therefore we do not recommend anyone be left in the Emergency Restraint Chair for more than ten hours total.**¹⁹⁶ (bold emphasis added).

The Customer Letter states the company understands some customers are keeping detainees in the restraint chair longer than the manufacturer intended. The company cautioned that the guidelines listed above should be followed carefully.

A version of the *Instructions* that followed the Customer Letter, published February 10, 2001, contains similar language.¹⁹⁷ It provides for the option of extending the two-hour time limit, but only under direct medical supervision of a doctor or a nurse.¹⁹⁸ It does not recommend anyone be left in the restraint chair more than ten hours.¹⁹⁹ During this investigation, the Ombudsman learned several jails relied on the older version of the *Instructions*.

The Ombudsman contacted E.R.C. Inc. President Tom Hogan about the time limit language. According to Mr. Hogan, the two-hour and ten-hour language is "arbitrary."²⁰⁰ He stated a time limit needed to be set, and two hours was a reasonable amount of time to

¹⁹⁴ E.R.C. Inc., EMERGENCY RESTRAINT CHAIR INSTRUCTIONS 11 (Feb. 10, 2001). The Ombudsman obtained two versions of the ERC Instructions during the course of his investigation. One instruction manual appears to be an older version when taking into consideration the "Patent in Progress" language on the manual and the black and white photos. Another manual, dated "February 10, 2001," states "Patented in 1998" and is printed in color.

¹⁹⁵ <http://www.restraintchair.com/diagram.htm> (last visited Oct. 30, 2008).

¹⁹⁶ Letter from Thomas Hogan, President, E.R.C. Inc., to Customer (Jan. 17, 2001).

¹⁹⁷ E.R.C. Inc., EMERGENCY RESTRAINT CHAIR INSTRUCTIONS (Feb. 10, 2001).

¹⁹⁸ *Id.* at 12.

¹⁹⁹ *Id.*

²⁰⁰ Telephone Interview with Tom Hogan, President, Emergency Restraint Chair, Inc. (June 11, 2008).

determine if the inmate is exhibiting unusual behavior that requires medical personnel involvement, and allows time for the jail to incorporate medical supervision of the inmate. This was based on his experience as a county sheriff and running his own jail where he used the restraint chair. The initial two hours is meant to seek medical attention.

The E.R.C. Inc. Customer Letter also revealed an additional policy basis for the two-hour limitation. According to the Customer Letter, two hours should be enough time to allow an inmate to calm down or sober up. This sentiment has been repeated by other correctional officers the Ombudsman contacted, who have stated an inmate will rarely need to be in a restraint chair longer than two hours. The Customer Letter states those two hours allow a correctional officer to seek medical or psychological help for the detainee. In addition, the letter reflects language used by the Jefferson County Jail's policy that extended use of the restraint chair beyond the two-hour limit may only be done under direct medical supervision.²⁰¹

2. Iowa Law and Case Law

Iowa law does not provide requirements for specific maximum limits for restraint device use or when medical staff should be consulted. It does state the restraint device "shall be used only when a prisoner is a threat to self or others or jeopardizes jail security."²⁰² It further requires personal visual observations of the inmate and the restraint device application every 15 minutes.²⁰³

Iowa case law has not provided a maximum time limit, but courts have criticized jails for not providing documentation to support continued use of restraints. In *Ogden v. Johnson*, the Northern District of Iowa upheld a jury verdict that found the arrestee's five-hour placement on a "restraint board" by Linn County Jail staff was unreasonable.²⁰⁴ The arrestee showed he was held on the board long after the need for restraint had ended, and the jury found this constituted excessive force. In approving the jury award, the court determined the board was "more than just uncomfortable. It is a restraint that should be used only for the amount of time necessary to restore order."²⁰⁵ Further, the court found the officer who approved the continued use beyond the reasonable time was not entitled to qualified immunity. The court upheld the \$11,500 jury award against the officer in his individual capacity for punitive damages and also awarded \$43,502.50 in attorney fees.²⁰⁶

In another similar case against the Linn County Jail, the same court found the jail could not justify the continued restraint of an inmate that lasted for eight hours and concluded

²⁰¹ *Id.*

²⁰² IOWA ADMIN. CODE r. 201—50.13(2)(f) (2008).

²⁰³ *Id.*

²⁰⁴ *Ogden v. Johnson*, No. C00-0034, WL 32172301 (N.D. Iowa Sept. 5, 2002).

²⁰⁵ *Id.* at *3.

²⁰⁶ *Id.* at *5, *7.

the restraint violated the inmate's Eighth Amendment rights.²⁰⁷ The court found the inmate's initial placement was not excessive under the circumstances, where the inmate prevented an officer from closing a door and physically resisted the officer. However, the court found the record could not support the inmate's continued restraint in response to his verbal abuse:

No evidence was offered that indicated Rogers presented a physical threat to inmates or staff or that jail security was jeopardized in any way. Mere verbal abuse by an inmate does not justify eight hours of immobility on "the board."²⁰⁸

The court found the actions of the officer, who was also one of the defendants in *Ogden*, were taken for no other purpose than to punish the inmate and inflict pain, humiliation, and suffering on him for the verbal abuse.²⁰⁹ The court described the officer's action as "cruel" when the defendant was denied bathroom provisions and had no choice but to urinate on himself. The court further criticized the lack of periodic reviews and documentation:

While Sergeant Johnson checked on Rogers once in awhile, no documentation of reviews and evaluations were offered evidencing any justification for the excessive eight hours Rogers spent immobilized on the board.²¹⁰

The court held the inmate's Eighth Amendment rights were violated by the continued use of the restraint board. The court again denied the defendant officer qualified immunity for his actions, and awarded the former inmate \$1,500 in compensatory damages plus attorney fees.²¹¹

The requirement that a correctional facility provide evidence that continued restraint is necessary to defend against constitutional rights allegations has been upheld by other federal district courts outside Iowa. In 2004 a federal district court in Virginia concluded a state prison could not substantiate the need to restrain an inmate in four-point restraints longer than the initial three hours after his placement.²¹² The inmate showed no further signs of aggression after this time and was released periodically for meal and bathroom breaks with no violence. However, the prison kept him restrained to a bed for 47 hours and 20 minutes, a regular practice by the prison when it determined an inmate needed to

²⁰⁷ *Rogers v. Dunn*, No. 00-0188-PAZ, 2001 U.S. Dist. LEXIS 22710, at *14 (N.D. Iowa Nov. 27, 2001).

²⁰⁸ *Id.* at *10.

²⁰⁹ *Id.*

²¹⁰ *Id.* at *10-11.

²¹¹ *Id.* at *14-15.

²¹² *Sadler v. Young*, 325 F.Supp.2d 689, 704 (W.D. Va. 2004), *rev'd on other grounds*, 118 Fed. Appx. 762 (4th Cir. 2005).

be restrained.²¹³ While substantiating the initial placement, the court in *Sadler v. Young* found:

Neither the testimony nor the reports suggest any reason for keeping Sadler restrained for nearly two days The absence of evidence of a need to restrain Sadler for nearly two days indicates that the defendants were executing a forty-eight hour punishment of Sadler as opposed to responding to an immediate disturbance I hold as a matter of law that the remaining defendant did not act in good faith in restraining Sadler for forty-seven hours and twenty minutes because there is no reasonably sufficient evidentiary basis showing that the defendants perceived Sadler to be a threat after . . . three hours after he was first restrained.²¹⁴

The court found that no reasonable jury could find the defendant's conduct required the application of force for nearly 48 hours.²¹⁵

3. Other Sources for Length of Time

Correctional, medical, or mental health articles, standards, and court cases reviewed by the Ombudsman do not designate a specific maximum time limit like the one proposed by the E.R.C. Inc. Customer Letter. Rather, many of the referenced sources require staff and medical monitoring and reviews of the inmate who is placed in the restraints. Many county jails set either a two- or four-hour maximum time limit, unless approval for additional time is given by a jail administrator or designee.

As mentioned earlier, the DOJ recommended a supervisor be present when the inmate is first placed in the chair, and medical and mental health staff should check the inmate at "appropriate intervals," though it is not known what specific time interval was intended. The NCCHC standards require health services staff be notified immediately, and in the event the inmate has a medical or mental health condition, a physician is notified immediately. The ACA standards require the jail's health authority be notified when restraints are used and require 15-minute visual checks of the inmate.

²¹³ *Id.* at 694-95.

²¹⁴ *Id.* at 702-704.

²¹⁵ *Id.* at 702.

Analysis

A. Review of Restraint Devices Used in Iowa County Jails

1. Manufacturer Testing and Research

According to E.R.C. Inc. President Tom Hogan, the policies drafted by the company were based on his experience as an EMT and county sheriff. Little or no medical research designates specific time period for medical checks, which he set at two hours, or maximum amount of time an inmate can be left in the restraint chair, which he set at ten hours. He also based the design of the chair on his experience in medical treatment and law enforcement. The slightly-reclined chair provides comfort that is not available with the restraint board, which straps the inmate face down on a piece of plywood. If the circumstance allows for it, when an inmate calms down or falls asleep, jail staff can loosen the straps for the inmate's comfort and may easily re-tighten the straps if the inmate suddenly becomes violent again.

Mr. Hogan emphasized the need for jail staff to observe the inmate and note any unusual behavior that may indicate an underlying medical or mental health cause for the aggressive actions. The initial two hours should be used to seek medical treatment if the inmate does not calm down after that time, and should follow medical advice on whether medical intervention is required.

A previous report issued by the Ombudsman on restraint chair use involved the Scott County Jail. The restraint chair used by the Scott County Jail on that occasion was manufactured by AEDEC International, Inc.²¹⁶ A report published in *The Progressive* reviewed the use of restraint chairs and provided deposition responses from Dan Concoran, President of AEDEC International, Inc.²¹⁷ The deposition was conducted as part of a civil lawsuit against Sacramento County, California, and its use of the restraint chair.

According to the deposition excerpt reprinted in the article, the only testing conducted on the restraint chair was done by Dan Concoran himself, who tested the chair on various friends while pulling the straps as hard as he could. It was his opinion the chair was less psychologically traumatizing than four-point restraints, being chained to a bench, or being strapped to a bed. However, that opinion was not based on any medical or psychological expert. While the manufacturer's "Statement of Purpose" said the chair was especially useful for restraining drug or alcohol-affected prisoners, a claim asserted in the "Manufacturer's Warning" during the Ombudsman's investigation of Scott County Jail, this conclusion was not based on scientific literature or on testing of individuals under the influence of alcohol, drugs, or narcotics.²¹⁸ The deposition also revealed no

²¹⁶ William P. Angrick II, Citizens' Aide/Ombudsman, INVESTIGATION OF SCOTT COUNTY JAIL'S USE OF FORCE 5 (2007), http://www4.legis.state.ia.us/caodocs/Invstgtv_Reports/2007/CIWPA010.PDF

²¹⁷ Anne-Marie Cusac, *The Devil's Chair*, THE PROGRESSIVE, April 1, 2000, available at http://www.progressive.org/mag_cusacchair.

²¹⁸ *Id.*

literature was relied on, and no studies or research were conducted, to determine the maximum amount of time a person could be restrained without causing injury.

2. Adverse Medical Effects of Restraint Use

In 2003 a psychiatric journal published a research article that analyzed the adverse effects of restraint use.²¹⁹ The research article included in its review of “restraints” the use of four- and five-point beds, restraint chairs, ambulatory restraints, and straight jackets.²²⁰ The article cited a report that reviewed 20 restraint-related deaths. It found 40 percent of the deaths were caused by asphyxiation. Asphyxiation can be caused by putting excessive weight on a patient’s back while in a prone (face down) position, placing a towel or sheet over the patient’s head to protect staff from spitting or biting, or obstructing the airway when pulling the patient’s arms across the neck area.²²¹

“Positional asphyxia,” where asphyxiation results when the body’s position interferes with respiration, had been found to occur when an individual is placed in a position that does not allow adequate breathing.²²² This was most often found when a person was placed in a prone position, including when law enforcement officers would transport individuals in this position. Included in the article was a study conducted on healthy adults to determine the physiological effects of restraint. The study found nine of ten healthy adults experienced prolonged recovery from exercise performed in the prone position, though the specific cause for the prolonged recovery was unknown.²²³

The National Institute of Corrections (NIC) provided an explanation of the mechanics of breathing and asphyxiation during a teleconference in 2000. During the process of breathing in, a person raises the ribs and contracts the diaphragm. When a person is in the prone position, the person has to lift the weight of his body to breath, and if the abdomen is compressed, the abdominal content is raised making it more difficult to contract. The presenter explained the typical reaction of the restrained person who is having difficulty breathing:

The natural reaction to that is to struggle more violently. The perception of those trying to subdue the individuals is that he needs more compression to be subdued. You then enter a vicious cycle in which compression makes air hunger, air hunger makes a greater struggle, and greater struggle demands

²¹⁹ Wanda K. Mohr et al, *Adverse Effects Associated with Physical Restraint*, 48 CAN. J. PSYCHIATRY 330 (2003).

²²⁰ *Id.* at 330, 331.

²²¹ *Id.* at 331, citing JOINT COMMISSION ON ACCREDITATION OF HEALTHCARE ORGANIZATIONS, *Preventing Restraint Deaths*, SENTINEL EVENT ALERT (Nov. 18, 1998).

²²² *Id.* at 332.

²²³ *Id.* at 331. The article states potential causes included “restriction of thoracic respiratory movements, airway compromise, and the release of catecholamines during physical exertion.” *Id.*

greater compression. Unfortunately, in some of these circumstances, the price of tranquility is death.²²⁴

The research article also noted restraint in a supine (face-up) position could predispose a patient to aspiration. Aspiration in this position can result when an individual has a decreased level of consciousness. Death can result from asphyxia, acute pulmonary edema, or pneumonitis.

While no literature was available on the subject when the research article was published, the authors reviewed blunt trauma to the chest (BTC) as another cause of sudden death.²²⁵ It is important to mention the article's review of BTC since a case reviewed by the Ombudsman, and included in this report, involved an officer striking an inmate in the chest while partially restrained in a restraint chair. BTC can lead to death as a result of *commotio cordis*.²²⁶ While this occurs most often in athletes, the article referenced a case where a child was struck in the chest during restraint, causing his death.²²⁷

Other adverse medical conditions discussed in the research article included catecholamine rush, rhabdomyolysis, and thrombosis – the latter condition arising when individuals are held immobile for long periods of time in the same position.²²⁸ Thrombosis, the formation of a blood clot in a blood vessel,²²⁹ led to the pulmonary embolism that killed a Utah state prison inmate mentioned earlier in this report who was held in a restraint chair for 16 hours.²³⁰ The article concludes that psychiatric literature has provided little information on the cause of death and injury due to physical restraints, and additional research is needed to provide additional data on the risk factor and adverse effects of restraint use.²³¹

3. Preferred Attributes of a Restraint Device

The Ombudsman reviewed several types of restraint devices used in Iowa jails. The primary differences in the types of restraint chairs are strap placement and how these straps restrain the inmate.

One type of restraint chair has two straps attached to the chair from the shoulders to the opposite waist areas, crossing the individual's torso. The exact place the straps cross the

²²⁴ Videotape: Application and Use of Restraints in Custody: Reducing the Risks (Nat'l Inst. of Corr. Teleconference, Apr. 19, 2000).

²²⁵ Mohr, *supra* note 220, at 332.

²²⁶ *Id.* The article defines *commotio cordis* as "a cardiac arrhythmia secondary to myocardial concussion during the vulnerable phase of cardiac electrical repolarization (just prior to T-wave peak) resulting from BTC." *Id.*

²²⁷ *Id.*

²²⁸ *Id.* at 332-33.

²²⁹ <http://www.medterms.com/script/main/art.asp?articlekey=25023> (last visited Oct. 30, 2008).

²³⁰ Sheila R. McCann, *Utah Settles Lawsuit Over Inmate's Death; State Settles Inmate-Death Suit For \$200,000*, SALT LAKE TRIBUNE (Utah), July 31, 1998, at A1.

²³¹ Mohr, *supra* note 220, at 335.

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torso depends on the height and size of the individual being placed in the restraint chair. The Ombudsman's concern arises from these straps and their potential for interfering with the mechanics of breathing. Asphyxiation may result if the straps are tightened to the point where the restrained person cannot fully raise the ribs and contract the diaphragm, simulating the complications that arise when a person is placed in a prone position. The Ombudsman must concede that this concern is not based on scientific research of this specific restraint device, but the lack of any scientific research conducted by the manufacturer is also the basis of the Ombudsman's concern.

The other type of restraint chair has straps that restrain the shoulders of the individual, going from a point above the shoulders to under the armpit. Though it has a strap for the waist, the device does not have straps crossing the individual's chest or torso that could restrict breathing.

The Ombudsman also has concerns about the restraint board. The restraint board reviewed by the Ombudsman shows the individual face-down on a piece of plywood. The restraint board is a ten-point restraint device, including an individual's ankles, thighs, wrists, upper-arms, waist, and head. The device used on the individual's head has one strap across the forehead and another close to the neck. The prone position used by the restraint board is the same prone position that creates the positional asphyxia risk. Further concerns arise regarding the restrictive head straps that force the individuals head to be turned perpendicular to the individual's shoulders, as well as the straps that cross the neck. The restraint board was found to be a contributing factor in a death of a Colorado inmate in 1998, though the medical condition caused by the board that purportedly contributed to his death is unknown.²³²

The Ombudsman does not endorse the use of any particular device or manufacturer, since many different devices exist on the market that restrain individuals in different ways. While not endorsing any specific device, the Ombudsman places emphasis on the construction of the device, taking into consideration adverse medical conditions that are more likely to arise in some devices than others. As mentioned above, the two restraint devices the Ombudsman has concerns about involve those that can restrict breathing. Though not reviewed in the cases addressed in this report, the Ombudsman has seen a variety of restraint beds and boards advertised on correctional websites that restrain an individual in the supine position.²³³ Problems can arise with inmates who are under the influence – as is common in inmates requiring restraint – if the inmate vomits but cannot clear the material due to their position. As mentioned in the psychiatric research article on the adverse effects of restraint use, above, aspiration in the supine position can also occur due to the individual's decreased level of consciousness.²³⁴

²³² Patricia Callahan, *Restraining Inmate 'Sadistic' ACLU Sues El Paso Sheriff*, DENVER POST, May 22, 1998 at B-07.

²³³ <http://www.pxdirect.com/restraints.htm> (last visited Oct. 30, 2008).

²³⁴ Mohr, *supra* note 220, at 332.

B. Standards for All Jails

1. New Detainee Intake Screening

Iowa law requires a medical history intake form be completed on each person admitted to the jail, which includes screening for potential self-injury or suicide.²³⁵ While no specific screen is required, an accurate medical and mental health screen can identify potential problems before they reach a crisis level. Identifying this potential problem may in turn reduce the need for physical restraint and risk of injury to either the inmate or jail staff. It can also protect a jail from potential federal or civil tort claims by inmates or a federal agency alleging a facility failed to recognize and treat a specific medical condition.²³⁶

The Ombudsman reviewed several intake forms used by Iowa jails and researched others that accurately identify potential mental health issues, including one endorsed by the National Institute of Corrections, Jail Division.²³⁷ The “Brief Jail Mental Health Screen” (BJMHS) was developed by researchers funded by the National Institute of Justice (NIJ), a research arm of the U.S. Department of Justice.²³⁸ The screen is an eight-question, “yes/no”-answer form that takes about two to three minute to complete.²³⁹ The screen is comprised of six questions inquiring about current mental health symptoms, and two questions about whether the inmate has ever taken medication or been hospitalized for emotional or mental health problems. If the inmate answers “yes” to two or more of the first six questions, or answers positively to either question seven or eight, the screening form recommends the jail refer the inmate for further mental health evaluation.

Based on the extensive research conducted using this test, and its endorsement by the National Institute of Justice, National Institute of Corrections, and the National GAINS Center, the Ombudsman believes Iowa jails would benefit by incorporating the test

²³⁵ IOWA ADMIN. CODE r. 201—50.15(6)(c) (2008).

²³⁶ The DOJ, Civil Rights Division has brought numerous claims against jails across the country under CRIPA. A list of settlements and court decisions involving jails and prisons can be found at <http://www.usdoj.gov/crt/split/findsettle.htm#Settlements>.

²³⁷ See *Appendix C* for a sample of the BJMHS. The National Institute of Corrections is an agency within the Department of Justice, Federal Bureau of Prisons. According to its website, the NIC provides training, technical assistance, information services, and policy/program development assistance to federal, state, and local corrections agencies. It also provides leadership to influence correctional policies, practices, and operations nationwide in areas of emerging interest and concern to correctional executives and practitioners as well as public policymakers. <http://www.nicic.org>.

²³⁸ JULIAN FORD ET AL., *MENTAL HEALTH SCREENS FOR CORRECTIONS* (2007). The Research for Practice discusses two research reports, (*Evidence-based Enhancement of the Detection, Prevention, and Treatment of Mental Illness in the Correction Systems* and *Validating a Brief Jail Mental Health Screen*), whose purpose was to create and validate a mental health instrument that corrections staff can use during intake. The reports developed the Correctional Mental Health Screen (CMHS) and the Brief Jail Mental Health Screen (BJMHS). The Research for Practice states the BJMHS takes less time to fill out and requires minimal training to administer. The researchers found both tests acceptable, compared to “longer, more cumbersome, and training-intensive tools currently used in clinical settings.” *Id.* at 10.

²³⁹ Henry J. Steadman et al., *Validation of the Brief Jail Mental Health Screen*, 56 *PSYCHIATRIC SERVICES* 816 (2005).

during the screening process.²⁴⁰ The test is free to download from a federal government website, and is found in the Appendix of this report.²⁴¹ The BJMHS, or other health-authority-approved mental health screen, should not replace other intake screening forms used to obtain non-mental health or current medication information from an inmate since the BJMHS does not screen for this information.

Ideally, intake screening is done by a licensed medical professional. However, budgetary constraints often limit a jail's ability to employ such individuals in this position. When such limitations are present, the Ombudsman shares the view of the APA and the NCCHC, which allows initial inmate screenings be performed by correctional staff as long as they are trained to identify potential medical and mental health issues in inmates.²⁴² Another reason the Ombudsman supports the incorporation of the BJMHS form is because, according to the NIJ's *Mental Health Screens for Corrections*, corrections classification officers, intake staff, or nursing staff can administer the BJMHS without specialized health training.²⁴³ The NIJ report states personnel can receive brief informal training before administration, relieving the need for the jail to cover extensive or specialized training in mental health for staff.

2. Assessment of Screened Inmates

It is imperative that inmates who screen positive for potential mental illness are assessed by a mental health professional. This was a critical failing the DOJ identified in its investigation of the Black Hawk County Jail. A review by a mental health professional can determine the detainee's mental health needs, whether those needs can be served by the jail, or if those needs can only be satisfied by an outside source, such as a mental health facility.

A mental health assessment is a follow-up process after the initial intake screen. It is required by the NCCHC and the ACA standards and is recommended in the DOJ Civil Rights Division's CRIPA investigations and other correctional and medical publications reviewed by the Ombudsman. Iowa law only requires a jail to have a written "plan" to provide prisoners access to services for the detection, diagnosis, and treatment of mental illness.²⁴⁴ However, it does not require a jail to take any action in the event an inmate responds he has a mental illness or may be suicidal.

Despite the absence of a state law requiring a jail to follow-up on an inmate's possible mental health condition, jails are required under the Eighth Amendment to seek treatment for an inmate's mental illness. Ignoring an inmate's mental health needs exposes a jail to the same liability as if it were to ignore an inmate's physical medical needs. Federal law,

²⁴⁰ <http://gainscenter.samhsa.gov/html/resources/MHscreen.asp> (last visited Oct. 30, 2008).

²⁴¹ <http://gainscenter.samhsa.gov/pdfs/disorders/bjmhsform.pdf> (last visited Oct. 30, 2008).

²⁴² STANDARDS FOR HEALTH SERVS. IN JAILS J-E-02, Discussion (Nat'l Comm'n on Corr. Health Care 2003).

²⁴³ FORD, *supra* note 239, at 2-3.

²⁴⁴ IOWA ADMIN CODE r. 201-50.15(6)(d) (2008).

under 42 U.S.C. § 1983, provides an avenue for pretrial detainees to file a legal action against jails for the deliberate indifference to their serious medical needs.²⁴⁵ This liability extends to an inmate's mental health care needs.²⁴⁶

The Ombudsman believes seeking treatment from a mental health professional for those inmates who screen positive for mental illness is a constitutional requirement under the Eighth Amendment. It is also consistent with standards and recommendations set forth by correctional organizations. Jails need to use the mental health professional with whom they currently contract or work with the county CPC on locating mental health professionals that can provide services to the jail.

3. Decision to Place Inmate in Restraint Device: When to Use

Restraint devices have been the subject of multiple litigations following inmate deaths and have cost jails and state governments millions of dollars in judgments and settlements, let alone the lives of the detainees placed in the chair. Despite disputes over the actual cause of an inmate's death and to what extent the restraint device's involvement played a role, lawsuits and settlements have led some law enforcement departments to abandon their use of the restraint devices in an effort to avoid liability.

This caveat should not be interpreted as a position against the use of restraint devices. Rather, it should be read that use of restraints must be accompanied by policies and procedures that are carefully written and closely followed to avoid restraint misuse and abuse by staff, which can lead to serious consequences for the correctional facility, staff, and the inmate. Litigation has led to the abandonment of specific restraint devices in some jurisdictions. However, the importance of having restraints available as an option in the correctional mental health setting was stressed in the American Psychiatric Association's Resource Document:

The efforts in recent years to minimize the use of seclusion and restraint of persons with mental illness have been a positive development. However, the nature of severe mental illness is such that seclusion and restraint cannot be eliminated as a necessary part of treatment and management. Therefore, it is crucial that there not be an expectation that seclusion and restraint be abolished in correctional mental health. Staff must feel that they are permitted to use seclusion and restraint when it is clinically necessary for the welfare and safety of the patient, other patients and the staff. . . . The

²⁴⁵ *Hartsfield v. Colburn*, 491 F.3d 394, 396 (8th Cir. 2007) ("[I]t is now settled 'that deliberate indifference is the appropriate standard of culpability for all claims that prison officials failed to provide pretrial detainees with adequate food, clothing, shelter, medical care, and reasonable safety.'" (quoting *Butler v. Fletcher*, 465 F.3d 340, 345 (8th Cir. 2006))).

²⁴⁶ *Vaughn v. Lacey*, 49 F.3d 1344 (8th Cir. 1995); *Smith v. Jenkins*, 919 F.2d 90 (8th Cir. 1990).

The Federal Bureau of Prisons' policy governing federal correctional institutions provides five situations when a prisoner may be placed in restraint, including when the inmate (1) assaults another individual, (2) destroys government property, (3) attempts suicide, (4) inflicts injury upon self, or (5) becomes violent or displays signs of imminent violence.²⁵³ The policy provides for the use of four-point restraints, but states the least restrictive restraint method must be used to control the inmate. Ambulatory restraints, which allow the inmate to eat, drink, and take care of basic human needs, should be initially used to restrain the inmate.²⁵⁴

Use of a less restrictive alternative is also implied by Iowa law. The Iowa Administrative Code states “[f]our/five-point restraints shall be used only when other types of restraints have proven ineffective.”²⁵⁵ The Ombudsman interprets this language to mean jails are obligated to consider or employ less restrictive restraints before restraint chairs, beds, and boards are used on an inmate. This may include placing an inmate in a strip cell, handcuffs, or ambulatory restraints as an initial step, and only use a restraint chair, bed, or board when the other restraints have proven ineffective. Further, the Ombudsman believes the decision to place an inmate in a chair, bed, or board should document how the less restrictive restraints failed to properly control the inmate.

4. Continuous Monitoring, 15-Minute Checks, and Periodic Reviews

Continuous monitoring of the inmate placed in a restraint chair, board, or bed is essential and required under Iowa law.²⁵⁶ Monitoring may be done either in-person or via CCTV. In several cases reviewed by the Ombudsman, monitoring was not apparent, and in at least one case, did not occur at all. Situations leading to injury or death, such as a restraint chair tipping over, an inmate choking on vomit, or an inmate suffering from excited delirium, can occur within minutes.

If video monitoring is going to be used in place of in-person monitoring, the video should be able to view the inmate's body and face. Federal regulations on the use of restraints and seclusion of hospital patients require video and audio monitoring to be in close proximity to the patient.²⁵⁷ The rationale for this requirement is to ensure staff can immediately intervene to meet the patient's needs.²⁵⁸ Preferably, the CCTV camera would be located in the room where the inmate is held in the restraint device. This would allow the staff member monitoring the video to be alerted if the inmate begins to have an obvious physical emergency, such as gagging, seizing, or becomes limp and

²⁵³ FEDERAL BUREAU OF PRISONS, PROGRAM STATEMENT P5566.06(1) (2005), http://www.bop.gov/policy/progstat/5566_06.pdf.

²⁵⁴ PROGRAM STATEMENT P5566.06(9).

²⁵⁵ IOWA ADMIN. CODE r. 201—50.13(2)(f)(2008).

²⁵⁶ *Id.*

²⁵⁷ Condition of Participation: Patients Rights, 42 C.F.R. §482.13(e)(15)(ii) (2007).

²⁵⁸ Medicare and Medicaid Programs; Hospital Conditions of Participation: Patients' Rights, 71 Fed. Reg. 71,378, 71,415 (Dec. 8, 2006) (to be codified at 42 C.F.R. pt. 482).

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unresponsive. An unacceptable camera angle would include viewing the back of a restraint chair that prevents viewing the inmate's face and extremities, viewing from a distance where a monitoring staff member would not be able to observe the details of the face and extremities, or viewing into a dark room. The Ombudsman has reviewed video where each of these elements were present.

The Ombudsman reviewed the Federal Bureau of Prisons' policy on inmate checks, which states "[s]taff shall check the inmate at least every fifteen minutes, both to ensure that the restraints are not hampering circulation and for the general welfare of the inmate."²⁵⁹ Requiring staff to ensure the restraints are not hampering circulation and checking the general welfare of the inmate would imply more is expected than only making sure the inmate is "alive and breathing."

Iowa law requires personal visual observation of the inmate and the restraint device application be made at least every 15 minutes. While the law is vague on what "personal visual observation" requires, the Ombudsman believes logic dictates that jail staff must check the well-being of the inmate. This would include checking whether the application of the restraint device is causing adverse medical conditions, such as cutting off circulation or restricting breathing. Such checks would require up-close, face-to-face observation of the inmate and each point of the restraint device's use on each extremity.

This interpretation seems consistent with statements provided by Linn County Sheriff Don Zeller during an Administrative Rules Review Committee hearing on April 4, 2008. Sheriff Zeller, as co-chair of the Iowa State Sheriffs and Deputies Association's Jail Committee, gave testimony to the legislative committee regarding proposed changes to the administrative rules governing jail operations. Regarding the 15-minute checks, the following exchange occurred:

Representative Dave Heaton: "I see that then when you talk about camera surveillance, you go on to say every 15-minutes that person has to be observed physically, I mean, face-to-face observation by personnel in the jail. Is that correct?"

Sheriff Don Zeller: "Let me give you an example. In Linn County Jail, before anybody would be placed in these types of restraints, that has to be approved by the shift supervisor who was on duty there. And, fortunately in our case we have nursing personnel on duty probably about 16-18 hours a day out of 24 hours a day. So not only is there things you talk about on camera, but exactly what you said, the physical – actually going in to look at the individual and checking the

²⁵⁹ PROGRAM STATEMENT P5566.06(10)(d).

restraints that are placed on there which are the hook and fastener type apparatus that helps restrain the person.”²⁶⁰

Sheriff Zeller’s testimony to the committee seems consistent with the Iowa Administrative Code requiring 15-minute visual checks of the prisoner *and the restraint device application*, as opposed to only reviewing whether the inmate is alive and breathing.²⁶¹ The Ombudsman believes blood circulation checks of the inmate accompanying the visual checks every 15 minutes are consistent with Iowa law requirements. While these checks would be best handled by medical personnel, budgetary constraints may demand such checks be done by correctional staff.

Though jails may only restrain an inmate for the amount of time it takes to alleviate the condition causing the restraint, Iowa law does not provide for periodic reviews of inmates after placement to determine if the inmate can be released.²⁶² The Ombudsman has reviewed several cases where periodic reviews were not done – or were not properly documented if they were done – though the inmate was left in the restraint device for several hours. When a jail is not able to provide documentation the inmate needed to remain in the device, it raises the question whether the restraint device was used for an excessive amount of time. If this is the case, the jail would violate Iowa law and the inmate’s constitutional rights against using the restraint as punishment. Failing to provide evidence showing the continued need for restraint use has led to adverse court judgments against jails.²⁶³

The Federal Bureau of Prisons requires a review every two hours for inmates placed in four-point restraints. “The goal of the two-hour reviews is to determine, as soon as possible, that the inmate has regained self-control and may be placed in lesser restraints.”²⁶⁴ In addition, removal of the restraints must be considered when the inmate is temporarily released from the four-point restraints for any reason and the inmate does not display any disruptive or aggressive behavior.²⁶⁵

Periodic reviews of the inmate are required to determine if the need for the restraint is necessary. The review should determine if the inmate is still a threat to themselves, others, or property. Verbal abuse from an inmate alone is not sufficient reason to place

²⁶⁰ Proposed Amendments to Ch. 50 Update Jail Inspection Standards: Hearing on ARC 6641B Before the Admin. Rules Review Comm., 2008 Leg., 82nd Gen. Assem., 2nd Sess. (Iowa 2008) (Statements of Rep. Dave Heaton, Member, Admin. Rules Review Comm. and Don Zeller, Linn County Sheriff). Under Iowa Code § 356.36, the Iowa Department of Corrections must consult with the Iowa State Sheriff’s Association when drawing up minimum standards for jails.

²⁶¹ IOWA ADMIN. CODE r. 201—50.13(2)(f)(2) (2008).

²⁶² IOWA ADMIN. CODE r. 201—50.13(2)(f) (2008).

²⁶³ See *Ogden v. Johnson*, No. C00-0034, WL 32172301 (N.D. Iowa Sept. 5, 2002); *Rogers v. Dunn*, No. C00-0188-PAZ, 2001 U.S. Dist. LEXIS 22710 (N.D. Iowa Nov. 27, 2001); *Sadler v. Young*, 325 F.Supp.2d 689, 704 (W.D. Va. 2004).

²⁶⁴ FEDERAL BUREAU OF PRISONS, PROGRAM STATEMENT P5566.06(10)(e) (2005).

²⁶⁵ *Id.*

an inmate in a restraint device and not sufficient reason for its continued use. Periodic reviews of an inmate should be included in any policy and practice on restraint chair use.

5. Medical Reviews During Restraint Device Use

Iowa law does not require medical reviews of inmates placed in a restraint device, either during or after its use. The ACA Standards require the health authority be notified to assess the inmate's medical and mental health condition.²⁶⁶ The NCCHC requires health services staff be notified immediately to review the inmate's health record and initiate health monitoring.²⁶⁷ The Federal Bureau of Prisons' policy requires qualified health personnel to initially assess the inmate when the inmate is placed in four-point restraints.²⁶⁸

A restraint device can be an effective temporary tool for dealing with violent inmates, regardless of the underlying cause of their behavior. However, it must be emphasized a restraint device, whether a chair, board, or bed, is to be used as a temporary means of preventing the inmate from harming him/herself or others, or from creating a security threat to the jail. This restricted use is recognized by at least one manufacturer of a restraint device commonly used in Iowa jails. The five cases reviewed in this report used a restraint chair manufactured by E.R.C. Inc. The company's instruction manual, which a purchaser receives with the chair, provides two warnings on the possible cause of an inmate's aggressive behavior and the need for medical review of the chair's use.²⁶⁹ After the last instructional "step," the manual reads:

Caution, violent behavior may mask dangerous medical conditions.

Detainees must be monitored continuously and provided medical treatment if needed.²⁷⁰ (emphasis found in original).

On the last page of the instruction manual under "Caution," it states:

Detainees should not be left in the Emergency Restraint Chair for more than two hours.

This time limit was established to allow for the detainee to calm down or sober up, and if needed it allows for the correctional office to seek medical or psychological help for the detainee. This two-hour time

²⁶⁶ PERFORMANCE-BASED STANDARDS FOR ADULT LOCAL DET. FACILITIES 4-ADLF-2B-03 (Am. Corr. Ass'n, 4th ed. 2004).

²⁶⁷ STANDARDS FOR HEALTH SERVS. IN JAILS, J-I-01, Compliance Indicators (Nat'l Comm'n on Corr. Health Care 2003).

²⁶⁸ FEDERAL BUREAU OF PRISONS, PROGRAM STATEMENT P5566.06(10)(f).

²⁶⁹ The Ombudsman reviewed two written policy manuals from E.R.C. Inc. The language relies on the most recent published manual.

²⁷⁰ E.R.C. Inc., EMERGENCY RESTRAINT CHAIR INSTRUCTIONS 11 (Feb. 10, 2001).

limit may be extended, but only under **direct** medical supervision (Doctor/Nurse).²⁷¹ (emphasis found in original).

The E.R.C. Inc.'s instructional video also mentions the need for medical supervision three times in the first two minutes of the video, ("This chair is designed to restrain people comfortably so you can keep them under control and get them medical attention if they need it."), and again as a caution at the end:

At this point they need to be monitored continuously in the event they would have a medical problem. Obviously if the person is out of control, they might have taken an overdose of alcohol or drugs. They might be, with this overdose, having heart trouble. They may have been maced during the arrest process and if so you need to get them medical treatment.²⁷²

In a letter to its customers, dated January 17, 2001, E.R.C. Inc. acknowledged that some of its customers keep detainees in the chair longer than the company intended, and stressed its customer should follow the following guideline:

We recommend that detainees not remain in the Emergency Restraint Chair for more than two hours at a time. This time limit was established to allow for the detainee to calm down or sober up, **and if needed it allows for the correctional officer to seek medical or psychological (sic) help** for the detainee. This two hour time limit may be extended but only under direct MEDICAL SUPERVISION (Doctors\Nurses) while performing range of motion exercises.²⁷³ (bold emphasis added).

Tom Hogan, President of E.R.C. Inc. and former Sheriff of Crawford County, Iowa, provided insight during a media interview behind the policy of the restraint chair he designs, manufactures, and markets. In response to a news report that his chair was being used to forcibly feed inmates in Guantanamo Bay, Cuba, Mr. Hogan stated, "[t]he reason we want them comfortable is because a lot of people who are violent or acting out are not doing it because of something they've done. They have a medical problem, they need to get medical help, but they need to be restrained while that happens."²⁷⁴ Mr. Hogan repeated these sentiments during an interview with the Ombudsman, when he stated the initial two hours should be used to determine if the inmate's behavior is caused by a medical or mental health condition, and to obtain medical services to review the inmate.²⁷⁵

²⁷¹ *Id.* at 12.

²⁷² Videotape: Emergency Restraint Chair Instructions (E.R.C., Inc.).

²⁷³ Letter from Thomas Hogan, President, E.R.C. Inc., to Customer (Jan. 17, 2001).

²⁷⁴ Carol Kloss, *Sheriff Designed Chair Now Reportedly Used on Gitmo Inmates*, KETV (Omaha, Neb.), Feb. 12, 2006, available at <http://www.ketv.com/news/6986646/detail.html>

²⁷⁵ Telephone Interview with Tom Hogan, President, Emergency Restraint Chair, Inc. (June 11, 2008).

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Absent a provision that is contrary to state or federal law, it is important a jail facility follows the guidelines provided by the manufacturer. Dr. Robert D. Jones, the Medical and Mental Health Director for the Montana Department of Corrections, stressed the need to follow a restraint device manufacturer's guidelines:

It's very important that the staff understand how to apply the devices. But also, I think they should be trained with guidelines from the manufacturer. [Correctional staff] really can be ingenious, but unfortunately that ingenuity can lead to modifications which can be deadly. So, I think it is very, very important that the restraint device, whatever it is, is used as recommended by the manufacturer and that there is training.²⁷⁶

The Ombudsman believes failing to follow a manufacturer's recommended use can create liability for the jail as well. With the absence of a comprehensive state or federal law on restraint device use, a court could use manufacturer guidelines to determine if a jail's actions were reasonable in the event an inmate is injured. As discussed earlier in this report regarding Maricopa County, Arizona, damages from restraint chair injuries can range up to the tens of millions of dollars.

As part of an NIC teleconference, Michael Thurber, Corrections Director for Lancaster County, Nebraska, addressed the liability concern as it relates to medical staff being involved with restraint use. Along with close observation, "the medical protocol from nurses or physician assistants that might be on duty, EMTs, to be able to help provide the medical need for that person, you're going to reduce the liability as much as you can."²⁷⁷ Dr. Robert D. Jones stated during this teleconference:

In situations where there's time and there is a planned event, I think it behooves the medical staff to pull the medical records to review the individual's medical history; to look for medication, to anticipate some of the problems that are there.²⁷⁸

The NIC teleconference provided a "Medical Action Plan" detailing the role of medical staff in the correctional setting. Medical staff involved in the use of restraints need to:

- Participate in the review of use of force,
- Be prepared,
- Know the risks involved, and
- Expect the unexpected.²⁷⁹

²⁷⁶ Videotape: Application and Use of Restraints in Custody: Reducing the Risks (Nat'l Inst. of Corr. Teleconference, Apr. 19, 2000) (on file with author).

²⁷⁷ *Id.*

²⁷⁸ *Id.*

²⁷⁹ *Id.*

Regardless of jail size or financial constraints, the Ombudsman believes a jail should follow the recommended standard set forth by several accrediting institutions reviewed in this report to notify a health authority of the inmate's placement in a restraint device. Further, jails should follow the manufacturer's instructions to seek *direct* medical supervision from a doctor or nurse – or other appropriate licensed medical professional – whenever it uses the restraint chair for extended periods of time lasting over two hours.

The question remains on what is required for “direct medical supervision.” A medical staff member would need to take vital signs of the inmate, indicating that the supervision and monitoring needs to be done in-person. The Ombudsman has considered the use of telemedicine, but does not believe that would be practical in the event medical personnel needs to conduct physical tests on the inmate. The Ombudsman believes reviews may be conducted by a doctor, nurse, physician's assistant, or other appropriate licensed medical professional.

6. Consultation with A Mental Health Professional

The state of Iowa has faced a dearth of psychiatric personnel, including psychiatrists, psychologists, and psychiatric nurses and counselors. This can compound the effects on an inmate and jail staff when an inmate has a possible psychotic episode, and a jail does not have the medical or mental health expertise to respond to the inmate's specific needs. However, an inmate's mental health needs cannot be ignored, and the potential adverse effects of placing an inmate with a mental illness in a restraint device carries a greater risk of physical and psychological repercussions than an inmate with no mental illness. This is in large part due to the amount of time an inmate with a mental illness spends in the restraint device compared to other inmates.

The Ombudsman heard repeatedly from corrections personnel that inmates will typically need to be restrained for between 45 minutes to 1½ hours. However, the restraint device cases reviewed in this report include incidents lasting 6, 7, 10, 11, and 12 hours. In each of the extensive use cases, the inmate had a history of mental illness. In some cases, the jail had no specific documentation or knowledge of the inmate's mental illness, nor are most correctional officers licensed to identify a specific mental illness.

A licensed mental health professional is able to identify the signs and symptoms of a mental illness, the needs of an inmate with the mental illness, and whether the jail facility can accommodate those needs. While recognizing the need for a mental health professional's services, actually contracting with such a person raises further problems, such as who qualifies as a “mental health professional,” when should the jail contact a mental health professional, and how would a jail obtain those services.

The Ombudsman borrows the definition of “mental health professional” from the NCCHC, which includes psychiatrists, psychologists, psychiatric social workers, psychiatric nurses, “and others who by virtue of their education, credentials, and experience are permitted by law to evaluate and care for the mental health needs of

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patients.”²⁸⁰ If the jail does not currently have a contact for mental health services, it should work with the county Central Point of Coordination (CPC) in its jurisdiction to locate potential sources that can offer such services, which may require looking outside the county.

The second issue relates to when a jail should contact a mental health professional. The Ombudsman believes any time an inmate who needs to be placed in restraints has a suspected or known mental illness, jail staff should contact a mental health professional. Staff’s awareness of a known or suspected mental illness can arise from the intake screening form, subsequent statements from the inmate regarding mental health history, and observations of the inmate that shows signs of mental illness. This identification would not require staff to diagnose a specific mental illness.

Staff may also suspect a mental illness, where other signs do not exist, in the event an inmate needs to be held in a restraint device for excessive periods of time. According to *Management and Supervision of Jail Inmates with Mental Disorders*, mental health examinations should be required for any inmate remaining in restraints longer than a few hours. “If in that time the inmate has not calmed down enough to be released to a normal cell situation, questions may arise as to whether mental illness lies at the root of the inmate’s continuing recalcitrant behavior.”²⁸¹ Consistent with this assertion, the Ombudsman believes the cases reviewed in this report that required restraints for six or more hours should have triggered concerns about the mental health of the inmate in restraints.

The third issue involves the manner of services the mental health professional must provide for an inmate placed in restraints. Unlike a medical staff member, the Ombudsman does not believe the mental health professional needs to provide in-person physical examination of the inmate. Such reviews of the inmate can be done remotely. The Ombudsman spoke to Christine Krause, Director of Behavioral Health Services at

²⁸⁰ STANDARDS FOR HEALTH SERVS. IN JAILS J-E-05, Definitions (Nat’l Comm’n on Corr. Health Care 2003). The Settlement Agreement entered into by Shelby County, Tennessee, as a result of a CRIPA investigation provided definitions for medical and mental health personnel. It defined a “Qualified Mental Health Professional” as a) an individual with a minimum of masters-level education and training in psychiatry, psychology, counseling, social work or psychiatric nursing licensed in the state to deliver those services, or b) a registered nurse with a bachelor’s degree in nursing with a minimum of two years psychiatric experience, or a registered nurse with a minimum of five years psychiatric experience. Settlement Agreement Between the United States and Shelby County, Tennessee (Aug. 15, 2002), available at http://www.usdoj.gov/crt/split/documents/shelby_settleagmt.htm. A mental health professional must be consulted before any non-routine use of restraints on an inmate with a diagnosis of mental illness.

The Settlement Agreement defined “Mental Health Staff,” who must authorize and supervise use of the restraint chair involving inmates with mental illnesses, as “individuals with a minimum of a bachelor’s degree and two years of experience providing mental health services.” *Id.*

²⁸¹ MARIN DRAPKIN ET AL., *MANAGEMENT AND SUPERVISION OF JAIL INMATES WITH MENTAL DISORDERS* 2-38 (2003). According to the publication, author Marin Drapkin has been involved with jail issues and jail officer training for 23 years. He is also the director of the Jail division of the Gallagher-Westfall Group, Inc., a private consulting group specializing in liability risk management for law enforcement agencies.

Mary Greeley Hospital in Ames, Iowa, who said her department relies on telemedicine technology that allows a psychiatrist 60 miles away to evaluate a patient at the hospital.²⁸² She quoted her cost to install the telemedicine equipment at between \$500 to \$750.

7. Written and Video Documentation

Iowa law directs that “[a]ll decisions and actions shall be documented” when a jail inmate is placed in four- and five-point restraints.²⁸³ This would include jail staff decisions to initially place an inmate in such restraints, observations by medical personnel, observations from the mandatory 15-minute checks, and decisions whether to release the inmate or continue the restraint use based on the inmate’s behavior and actions. The documentation should contain sufficient information to inform a supervisor or other reviewer what the staff member observed and the basis for any decisions made regarding restraint use.

While not required under Iowa law, many county jails videotape use of force incidents, including restraint device placement and use. However, this was not done in each case reviewed by the Ombudsman, and one jail stated it recorded over the video documenting the restraint chair before it knew of the Ombudsman’s interest in the incident. The Federal Bureau of Prisons requires video documentation of each use of force incident, including the use of a restraint device, which is reviewed by the warden and the regional director.²⁸⁴ Similarly, Iowa Department of Corrections requires audio-visual recording of all facets of the use of force incident and the recording must be clearly marked and stored as evidence.²⁸⁵

The issue of videotaping use of force incidents was addressed during the NIC teleconference on reducing the risks of restraint application and use. The teleconference provided a compelling rationale for videotaping which included administrative review and liability reasons. The following is an excerpt from the teleconference, presented by Larry Fischer, Jail Administrator at Binghamton, N.Y.:

Videotaping demonstrates a good faith interest on the part of the agency or organization, especially in the event of a planned force situation. You’re documenting the restraint. You’re documenting the position of the individual both before and during the time they’re being restrained and subsequently. You’re documenting the actions you have taken to prevent further injury to that individual.

²⁸² Telephone interview with Christine Krause, Dir. of Behavioral Health Servs., Mary Greeley Med. Clinic, (Apr. 18, 2008).

²⁸³ IOWA ADMIN. CODE r. 201—50.13(2)(f)(4) (2008).

²⁸⁴ FEDERAL BUREAU OF PRISONS, PROGRAM STATEMENT P5566.06(14)(c) (2005).

²⁸⁵ STATE OF IOWA DEP’T. OF CORR. POLICY AND PROCEDURES IO-SC-08(IV)(E) (2008).

Videotaping is also a useful tool for review, that you can look back through the history of your organization, history of incidents in the organization, and see that you have consistently managed the restraint issue properly. That you're consistently managed the planned uses of force properly. You can also highlight areas of training that you need additional scope or that you need additional concentration on.

Our experience has been that the videotaping of uses of force reduce lawsuits from the inmates. It is very, very hard for an inmate to claim they were beaten when the videotape clearly shows that they were not.²⁸⁶

Videotaping use of force incidents should document all circumstances demanding restraint device use. This includes initial placement, duration of use, and removal of the inmate. Such documentation allows for jail supervisors to review the procedures used by staff to place, monitor, and release the inmate and review any missed procedures with staff. Close video monitoring allows staff who are not utilizing direct continuous monitoring to view the inmate from a remote location, and respond immediately if the inmate shows signs of an emergency or injury.²⁸⁷ Most importantly for the jail, video monitoring and documentation can rebut accusations of physical abuse or procedural misconduct raised by an inmate, and may provide evidence the restraint was required due to the inmate's behavior.

The Ombudsman believes Iowa jails should retain copies of each restraint device use videos for at least two years, which is the statute of limitations for tort actions in Iowa.²⁸⁸

8. Time Limits

The Ombudsman has considered what, if any, time limits should be imposed on restraint device use. State and federal courts have refused to designate specific time limits, and Iowa law states only, "[t]he inmate will be restrained only for the amount of time it takes

²⁸⁶ Videotape: Application and Use of Restraints in Custody: Reducing the Risks (Nat'l Inst. of Corr. Teleconference, Apr. 19, 2000).

²⁸⁷ "Many systems require that a cell extraction leading to restraint, as well as the actual application, be videotaped. Such videos (and I have seen hundreds) are invaluable monitoring and training resources." Cohen, *supra*, note 250, at 307.

²⁸⁸ There seems to be some dispute whether a state's statute of limitations applies to § 1983 federal actions, or whether a four-year statute of limitations applies as a result of Congress passing 28 U.S.C. § 1658. Prior to § 1658 being passed in 1991, the U.S. Supreme Court held a state's statute of limitations for torts applied to § 1983 actions since the original 1871 federal law did not provide its own statute of limitation. *Wilson v. Garcia*, 471 U.S. 261, 275-76 (1985). The Eighth Circuit Court of Appeals previously held Iowa's two year statute of limitations for torts applies for § 1983 actions arising in Iowa. *Wycoff v. Menke*, 773 F.2d 983, 984 (8th Cir. 1985). However, an Iowa federal district court case pointed out the Eighth Circuit has not reviewed this issue since Congress passed § 1685, and the issue may still be unsettled. *Williams v. Hawkeye Comm. Coll.*, 494 F.Supp.2d 1032, 1039 (N.D. Iowa 2007).

to alleviate the condition causing the restraint.”²⁸⁹ The Ombudsman also could not locate any guidelines on time limits in correctional guidelines or medical and mental health treatises. The only source for time limits the Ombudsman could locate was E.R.C. Inc.’s policy instructing restraint chair use no longer than ten hours total, though this does not appear to be based on any medical or scientific research. As such, the Ombudsman declines to recommend any finite or static time limit on restraint chair use. Time limits must be determined on a case-by-case basis using the inmate’s immediate threat to self or others as the determining factor. This is a process required by Iowa law and enforced by federal case law within and outside of Iowa. As mentioned in a previous section dealing with periodic reviews, this report reviewed several federal court cases that have held an inmate’s continued restraint must be accompanied by evidence the inmate continued to be a threat to himself or others and provide documentation of reviews and evaluations.²⁹⁰

With no set time limits, the Ombudsman places greater emphasis on the need to have timely medical and mental health reviews of inmates placed in restraints. It is important to have at least direct, in-person medical reviews of inmates placed in a restraint chair and held longer than two hours, and repeat the in-person medical review every two hours thereafter. Extended periods of restraint device use can lead to circumstances similar to those that arose in the Utah prison, where an inmate died from blood clots after a prolonged stay in the restraint chair. That inmate was restrained for 16 hours. Several detainees who contacted the Ombudsman were kept in restraint chairs for at least ten hours with no in-person physical assessment of the inmate.

²⁸⁹ IOWA ADMIN. CODE r. 321—50.13(2)(f) (2008).

²⁹⁰ *Ogden v. Johnson*, No. C00-0034, WL 32172301 (N.D. Iowa Sept. 5, 2002); *Rogers v. Dunn*, No. C00-0188-PAZ, 2001 U.S. Dist. LEXIS 22710 (N.D. Iowa Nov. 27, 2001); *Sadler v. Young*, 325 F.Supp.2d 689, 704 (W.D. Va. 2004).

General Recommendations for Jails

The Ombudsman makes the following recommendations regarding inmate screening and restraint device use for all jail facilities:

- 1. A jail should incorporate a health-authority-approved mental health screen to be used on all newly admitted inmates soon after entering the jail. A screen should possess the following qualities:**
 - The screen has been vetted and approved by a mental health organization for its accuracy in identifying mental health conditions;**
 - The screen is brief and easy to administer;**
 - Limited training is needed for a screening officer to use the form;**
 - The screen notifies an officer when to refer an inmate for further mental health assessment based on the responses of the inmate.**
- 2. Inmates who screen positive for a mental illness must receive further assessment by a mental health professional. Assessments for referred inmates may require a jail to enter a formal relationship with a mental health professional who can become knowledgeable of the jail's services and limitations, and can accurately determine if the inmate needs to be transferred to another facility.**
- 3. Restraint devices must only be used when an inmate is an imminent risk to the inmate's self or others, or is jeopardizing jail security. Verbal abuse alone is not sufficient reason to place an inmate in a restraint device. Use of a restraint device should cease immediately when the condition causing the need for the restraint is no longer present. Jail policy should detail the conditions when an inmate may be restrained and when an inmate should be released.**
- 4. When the circumstances allow for it, jail staff must consider using less restrictive alternatives to restraint devices, which ensures the safety of the inmate and others. When a less restrictive alternative is not used, jail policy should require staff to report what alternatives were considered and the reason for not employing them.**
- 5. When a jail uses video for continuous monitoring, the video must provide a clear and accurate view of the inmate's body, including torso, extremities, and face. Staff must be able to identify emergency conditions on the video immediately when they arise.**
- 6. Personal, visual observation of the inmate and the restraint application every 15 minutes is required under Iowa law. This should include checking the inmate up-close and face-to-face for adverse medical conditions.**

- 7. Jails should conduct periodic reviews of the inmate for the purpose of determining whether the inmate can be released from the restraint device. After each review, staff should document whether the inmate was released and if not, the reason for keeping the inmate in the restraint device. Periodic reviews should be conducted at least every hour.**
- 8. A jail's restraint chair policy should, as a minimum standard, incorporate the recommended procedures for use found in the manufacturer's instruction manual. That policy should also include recommended medical reviews of the inmate placed in the restraint device.**
- 9. Absent specific manufacturer recommendations, a jail should incorporate medical review procedures in its policy that require direct, in-person medical reviews of a restrained inmate by a physician, nurse, physician's assistant, nurse practitioner, or other appropriate licensed medical professional.**
- 10. The person conducting the medical reviews should be a medical professional who is employed or contracted by the jail for the purpose of conducting medical reviews and assessments of the inmates. Medical reviews of an inmate should not be conducted by a person employed as an officer or administrator of the jail, even if the officer or administrator is a licensed medical professional.**
- 11. A jail should incorporate in its policy a requirement to contact a mental health professional whenever an inmate with a known or suspected mental health condition is placed in a restraint device. In the event any inmate is required to be held for longer than a few hours, a mental health professional should be contacted. To accommodate facilities that may not have a mental health professional in their immediate area, mental health reviews of an inmate may be conducted by telemedicine, enabling the mental health professional to view and talk to the inmate through video from an off-grounds location.**
- 12. Jail staff must document all decisions and actions when an inmate is placed in four- and five-point restraints. This includes the reason the inmate was placed in restraints, who ordered the inmate to be placed in the restraints, observations during 15-minute checks, observations of medical reviews conducted on the inmate, and the decision to release the inmate or keep the inmate in restraints after periodic reviews. Such documentation should be as detailed as possible.**
- 13. All facets of restraint device use should be videotaped, including placement, duration of use, and release. Jails should retain video copies of restraint device use for a period of at least two years.**

Jefferson County Jail – Findings, Conclusions, and Recommendations

A. Findings of Fact

Sheriff Jerry R. Droz and Jail Administrator Mike Simons operate the Jefferson County Jail. It is a 32-bed jail, housing an average of 20 inmates daily. The jail purchased the Emergency Restraint Chair in December 1996 from E.R.C. Inc., an Iowa company based in Denison.²⁹¹ The jail operates from one of the more detailed written policies on the maintenance and use of the restraint chair reviewed by the Ombudsman. Gordan Plepla, a jail consultant with whom the jail contracted for services, drafted the restraint chair policy. It is not known by Administrator Simons what sources the drafter relied on for the restraint chair policy language or whether he consulted with any medical or mental health professionals.²⁹²

According to Administrator Simons, the restraint chair is rarely used by the jail. However, during 2007, the jail used the restraint chair on five separate occasions on inmate T.H.²⁹³ T.H. was housed at the jail for pending criminal charges that arose from a bank robbery. He was first placed in the restraint chair approximately two months after his admittance to the jail when he took aggressive actions against jail staff and became a threat to himself or others, though he had been argumentative with staff since his arrival. The Ombudsman requested and received the security tapes relating to T.H.'s behavior prior to his placement in the restraint chair and his conduct while in the chair. The Ombudsman also reviewed the jail's medical sheets on T.H., incident reports, and facility logs for each occasion the restraint chair was used in April 2007.

1. Intake Screening and Medication

T.H. stated in his initial contact with this office that he suffered from bipolar disorder. During early conversations with Sheriff Droz and Administrator Simons, these officials indicated to the Ombudsman they were aware of some mental health issues with T.H., based on their extensive history dealing with him, but did not know his specific diagnosis or what treatment he was receiving. Intake screening forms also show T.H. reported he was under a doctor's care for mental health issues. Sheriff Droz told the Ombudsman it was his experience dealing with T.H. that when T.H. was on medication, he was very easy to deal with and talk to, but when he was off medication he turned into a different person.

While at the jail, T.H. was listed as receiving five different medications. After reviewing T.H.'s medical sheets, the Ombudsman noted a pattern of T.H. refusing to accept a medication called carbamazepine, which the jail's medical log noted as being for

²⁹¹ The President of E.R.C. Inc. is Tom Hogan, Sheriff of Crawford County, Iowa.

²⁹² Mr. Plepla drafted Jefferson County Jail's policy from his out-of-state based consulting firm and has since retired from jail consultation.

²⁹³ For purposes of this report, the Ombudsman is reviewing placement in the restraint chair on the four occasions before our office was contacted by T.H.

“seizures.” Based on his own research, the Ombudsman learned this drug had a lesser-known role of acting as a mood stabilizer for the purpose of treating bipolar disorder.

When asked about the purpose of the medication, Administrator Simons did not know who prescribed it or whether its intended purpose was for seizure control or for mental health issues. Citing Sheriff Droz’s experience with T.H. as being difficult when off his medication, coupled with T.H.’s refusal to take carbamazepine in the days and weeks leading up to his placement in the restraint chair, the Ombudsman requested that Administrator Simons find out who prescribed the medications and why. The Ombudsman expressed his concern about the different reaction the jail could expect when T.H. refused to take his medication. He could either be expected to suffer a physical seizure or a psychotic episode.

The jail located the prescribing doctor at University of Iowa Hospitals and Clinics (UIHC), and with help from the Ombudsman, was able to obtain a medication report from the hospital.²⁹⁴ The medication report stated T.H. has “a history of bipolar disorder, antisocial and paranoid personality disorder.” T.H. was prescribed the carbamazepine and Haldol for these disorders. The Ombudsman also learned T.H. had been hospitalized at UIHC for three weeks in December 2006 for a manic episode, two months prior to his arrest in February 2007.

According to a National Institute of Mental Health article published in the periodical *Mental Health News*, “bipolar disorder” is a brain disorder that causes unusual shifts in a person’s mood, energy, and ability to function.²⁹⁵ Approximately 5.7 million Americans 18 and older have bipolar disorder. It causes dramatic mood swings – from overly “high” and/or irritable to sad and hopeless. The periods of highs and lows are referred to as episodes of mania and depression. The signs and symptoms of mania (or a manic episode) include:

- increased energy, activity, and restlessness;
- excessively high, overly good, euphoric mood;
- extreme irritability, racing thoughts and talking very fast, jumping on one idea to another;
- little sleep needed;
- unrealistic beliefs in one’s abilities and powers;
- poor judgment;

²⁹⁴ Administrator Simons reported the UIHC refused to provide the records due to HIPAA concerns. The Ombudsman contacted the hospital’s legal counsel, who identified a statutory provision allowing permitted disclosures from a covered entity to a correctional institution that has lawful custody of an individual and that institution represents the information is needed for the health care of the individual. Public Welfare & Human Services, 45 C.F.R. §164.512(k)(5)(2007).

²⁹⁵ The National Institute of Mental Health, *Understanding and Treating Bipolar Disorder*, MENTAL HEALTH NEWS, Fall 2007, at 1.

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- provocative, intrusive, or aggressive behavior, and denial that anything is wrong.²⁹⁶

According to an article by Dr. Richard H. McCarthy, mania causes highs of elevated energy mood and extreme pleasure seeking. This stands in sharp contrast to the lows and misery of depression and its complete lack of energy, which is part of the cycle with bipolar disorder. One problem with mania patients is they typically feel good when they are ill and, therefore, it is hard to get someone in a mania episode help if they will feel less good after treatment.²⁹⁷

Administrator Simons provided the Ombudsman with the medical questionnaire T.H. completed upon his arrival at the jail and the booking questions contained on the jail's computer. The questionnaire is a 27-question sheet asking about medical and mental health history, to which an inmate answers "yes" or "no." On this hard-copy questionnaire, T.H. answered "yes" to whether he was recently hospitalized, "yes" to whether he was under a doctor's care, and "yes" to whether he was on medications. The computer's follow-up booking questions and responses contained the following information:

Question: Have you recently been hospitalized?
Answer: Yes, in December.

Question: Are you under a Drs (sic) Care?
Answer: Yes, for mental health.

Question: Are you on any prescription medications?
Answer: Yes, but doesn't know the names of them.²⁹⁸

The questionnaire and follow-up questions encompass the intake and screening process at Jefferson County Jail. The jail has no system in place where an inmate that answers positively about being recently hospitalized, reports a mental illness, or shows signs or symptoms of mental illness is referred to a mental health professional. As such, after reporting he had been recently hospitalized and was under a doctor's care for mental health, T.H. was not referred to or assessed by a mental health professional. A mental health professional did not have an opportunity to determine T.H.'s condition or whether the jail had the facilities or expertise to care for his mental health needs.

The Ombudsman noticed on the UIHC medication sheet obtained from the hospital that the prescribing physician ordered a prescription of Haldol, along with the carbamazepine. The Ombudsman found no mention of a Haldol dosage in the materials previously

²⁹⁶ *Id.*

²⁹⁷ Richard H. McCarthy, *Working with Medication: So Many Medications for Bipolar Disorder – A Good Problem to Have*, MENTAL HEALTH NEWS, Fall 2007, at 1, 34.

²⁹⁸ E-mail from Capt. Michael S. Simons, Jail Adm'r, Jefferson County Jail, to Andy Teas, Assistant Ombudsman, Iowa Citizens' Aide/Ombudsman (Aug. 3, 2007, 11:09 CST) (on file with author).

provided by the jail. Haldol is an antipsychotic drug commonly prescribed to treat acutely agitated patients.²⁹⁹ The Ombudsman contacted Martin's Pharmacy where the prescription was ordered. According to the pharmacist, the Haldol was ordered by the UIHC doctor, but was never filled by the jail. In fact, when the Ombudsman contacted the pharmacy in January 2008, the Haldol prescription was still on hold, eight months after it was ordered by the doctor. According to the pharmacist, the jail will occasionally not fill a prescription if an inmate is expected to be released soon, such as on bail.

When the Ombudsman contacted Administrator Simons about the Haldol, Mr. Simons had no prior knowledge of a Haldol prescription and was not able to respond why the prescription was not filled by the jail. The Ombudsman noted to Mr. Simons the Haldol prescription was ordered one month before T.H. was required to be placed in restraints. After consulting with his staff, Mr. Simons reported that T.H. had been refusing to take Haldol before the doctor reordered the prescription, so it was never requested from the pharmacy.

Pursuant to an earlier request for T.H.'s medical records, the jail provided its medical sheets which list the dates, times, and medications offered to T.H., as well as whether he accepted or refused the medication. These sheets indicated when T.H. was offered carbamazepine and when he refused to accept it. However, there is no reference to Haldol or its generic in any of the materials the jail provided. As a result, the Ombudsman cannot substantiate whether there was even an offer of Haldol for T.H. to refuse.

2. Treatment Received Prior to Restraint Chair Use

During his entire incarceration at Jefferson County Jail, T.H. never saw a psychiatrist or other mental health professional until his civil commitment that occurred more than seven months after entering the jail. As mentioned above, Jefferson County Jail currently has no contract for psychiatric or mental health services. In cases where an inmate specifically requests mental health treatment, the inmate will first see a local medical doctor. This is true also for inmates who exhibit "unusual behavior,"³⁰⁰ or attempt to hurt themselves or others. Only in cases when a medical doctor makes a referral will the jail contact the local psychiatrist to set up an appointment.³⁰¹ Otherwise, the jail will only contact a psychiatrist if the inmate has a standing appointment.

²⁹⁹ <http://www.rxlist.com/cgi/generic/haloper.htm> (last visited Oct. 30, 2008). Haldol is the brand name for haloperidol.

³⁰⁰ In response to the Ombudsman's question under what circumstances the jail contact the psychiatrist, Administrator Simons replied, in part, "if an inmate exhibits unusual behavior, attempts to hurt themselves or others." Responses to Ombudsman Questions (Feb. 26, 2008).

³⁰¹ The Ombudsman spoke to Clinical Director Marjorie Gerber from the Community Mental Health Center in Fairfield. Ms. Gerber stated she saw inmates a couple of times each month in the office, but was not aware whether the jail initiated contact, or if it was based on medical doctors making a referral.

While T.H. was incarcerated, the jail received a series of warning signs that T.H. had a potential mental illness. He informed the jail during admission that he was under a doctor's care for mental health issues and was recently hospitalized, he was placed in restraints on five separate occasions for violent behavior, he started numerous food and water strikes that resulted in the jail consulting with medical doctors, he incurred 13 criminal charges for assaults on correctional officers, and, according to Mr. Simons, T.H. was "highly agitated most of a 24-hour period."³⁰² A review of the jail's records do not indicate T.H. was ever referred to a medical doctor due to an existing threat of harm to himself or others, or for any "unusual behavior."

3. Immediate Facts and Circumstances of Restraint Chair Use

The Ombudsman reviewed security tapes and staff reports on each of the incidents in which T.H. was placed in the restraint chair during the April 2007 timeframe. While there were some issues regarding the poor quality of the tapes, and not being able to locate some of them immediately upon request, the jail generally executed a good policy of documentation during the restraint chair use.

a. April 17, 2007

T.H. was first placed in the restraint chair on April 17, 2007. Prior to his placement, T.H. was allegedly disobeying orders to return his food tray for meals that were provided an hour earlier. According to incident reports, a female officer entered T.H.'s cell to retrieve the tray that T.H. refused to give her. T.H. took an aggressive stance when the officer took the tray and said "[c]ome on bitch, take it away from me."³⁰³ Another officer entered the cell and physically forced T.H. to his bed, face down. Four officers were used to place T.H. in the restraint chair within the cell. According to the reports, T.H. continued to resist and spat pieces of apple while officers struggled to place the 63-year old, 160-pound inmate in the restraint chair.

After T.H. was restrained, officers set the mobile restraint chair, advertised by its manufacturer as a "padded cell on wheels," in the jail's day room.³⁰⁴ The day room contained a closed-circuit camera that enabled officers to monitor T.H. from the jail's control room. The security tape from the control room on this occasion was in such bad condition it provided no relevant information to this investigation, though officer reports indicate the CCTV monitor was working properly during this time. T.H. remained in the restraint chair on this occasion for two hours before he was released.

³⁰² Letter from Capt. Michael S. Simons, Jail Adm'r, Jefferson County Jail, to Andy Teas, Assistant Ombudsman, Iowa Citizens' Aide/Ombudsman (Feb. 26, 2008) (on file with author).

³⁰³ Resistance Report from Sgt. Phil Stocks (Apr. 17, 2007).

³⁰⁴ <http://www.restraintchair.com/> (last visited Oct. 30, 2008).

b. April 23, 2007

On April 23, 2007, T.H. placed wet paper on the window of his cell, blocking the security camera's view and causing what the jail considered a safety and security issue. When asked over the intercom to remove the paper from the window, T.H. refused. A correctional officer contacted Administrator Simons about how to handle the situation. Administrator Simons interpreted the situation as threatening safety and security and directed T.H. to be placed in the restraint chair. T.H. previously charged at an officer earlier in the evening, so additional officers were called to assist. Before a cell entry was accomplished, T.H. removed the paper from the window, but when an officer directed him to hand the papers through a meal slot, he refused. Three officers then entered T.H.'s cell and placed him in the restraint chair.

During his placement in the restraint chair at approximately 5:00 a.m., T.H. cursed and threatened the officers and tried to grab officers' hands during the 15-minute circulation checks. Even after an hour in the chair, T.H. threatened to one officer that he was going to "knock your teeth out, kick you in the nuts, and chop you in the throat."³⁰⁵ T.H. remained hostile for the next six hours.

After the first two hours, officers contacted the Jefferson County Hospital and spoke to "Mr. Harl." The officers reported T.H.'s disposition as still being hostile. Mr. Harl approved two more hours in the restraint chair. At 9:02 a.m., officers spoke to Dr. Buck and explained T.H. was still threatening staff and still very angry.³⁰⁶ Dr. Buck said it would be all right to keep T.H. in the restraint chair for another two hours. T.H. was eventually removed from the restraint chair at 11:08 a.m., approximately six hours after the initial placement.

c. April 24, 2007

The day after being released from the restraint chair, T.H. instigated events that, again, would lead to his placement in the restraints. At 7:16 p.m., T.H. refused to give his meal tray to a correctional officer. Earlier in the evening, he made threats against a female correctional officer, saying "you want to f--k with me, you're going to get it girl."³⁰⁷ When T.H. refused to hand over his meal tray, three correctional officers entered the cell, and T.H. immediately laid on the ground. When the tray was picked up, an officer told T.H. he would not be placed in the restraint chair. After saying this, T.H. jumped to his feet and took an aggressive stance against the officers, making a fist. The three officers then secured T.H. and placed him in the restraint chair.

³⁰⁵ Incident Report from C.O. Gabe Tramel (Apr. 23, 2007).

³⁰⁶ This information was provided on a non-descript printout provided by the jail, listing the dates and times officer contacted medical doctors while T.H. was restrained. This document states "I called JCH ER and spoke to Dr. Buck. The Ombudsman learned Dr. Buck works in the Fairfield Clinic, not the Jefferson County Hospital's emergency room.

³⁰⁷ Incident Report from C.O. Kayleen S. Martin (Apr. 24, 2007).

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T.H. remained in the restraint chair for the next 12 hours. Jail logs show officers checked T.H.'s circulation every 15 minutes. During his stay in the restraint chair, T.H. remained hostile, making threats against officers and trying to grab their hands when they checked on him. At approximate 3:00 a.m., eight hours after being placed in the restraint chair, T.H. yelled at officers,

“I’m going to hurt you motherf---rs. I’m in here because I wanted to be in here, you didn’t put me in this chair, don’t f--king touch me. I’m gonna hurt you motherf----r.”³⁰⁸

Soon after, when a female officer checked his circulation, T.H. said, “If you touch me where I’m going to f--king hurt you.”³⁰⁹

Jail staff contacted the Jefferson County Hospital every two hours and spoke to the emergency room doctor on call to seek approval for extended use of the restraint chair. Staff would describe T.H.'s disposition over the phone, and approval for extended use was granted each time. Throughout the jail's use of the restraint chair, staff spoke to Dr. Pool, Dr. Trigger, and Dr. Pandit. When T.H. stated at 7:00 a.m. he would fight the correctional officers if he was released, staff contacted Dr. Pandit to approve extended use for the restraint chair. T.H. had been in the restraint chair for 12 hours by this time. Dr. Pandit approved an additional two hours, but said she had concerns if he were restrained any longer than that.

Despite Dr. Pandit's approval for an additional two hours, Administrator Simons directed staff to remove T.H. from the restraints. T.H. was removed without incident.

d. April 30, 2007

On April 30, at approximately 12:30 a.m., T.H. began beating his cell window with his suicide smock. Three correctional officers entered his cell to retrieve the suicide smock and blanket and transferred him to a detox cell. During this transfer, T.H. spat on officers and attempted to head-butt them. Officers handcuffed T.H. behind his back and placed a foam helmet on his head. T.H. was first placed in an isolation room, where he was free to move around with the restriction of his hands being cuffed. After 2½ hours, T.H. was able to pry off his foam helmet. T.H. was placed in the restraint chair at 4:30 a.m. when he threatened, spat on, and attempted to kick officers who were adjusting the foam helmet.

T.H. remained in the restraint chair for 11 hours. Jail staff contacted the Jefferson County Hospital every two hours and spoke to Dr. Larson and Dr. Studer on separate occasions. Jail staff checked T.H.'s circulation every 15 minutes and documented T.H.'s aggressive behavior while in the restraint chair, including using profanity, making verbal

³⁰⁸ Incident Report from C.O. Sandi Ropp (Apr. 25, 2007).

³⁰⁹ *Id.*

threats against the officers, and trying to grab their hands. Though there was no documentation of T.H.'s state of agitation when he was let out at 3:15 p.m., Mr. Simons reported he took this into consideration, along with safety concerns for T.H. and staff, when he approved the release.

4. Doctor Approval for Continued Use

After reviewing Jefferson County Jail's incident reports, security tapes, and medical sheets, the Ombudsman contacted the medical facilities involved in approving the extended use of the restraint chair on T.H. The jail has a contract with the Fairfield Clinic, P.C. (Clinic) for medical services. When the Clinic was not available for approval of the chair's use, the jail's telephone calls were transferred to the Jefferson County Hospital (Hospital) emergency room. During the course of T.H.'s various restraints, four of the medical staff the jail contacted were with the Clinic – doctors Buck, Poole, and Larson, and PA Harl – while three were from the Hospital – doctors Larson, Studer, and Pandit.

Each time the jail contacted the Hospital, the jail was not consulting with doctors directly employed by the Hospital. The Hospital contracts with Acute Care, Inc. (Acute Care) for its emergency room doctors. Acute Care is a private corporation based out of Ankeny, Iowa. According to its website, Acute Care provides emergency medical physicians to 60 hospitals throughout the United States.³¹⁰ The Ombudsman contacted and received permission from the Acute Care and the Clinic administrators to question the doctors involved in approving extended use of the restraint chair.

The Ombudsman sent each medical professional the same set of questions regarding:

- the doctor's experience with restraint devices,
- the doctor's knowledge of the restraint chair used by Jefferson County,
- general medical concerns the doctor had about restraint chairs,
- whether an inmate's mental health history would have any effect on restraint approval, and
- whether the doctor believed over-the-phone consultation was the best way to evaluate an inmate for possible medical concerns.

The Ombudsman received a variety of responses. Though the Ombudsman sent each medical personnel an individually addressed letter, he received from the Clinic a single response signed by Doctors Buck, Poole, and Larson, but written in the first person. In response to what experience the doctors had with restraint devices, the Clinic replied it has a "papoose board" it occasionally uses when repairing a young child's laceration. The Clinic did not have a working knowledge of the restraint chair used by the jail. The only information the Clinic requested from the jail was whether the restraint was needed for the inmate's safety or those around him. The Clinic did not indicate to the

³¹⁰ <http://www.acutecare.com/aboutus.php> (last visited Oct. 30, 2008).

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Ombudsman it had any medical concerns for T.H. while in the restraint chair or whether those concerns could be addressed over the phone.

The Ombudsman received individual responses from the three Acute Care physicians contracted by the Hospital. No doctor was familiar with the restraint chair used by Jefferson County Jail. One physician replied he felt comfortable giving approval over the phone, while a second felt it was “never ideal,” stating face-to-face evaluations by a trained health care provider who is responsible for the well-being of the inmates is the ideal.³¹¹ During a phone conversation, a third physician told the Ombudsman she did not feel comfortable giving approval over the phone compared to in-person observation, but she later refused to respond in writing to any of the Ombudsman’s questions, stating “[m]y knowledge of use of restraint devices in correctional facilities is by no means expert opinion. Hence, I refrain from commenting on the issue as my experience is based more in ED than elsewhere.”³¹²

Due to the variety and inconclusiveness of responses received, the Ombudsman contacted the Iowa Board of Medicine (IBOM) as the professional licensing and disciplinary agency in the state to determine to what extent physicians can and should be used for restraint chair approval. The Ombudsman presented the facts as they pertained to Jefferson County, absent any names or locations involved. The Ombudsman sought the opinion of the IBOM on the following areas:

- Whether evaluating adverse medical symptoms associated with extended restraint chair use could be effectively identified and evaluated by a medical professional over the phone.
- Whether a medical professional could accurately identify a potential mental illness over the phone.
- Whether medical professional should be placed in the position of granting extended use of the restraint chair that is used in a correctional setting.

The IBOM replied that it “does not possess the necessary medical expertise regarding proper procedures for medical approval of the use of restraint devices in the jail setting,” and declined to provide any guidance on the matter.³¹³

³¹¹ Letter from Dr. Studer to Andy Teas, Assistant Ombudsman, Iowa Citizens’ Aide/Ombudsman (received Nov. 14, 2007) (on file with author); Letter from Dr. Brandon Trigger to Andy Teas, Assistant Ombudsman, Iowa Citizens’ Aide/Ombudsman (Nov. 18, 2007) (on file with author).

³¹² Letter from Dr. Kalpana Pandit to Andy Teas, Assistant Ombudsman, Iowa Citizens’ Aide/Ombudsman (Dec. 1, 2007) (on file with author).

³¹³ E-mail from Kent M. Nebel, Dir. of Legal Affairs, Iowa Bd. of Med., to Andy Teas, Assistant Ombudsman, Iowa Citizens’ Aide/Ombudsman (Jan. 7, 2008, 16:00 CST) (on file with author).

5. Civil Commitment

During his incarceration, T.H. incurred an additional 13 charges for assaults on officers between April 9 and September 4, 2007, in addition to the criminal charge of robbery that placed him in jail. Soon after T.H.'s last assault, the Ombudsman contacted the county attorney on September 20, 2007, about a possible civil commitment. The Ombudsman previously spoke to the jail administrator and sheriff, who indicated an application for civil commitment would not be successful for an inmate in jail because the magistrate considers the person to already be in a secure environment. The Jefferson County Attorney, Tim Dille, expressed the same apprehension, saying the magistrate views persons in jail as not being a harm to themselves or others. However, Mr. Dille agreed he would work with the jail staff to file a civil commitment petition with the court.

Within four days, the civil commitment order was granted by the magistrate. By September 25, 2007, T.H. was admitted into the UIHC. T.H. remained at UIHC for approximately 18 days. Medical notes stated he was threatening, spitting, throwing food, and irritable during admission. Medications were adjusted during his stay at UIHC, and he was released back to the jail with instruction to have the local ER administer an antipsychotic medication shot.

During the time between T.H.'s return from UIHC and his acceptance at Iowa Medical and Classification Center for a competency evaluation, Mr. Simons reported T.H.'s agitation level "was near none upon his arrival back to us from UIHC."

B. Analysis, Conclusions, and Recommendations

The Ombudsman identified several areas that need attention by Jefferson County Jail. Jail staff were aware immediately of T.H.'s mental health needs as early as the booking process, and since law enforcement and the jail had a history of encounters with T.H., it can be argued they were aware of his needs even before booking. This section will detail the identified problems and recommendations concerning intake screening and assessments. This section will also review restraint chair procedures, with focus on how and when to consult with medical staff.

1. Mental Health Screen and Assessment

According to the NCCHC, new-detainee intake screening is one of the most important functions of the jail.³¹⁴ This process can identify an inmate's immediate and long-term needs, and help determine early whether the jail is able to accommodate those needs. In response to questions asked by the intake officer, T.H. informed the jail he was recently hospitalized, he was under a doctor's care for mental health, and he was on medication. Despite these answers, the jail did not seek a mental health assessment to determine what

³¹⁴ Judith A. Stanley, *The Most Important Standard: Receiving Screening*, CORRECTCARE, Fall 2004, at 20, available at <http://www.ncchc.org/pubs/CC/archive/18-3.pdf>.

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mental health services the jail needed to provide T.H., and whether it could in fact provide for those needs.

A review of its policy shows the jail is primarily concerned with a detainee's mental health as it relates to suicide.³¹⁵ The policy is not centered on how to respond to a detainee with mental health needs who may not have suicidal tendencies, as T.H. reported he did not. The policies provided by the jail do not instruct an intake officer on what steps to take if an inmate reports a mental illness, but who otherwise provides no indication of a suicide threat. Questioning a detainee's mental health history at intake should be aimed at determining whether a detainee needs to be referred to a mental health professional for further review.

The Ombudsman supports the use of the Brief Jail Mental Health Screen (BJMHS) during new-detainee intake screening. This form not only alerts intake officers of a potential mental illness, but also clearly directs when to refer a detainee for further mental health evaluation. This does not act as a supplement for an officer's observations of the detainee, particularly if the detainee does not answer the form's questions truthfully. However, it can make the decision of when to refer a detainee more clear for the officer. In the case of T.H., the Ombudsman believes the BJMHS, or other health-authority-approved mental health form, would have led T.H. to services much more quickly, as there was no apparent effort on his part to "hide" his mental health history.

The BJMHS would have limitations in Jefferson County Jail, however, since the jail does not currently have a provider for mental health services. The Ombudsman believes the need for the jail to enter a formal relationship with a mental health professional is essential as part of its intake process. At the same time, the Ombudsman recognizes the difficulty in contracting for services due to the shortage of professionals in the psychological field. Marjorie Gerber, the Clinical Director for Life Solutions Behavioral Health, located in Fairfield, can provide a list of possible contacts for the jail. In addition, the Ombudsman encourages the jail to contact its county central point of coordination (CPC) official who can locate potential service providers.

The Ombudsman does not believe services for intake screening referrals need to be made by a licensed psychiatrist. Mental health professionals can include psychiatrists, psychologists, psychiatric nurses, and even social workers or others who, based on their education and experience, are permitted to evaluate a person's mental health needs. A formal relationship between the mental health staff person and the jail is important so the mental health professional can gain detailed knowledge of the resources and staff the jail is able to provide, and accurately determine whether the jail can adequately provide for

³¹⁵ Jefferson County Jail's admission policy states "[a]ll staff involved in the booking process or the supervision of inmate shall be trained in suicide prevention." The admission policy also includes a section specifically for suicide screening during the intake procedure. JEFFERSON COUNTY JAIL POLICY AND PROCEDURE III-1 (2007). The Jail has a separate policy devoted to suicide prevention, which includes procedures for screening and classification of suicidal inmates. JEFFERSON COUNTY JAIL POLICY AND PROCEDURE III-1A (2007).

the detainee's mental health care needs or if steps need to be taken to relocate the detainee to another facility.

Having a designated mental health professional may also reduce the jail's liability for not providing mental health treatment to an inmate. The Eighth Circuit has recognized a correctional facility's liability under the Eighth Amendment for failing to provide mental health services to inmates who require them.³¹⁶ Providing mental health care serves the interests of the jail, its employees, and the detainee.

Conclusion: Jefferson County Jail does not currently have a mental health screen in place that identifies a potential mental illness in newly admitted inmates and instructs the screening officer when to contact a mental health professional for further assessment. Jail policy is primarily centered around suicide detection and prevention only. The jail should incorporate a questionnaire covering an inmate's mental health history for the purpose of determining treatment needs of the inmate.

The Ombudsman makes the following recommendations:

- 1. Jefferson County Jail should incorporate a health-authority-approved mental health screen, such as the Brief Jail Mental Health Screen, that identifies an inmate's past and current mental health information. This form would preferably notify the officer performing the screen when an inmate should be referred to a mental health professional for further assessment.**
- 2. The jail should take immediate steps to review entering a formal relationship with a mental health professional that can provide initial assessment services for the jail on a regular basis. This may include contacting the local mental health facility in Fairfield, Life Solutions Behavioral Health, as a resource for a mental health professional referral.**

Entering into a contract for mental health services with a mental health professional will ensure timely treatment and intervention for inmates in need of mental health services. If necessary, the mental health professional can inform the jail when a detainee's required care is beyond the jail's capabilities and needs to be transferred to another facility.

2. Mental Health Services After Intake

According to Administrator Simons, inmates will only see a psychiatrist if referred by a local medical doctor. This applies whether an inmate specifically requests mental health treatment or exhibits unusual behavior. Direct contact with a psychiatrist for mental

³¹⁶ *Vaughan v. Lacey*, 49 F.3d 1344, 1346 (8th Cir. 1995) ("Prison staff violate the Eighth Amendment if they are deliberately indifferent to an inmate's serious mental-health-care needs." (citing *Smith v. Jenkins*, 919 F.2d 90, 92-93 (8th Cir. 1990))).

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health issues is never the first step unless the inmate is already seeing the local psychiatrist.³¹⁷ Despite T.H.'s growing agitation while at the jail, there is no indication, based on conversations with Administrator Simons or review of T.H.'s medical records, that the jail consulted with a medical doctor about his aggressive behavior. Even after T.H. needed to be placed in the restraint chair on four separate occasions, the jail did not consult with a local medical doctor about a referral for mental health.

Nor was a local medical doctor consulted about T.H.'s aggressive behavior after he committed assaults on correctional officers that lead to 13 additional criminal charges during his jail stay. When T.H. refused to take his prescribed Haldol for bipolar disorder and routinely spat out or flushed his other medication, there was no consultation with a local medical doctor. There was also no record of a medical consultation after he became verbally abusive with a cardiologist during a medical appointment, who terminated the visit.³¹⁸

T.H.'s continuous aggressive behavior, his refusal to take medication, and his jail admission statement that he was under a doctor's care for mental health should have been sufficient notice to the jail to follow its own practice of consulting a local medical doctor for a referral. Moreover, the Ombudsman believes the jail should have contacted a mental health professional for advice on what avenues to take with T.H. Relying solely on a local medical doctor for a referral is not sufficient to identify when an inmate needs to see a mental health professional. No local medical doctor referred T.H. to a mental health professional on February 21, 2007, when the Fairfield Clinic refused to treat him due to his past behavior and said they would never see him again.³¹⁹ None of the local medical doctors that were consulted during the four restraint chair placements referred T.H. for mental health services at any time.

As mentioned in the previous section, Jefferson County Jail needs to establish a relationship with a mental health professional to address issues relating to where it can directly refer concerns about an inmate's ongoing mental health condition and needs. Inmate's mental health can quickly deteriorate after intake for a variety of reasons, whether stress from incarceration, not receiving proper medication, or a delay in the manifestations of mental illness. For these reasons, jail staff need a mental health professional to contact to report growing signs and symptoms from an inmate.

Though staff reported agitation early in his reception to the jail, T.H.'s behavior and actions became worse as time passed, to the point where he was regularly assaulting correctional officers. In reference to this period of time, Administrator Simons described T.H.'s behavior as "highly agitated most of a 24-hour period."³²⁰ It is likely a mental health professional could have identified the connection between T.H.'s aggressive

³¹⁷ Letter from Capt. Michael S. Simons, Jail Adm'r, Jefferson County Jail, to Andy Teas, Assistant Ombudsman, Iowa Citizens' Aide/Ombudsman (Feb. 26, 2008) (on file with author).

³¹⁸ Jefferson County Jail, Inmate Incarceration Report 14 (Feb. 22, 2008) (on file with author).

³¹⁹ *Id.* at 16.

³²⁰ *See* Letter from Capt. Michael S. Simons to Andy Teas, *supra* note 318.

behavior, his ongoing mental health treatment, and his refusal to take medication prescribed for his mental illness. Further, a mental health professional may have been able to recognize that the carbamazepine was not prescribed for “seizures,” as was listed on the jail medication sheets, but was intended for the purpose of treating T.H. for bipolar disorder. Recognizing the signs and symptoms of mental illness and responding to them appropriately is important for providing the medical attention the inmate needs, protecting staff from assault and injury, and protecting the jail from liability. If the inmate’s medical or mental health needs are beyond those the jail can provide, a mental health professional would be able to advise the jail when to transfer the inmate to another facility or initiate civil commitment proceedings.

Conclusions: The jail did not follow its own practice of referring an inmate who displays signs of mental illness to a medical doctor as a result of the potential mental illness. The jail was provided with multiple signs of T.H.’s mental illness, the most apparent being him stating he was under a doctor’s care for mental health. However, the Ombudsman believes T.H.’s highly aggressive behavior and refusal to take his medication should have also alerted staff of a potential mental illness.

The Ombudsman believes medical professionals with no formal training in mental health are not the appropriate referrals for a person with a suspected mental illness. The jail relies on medical professionals to make mental health referrals, but in T.H.’s case, at no point was a mental health referral made. The Ombudsman stresses the need for the jail to enter a formal relationship with a mental health professional who can assess an inmate with a suspected mental health condition.

The Ombudsman makes the following recommendations:

3. Jefferson County Jail should establish a formal relationship with a mental health professional for consultation and to evaluate inmates whenever they show signs of a potential mental illness. It should not rely on local medical doctors to refer inmates to a mental health professional. The jail should use the local contact provided in the previous section and the county central point of coordination for recommendations to mental health professionals that may provide services.

3. Use of the Restraint Chair

a. When to use

Jefferson County Jail’s restraint chair is supported by an eight-page policy and procedure manual detailing when and how to use the restraint chair. Its policy states the purpose of the restraint chair “is to protect corrections personnel from bodily harm in the performance of their duties when inmates become aggressive, violent or combative, and

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to bring these individuals under situational control without serious injury to themselves or others.”³²¹

The policy details maintenance, inspection, and storage of the restraint chair, and requires that only those Jefferson County Sheriff’s Office and Correctional Facility employees who have received training on the restraint chair be involved in its use. It further instructs officers to never treat the restraint chair as a toy. Emphasis is placed throughout the written policy in bold capitalized letters on issues relating to not provoking inmates, not using the restraint chair as a means of punishment, restricted placement of straps, and warnings that misuse can lead to death.

The policy bullet-points when the restraint chair may be used, including:

- To prevent an inmate from self-injury.
- To prevent an inmate from injuring others.
- To prevent property damage.
- Situational control of aggressive, violent or combative mentally disturbed individuals when peaceful attempts to regain situational control have failed.
- Situational control of extremely alcohol intoxicated individuals who are aggressive, violent or combative when peaceful attempts to regain situational control have failed.
- Situational control of individuals under the influence of narcotics, drugs or vapors; who are aggressive, violent, or combative when peaceful attempts to regain situational control have failed.
- Situational control of all other aggressive, violent, or combative inmates when peaceful attempts to regain situational control have failed.³²²

In four of the seven points, the words “when peaceful attempts to regain situational control have failed.” This implies an obligation by correctional staff to attempt other resolutions before concluding a restraint chair must be used to control the inmate.

The Ombudsman believes a determination that peaceful attempts will fail can be implied by the circumstances of a situation. During the events of April 17, 2007, T.H. refused to hand over his meal tray, and when a female officer entered the cell to retrieve the tray, T.H. stood and threatened, “Come on bitch, take it away from me.”³²³ Another officer entered the cell and forced T.H. to the bed before he was placed in the restraint chair. Such action by the inmate may indicate seeking a peaceful resolution would not have been successful, and if the inmate is not physically controlled while displaying an intent to assault an officer, a delay could lead to serious injury on the officer. The Ombudsman

³²¹ JEFFERSON COUNTY JAIL POLICY AND PROCEDURE I-10A at 1, Purpose (2007).

³²² *Id.* at 3, Policy.

³²³ Resistance Report from Sgt. Phil Stocks (Apr. 17, 2007).

does not believe further steps to seek a peaceful resolution were required during the April 17 incident.

The Ombudsman has some concerns regarding T.H.'s placement on April 23, 2007. On this date, T.H. placed wet paper on his window, blocking the view of the security camera. He refused orders to remove the papers, though he eventually did so approximately five minutes after ordered. However, T.H. ignored instructions to hand the paper to officers through the meal slot. As a result, officers entered the cell and placed him in the restraint chair.

Refusing verbal commands is not contemplated in the jail's policy as a basis for placing an inmate in the restraint chair. The officers' actions by themselves appear excessive. While T.H. may have created a safety and security concern by placing the wet paper on the window, this was remedied by T.H. later removing the paper. Further safety concerns could have been resolved by having officers enter the cell and remove all paper products. When T.H. was refusing orders, Officer Gabe Tramel's report stated that T.H. looked at him during the order, "but would not respond."³²⁴ At that point, T.H. was sitting on the floor with his mattress. Based on the written reports provided by the jail, there is no indication T.H. was aggressive, making threats, or destroying the cell. In fact, Officer Tramel's report stated "I then discussed with Ropp and Richardson that we would not need to use the cell entry pad due to him lying on the floor."³²⁵ The incident report does not indicate T.H. resisted or fought with officers when they entered the cell, and the only indication he began fighting was when he was placed in the restraint chair. At the time staff determined T.H. would be placed in the restraint chair, his violation was refusing to hand over the paper.

Iowa law states a restraint device is not to be used as punishment. This restriction is echoed in the jail's written policy, the restraint chair manufacturer's instructions, court cases, and correctional publications. When an inmate is placed in a restraint chair in response to his past action, the decision begins to take on the appearance of punitive measures.³²⁶ At the time officers entered the cell, T.H. was not showing aggressive action or actively causing a security problem for the jail. He was refusing to hand over paper as directed. Officers could have entered the cell, secured T.H., and removed the paper themselves without using the restraint chair.

This suggested approach is the one used the next time officers had to enter T.H.'s cell on April 24. Three officers entered his cell when T.H. refused to hand over his meal tray. One officer had a cell entry pad. According to Sgt. Rick Smith report, the officers had no intent to place T.H. in the restraint chair after retrieving the tray:

³²⁴ Incident Report from C.O. Gabe Tramel (Apr. 23, 2007).

³²⁵ *Id.*

³²⁶ Fred Cohen, *Restraints as Torture? A Consent Decree Is Reopened*, 18 CORRECTIONAL L. REP. 65, 78 (2007).

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We determined we would back out of [T.H.'s] cell one by one, so I took the pad off Inmate [T.H.'s] back and stood up myself. Up to this point we had no resistance from Inmate. I then said to [T.H.], "I am not going to put you in the chair since you did comply without becoming hostile."³²⁷

It was only after T.H. took an aggressive stance against the officers and made a fist when let up that the decision was made to place him in the restraint chair. The different responses from the officers between the April 23 and April 24 incidents are apparent. They are similar in that T.H. refused direct orders, and a cell entry was accomplished. The two situations are also similar in that there was no hostility from T.H. during cell entry. The only apparent difference is the officers' decision to place T.H. in the restraint chair. On April 24, that decision was made only after T.H. took aggressive action against the officers when they were leaving the cell. At that point, officer safety was an issue, and restraint chair use can be justified. This argument is difficult to make for the April 23 incident, when the security threat subsided and T.H. refused to follow a directive but showed no signs of aggression.

On April 30 T.H. was placed in the special status cell after he spat in a C.O.'s face. He was then taken to the detox cell after he kept hitting the cell door with his clothes and blanket. When T.H. was able to pry his "soft-helmet" off while handcuffed, officers entered his cell to adjust it, at which time T.H. spat directly in an officer's face. He then attempted to kick an officer when they left the cell. Shortly after, Administrator Simons gave approval to place T.H. in the restraint chair.³²⁸ This incident represents the jail's attempt to respond to T.H.'s aggression with incremental steps of restraint, instead of immediate placement in the restraint chair. T.H. displayed immediate and ongoing aggression toward the officers, and after exhausting less restrictive alternatives, the jail placed T.H. in the restraint chair.

A pattern becomes clear while reviewing the four April incidents. On April 17 and 23, officers immediately placed T.H. in the restraint chair with little warning or attempt to resolve the conflict before its use. By April 24 and 30, officers took multiple steps in trying to resolve the situation, such as removing a meal tray with no intent to use the restraint chair and using less restrictive alternatives to the restraint chair use. The Ombudsman believes these steps were consistent with the jail's written policy of using the restraint chair "when peaceful attempts to regain situational control have failed."

Conclusion: The Ombudsman believes the jail was justified in its use of the restraint chair under Iowa law. However, the Ombudsman questions its use under jail policy on April 23 when the circumstance appears to offer an alternative to the restraint chair use, and the immediate threat to the security of the jail had subsided. The Ombudsman borrows analogies from *Management and Supervision of Jail Inmates with Mental Disorders*, addressing alternatives to the use of restraints:

³²⁷ Incident Report from Sgt. Rick Smith (Apr. 24, 2007).

³²⁸ Incident Report from Sgt. John Wayne Cornelius (Apr. 30, 2007).

Consistent with the notion of using the least restrictive alternative, officials should consider whether an inmate simply can be placed in a cell out of earshot of other inmates prior to gagging. Similarly, if an inmate is tearing up a cell, is placing him in a strip cell, which contains nothing he can destroy, a less restrictive response than putting him in restraints?³²⁹

It must be noted that jail practices seemed to have changed after this incident to explore less restrictive alternatives to restraint chair placement, and it was employed only after those efforts were not successful. The Ombudsman encourages the continued practice of using the restraint chair only “when peaceful attempts to regain situational control have failed.”

The Ombudsman makes the following recommendations:

4. Jefferson County Jail should review its policy and training to explore steps jail staff can take to use less-restrictive alternatives to a restraint device, especially if the inmate can be secured to no longer pose an immediate threat to others or jail security.

b. Documentation

Jefferson County Jail’s restraint chair policy states:

All officers involved will accomplish a report of the circumstances surrounding the use of the E.R.C. prior to the end of that shift. These reports are to be submitted to the Jail Administrator. These reports will include the noting of time in and out of the E.R.C. These reports must be very detailed.

Resistance reports will be completed by each officer involved city or county. NO EXCEPTIONS.³³⁰ (emphasis found in original).

In each of the cases when T.H. was placed in the restraint chair, correctional officers drafted reports of the incident, as required under jail policy. The Ombudsman obtained six typed officer reports for the April 17 placement, two typed reports and a third hand-written “resistance report” from April 23, eight typed reports for the April 24-25 placement, and three typed reports and several hand-written “resistance reports” for April

³²⁹ MARIN DRAPKIN ET AL., MANAGEMENT AND SUPERVISION OF JAIL INMATES WITH MENTAL DISORDERS 2-37 (2003).

³³⁰ JEFFERSON COUNTY JAIL POLICY AND PROCEDURE I-10A at 7, Reporting use of the Emergency Restraint Chair (2007).

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30. There were no reports detailing T.H.'s removal from the restraint chair or his disposition at the time of removal.

The officers' reports were detailed and provided a vivid picture of what occurred in the time before and during each placement. Included with the reports were activity logs for each of the dates detailing when T.H. was checked for circulation every 15 minutes. Each date included an "Activity Report by Location" that stated only T.H.'s location, the time he was checked, and the officer who checked in on him. During T.H.'s placement on April 23 and 30, the jail provided a "Facility Log" that included much more detail of the restraint, including the date, time, offender, and brief notes documenting T.H.'s placement in the restraint chair; visual or physical checks; statements made by T.H.; when officers contacted medical doctors; and his removal. The system, developed by Professional Computer Solution in Ottumwa, Iowa, is not currently required by the jail to document restraint chair placement and use. According to Administrator Simons, it is used at the discretion of the officer on shift.

The Ombudsman also reviewed videos of T.H.'s placement during each of the incidents. The videos did not provide as consistent information as the written reports. Many of the security videos were so poor they provided little or no relevant information to the investigation. The videos from April 17, 23, 24, and 25 were not discernable.³³¹ The jail also could not provide all of the tapes immediately when requested; some taking several weeks to locate. However, all requested recordings were eventually made available.

Conclusions: Jefferson County Jail has included excellent language on documentation requirements in its restraint chair policy. The jail should ensure the inmate's release is documented and include the reason for the release and the inmate's disposition upon release. Administrator Simons reported he made the decision to release T.H. based on his agitation level and consideration of the inmate's and staff's safety. Administrator Simons or any other official who is involved in the release should document these observations in a report soon after release.

The Facility Log provides sufficient detail to comply with Iowa law requiring documentation of all decisions and actions. In contrast, the "Activity Report by Location" does not provide nearly as much information. The jail should incorporate the Facility Log during each restraint chair use due to its capacity to detail what action took place at what time and its convenience in providing a quick review of the events.

It is not clear why some of the security tape quality was so poor. Based on the incident reports, there were no reported problems from the control desk while monitoring T.H. on the CCTV. Possible causes could be the age of the tapes or because of wear and tear from their recycled use. Visual recording of restraint chair placement and use is an excellent tool for the jail to combat allegations of physical abuse by an inmate, to identify

³³¹ The Ombudsman was able to review videos of restraint chair placement and use on these dates that recorded different times or locations in the jail.

problems the jail needs to address if policy is not followed, and to use as a training tool for officers. The jail should ensure the tapes can accurately record the events taking place.

The Ombudsman makes the following recommendations:

5. Jefferson County Jail should incorporate and consistently execute an event log that provides sufficient information for an accurate review at a later time. The jail should record in writing all decisions and actions taken towards an inmate who is placed in a restraint device, including the reason for release.

6. The jail should ensure its video recording equipment is functional and portrays an accurate account of the events it is supposed to record. Copies of recordings should be filed separately from other security tapes, and copies should be retained for at least two years.

c. Consultation with medical and mental health staff

During each of T.H.'s restraint sessions that lasted over two hours, the jail contacted medical doctors to receive approval for additional time. On each occasion, the doctors gave approval, even when the restraint chair had already been used for 12 hours. On each occasion, the doctor giving approval did not review T.H.'s condition in person. On each occasion, the doctor did not have personal knowledge of the restraint device used by the jail. Some doctors had no personal knowledge of T.H. himself, or his medical or mental health history. On each occasion, the jail did not follow its own written policy requiring inmates to be held in the restraint chair for "NO MORE THAN 2 HOURS WITHOUT DIRECT MEDICAL SUPERVISION."³³² (emphasis found in original).

The Ombudsman has concerns over using telephonic medical consultation, especially when the medical professional has no working knowledge of the restraint device in use or the inmate on whom it is being used. The Ombudsman inquired from each of the medical doctors involved in approving extended use of the restraint chair what their familiarity was with the device. Of the six doctors who replied to the written question, none had knowledge of the specific device used by the jail.

The Ombudsman believes the need for direct medical supervision beyond the initial two hours is essential for restraint chair use. This position is based on the Ombudsman's review of the *ACA Standards for Adult Local Detention Facilities*, the *NCCHC Standards for Health Services in Jail*, the *APA Resource Document on the Use of Restraint and Seclusion in Correctional Mental Health Care*, the DOJ's investigation and recommendation to Black Hawk County Jail, and the E.R.C. Inc. Instruction Manual. None of these sources make an exception for medical reviews when an inmate is placed in a restraint device, generally, and none provide that an inmate can remain in a restraint

³³² *Id.* at 6, Supervision.

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device for extended periods of time without direct medical supervision. On the contrary, each of these sources recommend contacting medical services in the event an inmate is placed in restraints.

When asked whether the doctor could find resolution for his or her medical concern by telephone only, the Ombudsman received a variety of responses from the doctors involved in T.H.'s case. One doctor's entire response was "possibly," with no further explanation. Another said medical concerns typically could be broached over the phone, but it is never the ideal method, while a third doctor explained feeling uncomfortable with it, and a face-to-face evaluation would have been better. The single response this office received from The Fairfield Clinic, signed by three doctors, did not address this written question at all. When this specific issue of telephone consultation was posed to the Iowa Board of Medicine, its Director of Legal Affairs replied that it lacked the expertise to respond.³³³

If the restraint involves an inmate with a suspected mental illness, a mental health professional should be contacted. The DOJ concluded mental health personnel must be involved in decisions to restrain inmates and the monitoring while restrained. The NCCHC requires a physician be notified immediately if the restraint involved an inmate with a mental health condition so appropriate orders can be given. The ACA requires the health authority to be notified to assess the inmate's medical and mental health condition, and determine if there is an emergency related to these conditions that requires attention. E.R.C. Inc. states violent behavior can mask a medical condition, and its two-hour time limit recommendation allows its customers to seek medical or psychological help for the detainee. The two-hour time limitation can be extended only under direct medical supervision. The Ombudsman does not believe an inmate's medical and mental health conditions can be fully evaluated by a phone conversation with medical staff who have little or no knowledge of the inmate or jail procedures.

Conclusions: Considering the language in the Jefferson County Jail policy, the restraint chair manufacturer instructions, and correctional associations' policies, the Ombudsman believes direct medical supervision is required for any inmate placed in the restraint chair for longer than two hours. This would mean face-to-face supervision by a doctor, nurse, physician's assistant, or other licensed medical professional. The Ombudsman believes the answers provided by the doctors involved in T.H.'s restraint and the response by Iowa Board of Medicine highlights the problems and potential harm if jail staff rely on consultation with medical personnel over the phone.

Pursuant to this report's prior conclusion that the jail should establish a formal relationship with a mental health professional for new inmate intake and assessment services, the Ombudsman believes such a relationship would provide an invaluable service for restraint chair use when the inmate has a suspected mental illness. A mental

³³³ E-mail from Kent M. Nebel, Dir. of Legal Affairs, Iowa Bd. of Med., to Andy Teas, Assistant Ombudsman, Iowa Citizens' Aide/Ombudsman (Jan. 7, 2008, 16:00 CST) (On file with author).

health point person should be familiar with the jail's facilities, the staff involved, and potentially the inmate subject to restraints. A mental health professional would be in a better position to evaluate an inmate's condition to determine if the inmate's behavior and aggression is the result of a mental illness that needs to be treated by other means than prolonged placement in restraints, and relay this information to jail staff. The mental health point person should be contacted as soon as the decision is made to place the inmate in restraints.

The Ombudsman makes the following recommendations:

7. Jefferson County Jail should enter a formal relationship with a mental health professional, whether the same or different resource for assessment, to provide reviews of inmates placed in the jail's restraint device. The jail should ensure the review involves a visual review by the mental health professional, and not rely on phone consultation alone. If a mental health professional cannot conduct reviews in person, an alternative could involve telemedicine, where the mental health professional can observe the inmate by video.

d. When to release

The Ombudsman is not taking a position on maximum time limits for restraint device use. Instead, extended use of restraints will depend on the disposition of the inmate and whether the inmate remains an immediate threat to himself or others. T.H.'s circumstances represented the longest use of a restraint device investigated by this office. Fortunately, his disposition and actions were documented through activity logs and incident reports by the jail. During even the 11- and 12-hour time periods, the jail was able to demonstrate the continued threat T.H. posed to staff. This is important considering at least two U.S. districts court cases in Iowa have found against jail facilities that could not justify extended use of the restraint device on inmates.³³⁴

As discussed previously, the lack of time limits means greater emphasis must be placed on medical and mental health services, especially when an inmate is restrained for extended periods of time. Several county law enforcement and corrections officers the Ombudsman spoke with stated restraint chair and board use often does not last longer than two hours. The restraint chair manufacturer states the initial two-hour time limit allows officers to seek medical or psychological health, and any use beyond this time must be accompanied by direct medical supervision by a doctor or nurse.³³⁵

Clearly, the restraint chair sessions that lasted six or more hours in this case constituted exceptional periods of restraint chair use. However, such lengthy stays may not occur if

³³⁴ *Ogden v. Johnson*, No. C00-0034, 2002 WL 32172301 (N.D. Iowa Sept. 5, 2002); *Rogers v. Dunn*, No. C00-0188-PAZ, 2001 U.S. Dist. LEXIS 22710 (N.D. Iowa Nov. 27, 2001).

³³⁵ Letter from Thomas Hogan, President, E.R.C. Inc., to Customer (Jan. 17, 2001).

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the inmate is seen by medical and mental health personnel, mentioned in the previous section, who can provide or recommend emergency medical and mental health care.

Conclusion: The Jefferson County Jail documented the need for the continued use of restraints on each occasion, and the Ombudsman does not find the jail held T.H. longer than required under Iowa law. However, the jail should have taken the opportunity to seek the services of a mental health professional. At the least, after T.H. was placed in the restraint chair on the first occasion, the jail should have recognized the need for such services existed. The jail should have also followed its own written policy to have direct medical supervision of the inmate in the restraint chair every two hours. Such resources may have offered intervening medical or mental health services to reduce the length of time T.H. spent in the restraint chair.

The Ombudsman makes the following recommendations:

8. Jefferson County Jail should enter a formal relationship with a mental health professional, whether the same or different resource for assessment, to provide reviews of inmates placed in the jail's restraint device. The jail should ensure the review involves a visual review by the mental health professional, and not rely on phone consultation alone. If a mental health professional cannot conduct reviews in person, an alternative could involve telemedicine, where the mental health professional can observe the inmate by video.

Woodbury County Jail – Findings, Conclusions, and Recommendations

A. Findings of Fact

G.A. contacted the Ombudsman on November 13, 2006, complaining about being placed in a “detoxification cell” for 18 days with no access to showers or hygiene. After reviewing jail records, the Ombudsman determined the allegations were unsubstantiated. However, during the investigation, the Ombudsman discovered G.A. was placed in a restraint chair on two occasions: one lasting seven hours with no review by medical staff. This action, coupled with G.A.’s documented mental health history, raised concerns with the Ombudsman.

1. Intake Screening and Treatment Before Restraint Device

Assistant Chief Deputy Robert Aspleaf explained to the Ombudsman that G.A. had a history of mental illness before he entered the jail. In 2004 G.A. was arrested for assault and spent time at Woodbury County Jail. During his incarceration at that time, G.A. was prescribed Paxil, Risperdal, and Depokote while at the jail for “psychosis” and “depression.” The jail’s medical records from his 2006 incarceration revealed G.A. was diagnosed with adjustment disorder with anxiety, depression, and anti-social personality disorder. The Ombudsman requested, but never received, medical or mental health intake sheets from G.A.’s 2006 admission into the jail, so it is unknown what information G.A. reported to intake staff regarding medical or mental health history.³³⁶ However, four days after his June 25, 2006, admission into the jail, G.A. filed a medical request to see a mental health professional. He reported depression and anxiety. Despite the jail having in its possession the 2004 medical sheets listing G.A.’s previous diagnosis and medications, G.A. was not seen by the physician’s assistant until September 1, 2006.

The day G.A. saw the physician’s assistant, he was prescribed Seroquel, a drug commonly prescribed for bipolar disorder and schizophrenia. Medical sheets drafted at this time stated he was diagnosed with adjustment disorder with anxiety, depressive disorder, and anti-social personality disorder. Before this date, jail staff reported several incidents of aggressive behavior and specific threats against officers.

2. Immediate Facts and Circumstances of Restraint Devices Use

On September 2, the day after he was evaluated by the physician’s assistant, G.A. was directed out of his cell when he tore the cell light from the wall. When he walked out of the cell, G.A. was carrying a sharpened toothbrush in his hand, which he dropped when an officer yelled at him. However, he tried to strike the officer whom he previously made threats against, and a struggle resulted in injuries to the officer. Officers took G.A. to a padded cell, where he continued to make threats. When officers observed him peeling

³³⁶ E-mail from Linda Brundies, Assistant Ombudsman, Iowa Citizens’ Aide/Ombudsman, to Robert Aspleaf, Assistant Chief Deputy, Woodbury County Sheriff’s Office (Feb. 22, 2008, 7:29 CST) (on file with author); e-mail from Robert Aspleaf to Linda Brundies (Feb. 25, 2008, 13:49 CST) (on file with author).

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the padded wall off the cell window, they placed him on a restraint board. G.A. was able to loosen the straps and get his head free, and officers then transferred him in a restraint chair, where he remained for three hours.³³⁷

The next day, a dispute arose between G.A. and the officer regarding peanut butter. That dispute accelerated when officers noticed G.A. had pulled wall padding from the cell window as he had done the previous day. Officers immediately called for the restraint chair. While waiting for officers to arrive, G.A. continued to make threats toward officers. He held pieces of the padded wall in his hands and wrapped his head with a t-shirt, which he later described was intended to protect himself from pepper spray. When officers entered the cell, G.A. threw the pieces of wall at the officers. Shortly after, G.A. was placed on a restraint board, but when the straps did not hold, was transferred to the restraint chair at 4:52 a.m.

The jail was able to provide limited documentation of G.A.'s stay in the restraint chair. A log periodically states "CKING STRAPS ON [G.A.]," or similar words, followed by the initials of the officers who checked the straps. However, while the jail recorded the cell entry and initial placement in the restraint board and restraint chair, the jail did not document on video the duration of the restraint chair use. The jail could not provide any documentation showing staff periodically reviewed G.A.'s behavior to determine if he should be removed from the restraint chair or provide reports supporting the staff's decision to release G.A. from the restraints.

The Ombudsman received written documentation showing the staff nurse, Dan Nettleton, conducted a physical check on G.A. during the September 2 restraint use, but did not receive documentation indicating he reviewed the inmate during the seven-hour restraint on September 3. Mr. Nettleton told the Ombudsman a nurse would normally assess an inmate, the restraint device, the inmate's mental status, and his need to use the bathroom. According to Mr. Nettleton, he was on-call on September 3, but could not recall a notification to check on G.A. He further stated if he was called in, documentation should exist showing he was called in. The Ombudsman found no such documentation.

In the months following his placement in the restraint devices, G.A.'s Seroquel medication was adjusted on four additional occasions. After these adjustments were made and administered on a regular basis, Chief Robert Aspleaf reported to the Ombudsman that the jail had no further problems with G.A.'s behavior.

³³⁷ Jail documents refer to their restraining device as a "restrainer chair." For purposes of consistency, this report refers to the device by the general term "restraint chair."

B. Analysis, Conclusions, and Recommendations

The Ombudsman reviewed Woodbury County Jail's incident reports, security videos, activity logs, and restraint chair policies. The Ombudsman identified several areas of concern in G.A.'s case including intake screening and response to medical requests, medical review of the inmate during restraint chair use, notification of a mental health professional of restraint chair use, and documentation of periodic review to determine the continued need for the restraint chair.

1. Intake Screening and Response to Medical Requests

The Ombudsman cannot fully determine to what extent the jail had notice of G.A.'s mental health history. In reply to our requests for the 2006 jail intake screen, the jail asserted the Ombudsman's office had everything in the file. Iowa law requires certain procedures to be followed during a jail's booking process, including separating certain classes of detainees and identifying detainees that may be suicidal.³³⁸ Iowa law also requires during admission that jails determine if a detainee has a communicable disease, determine whether a detainee needs to see medical personnel, and provide a medical history intake form.³³⁹

According to Woodbury County Jail's policy and procedure, the jail has a formal relationship with Siouxland Mental Health (Siouxland) to see and treat inmates twice weekly.³⁴⁰ When an inmate requests mental health treatment during booking, the booking officer will notify nursing staff and refer an inmate to Siouxland if appropriate. In addition, Siouxland, through a program called "Project Compass," reviews the booking files each morning to evaluate new detainees for mental health problems.³⁴¹

Woodbury County Jail stated this office had "tapped the well" in response to its request for mental health intake sheets during G.A.'s booking.³⁴² Based on the record in the Ombudsman's possession, there was no medical or mental health history information dated the day of G.A.'s admission, June 25, 2006. If the Ombudsman received all the information in the jail's possession regarding G.A.'s screening, it appears no medical or mental health screen was done for G.A.

Aside from the implications that the jail violated Iowa law by not being able to locate or provide the intake documents this office requested, further concerns arise regarding the consequences of the jail's failure to administer a medical history for G.A. The jail

³³⁸ IOWA ADMIN. CODE r. 201—50.13(1) (2008).

³³⁹ IOWA ADMIN. CODE r. 201—50.15(6) (2008).

³⁴⁰ WOODBURY COUNTY JAIL POLICIES & PROCEDURES FOR HEALTH SERVS.: MENTAL HEALTH SITUATIONS, NURSING ASSESSMENT AND TREATMENT JSOG 118 (2007).

³⁴¹ *Id.*

³⁴² E-mail from Linda Brundies, Assistant Ombudsman, Iowa Citizens' Aide/Ombudsman, to Robert Aspleaf, Assistant Chief Deputy, Woodbury County Sheriff's Office (Feb. 22, 2008, 7:29 CST); E-mail from Robert Aspleaf to Linda Brundies (Feb. 25, 2008, 13:49 CST).

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provided documentation and medical sheets from G.A.'s previous stay at the jail in 2004. These sheets show G.A. was receiving three separate medications for his diagnosed psychosis and depression. However, no psychotropic medication was administered upon his admission in 2006. Nor was he prescribed medication for depression and anxiety until over two months had passed since he submitted a medical request. The Ombudsman believes the jail's apparent failure to conduct a medical history screen for G.A. upon his admission to the jail in 2006 contributed, in part, to the jail's failure to identify any previously diagnosed or new mental health condition.

Conclusion: Iowa law requires a medical history screen for all inmates admitted into a jail. The medical screen should identify physical medical conditions as well as mental health history that may require attention for purposes beyond only identifying whether an inmate is suicidal. This was not done when G.A. was admitted to the jail. Further, it took over two months for the jail to respond to G.A.'s request for medical attention for his depression and anxiety, a condition the jail was previously aware of during his incarceration two years earlier. The Ombudsman believes this was an unreasonable delay in obtaining necessary medical attention.

The Ombudsman makes the following recommendations:

1. Woodbury County Jail should provide a medical history screen, which includes current medical conditions and medications, along with a mental health history screen for all inmates entering the jail. The Ombudsman supports the use of the Brief Jail Mental Health Screen or other health-authority-approved mental health form to identify potential mental health conditions among inmates. The jail should consult with its current nursing staff and Siouxland to determine which screening form would be appropriate for the jail.

2. The jail must respond to an inmate's requests for mental health complaints in a reasonable amount of time.

2. Decision to Use Restraint Devices

Woodbury County Jail policy provides several reasons for placing an inmate in a restraint device, though under what conditions an inmate may be placed in a restraint device varies throughout the written policy.

Under "Purpose," the restraint board policy states:

To restrain a subject as to keep them, from **harming themselves or others.**³⁴³ (emphasis added).

Under "Policy," it states:

³⁴³ WOODBURY COUNTY JAIL POLICY, JSOG 149 4.4.2, Restrainer Board (Jan. 1, 2007).

The restrainer board may be used when an inmate is **combative, belligerent, suicidal or destroying his/her cell.**³⁴⁴ (emphasis added).

Under “Guideline,” it states:

Restraint devices shall not be applied as punishment and shall be used only when a prisoner is a **threat to self or others or jeopardizes jail security.**³⁴⁵ (emphasis added).

Later under “Guideline,” it states:

Verbal threats in themselves are not justification for the restraint device, or actions that are annoyances to the jail, i.e. food throwing, yelling, fist pounding or kicking. However, head banging may result in physical injury to the subject and cause rise to consider use of the device.³⁴⁶ (emphasis added).

Still later under “Guideline,” it states:

Inmates that are **belligerent and are destroying cell areas and causing extreme destruction** to the cell and physical harm to themselves may become necessary to use the restraint device.³⁴⁷ (emphasis added).

Each of these statements directing when the restraint board can be used appear on the first page of the policy. The policy provides contradictory directions when restraint device use is authorized. While the “Purpose” section does not mention destruction of the cell, it is mentioned in the “Policy” section. While the “Guideline” states restraint devices will be applied *only* when a person is a threat to self or others, or jeopardizes jail security, it later authorizes the use of restraint devices when the inmate is destroying a cell area and causing extreme destruction to the cell.³⁴⁸

While the policy seems to contradict itself, there is no provision in Iowa law allowing an inmate to be placed in a four- or five-point restraint for destruction of his cell while no other element of threat to self or other, or jeopardizing jail security is present. The section of the policy stating an inmate will be placed in a restraint device only on those

³⁴⁴ *Id.*

³⁴⁵ *Id.*

³⁴⁶ *Id.*

³⁴⁷ *Id.*

³⁴⁸ *Id.* It must be noted the policy under “Guideline” provides four elements connected by “and.” The policy is unclear whether any single element can justify restraint device use, or if all four must be present to justify its use. The general principle would be that all four elements would have to be present under the conjunctive “and,” and if any single element would justify its use, the policy would have used the disjunctive “or.” *See State v. Valin*, 724 N.W.2d 440, 446 (Iowa 2006). *But see In re Detention of Altman*, 723 N.W.2d 181, 187 (Iowa 2006).

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occasions when the inmate is a threat to self or others, or is jeopardizing jail security is consistent with Iowa law.

Restricting restraint device use to only the circumstances provided under Iowa law raises concerns about how the restraint board and the restraint chair were used on G.A. Incident reports from the officers involved during the September 3 placement do not indicate G.A. was a threat to himself or others, or a threat to security. Officer Blanchard's report reads as follows:

Officer Hutzell was opening the food pass to the cell to give [G.A.] his peanut butter when it was noticed that he had a piece of padding from the wall of the cell. [G.A.] told me that all we had to do is listen to him and he wouldn't give us these problems. I then asked for an Officer to bring the restraint chair to booking so that G.A. could be placed in it again. . . .

While waiting for RISC team member to arrive [G.A.] was taunting Officer's (sic) as they would pass the windows or door to his cell. [G.A.] was making threat to beat Officer's (sic) and that we should know better than to mess with him. I heard G.A. continue with his threats and behavior until I left the booking area.³⁴⁹

Officer Lewis' report reads:

On the above date and time, Officer Blanchard informed me that Inmate G.A. was threatening Officers and that we were going to call the RISC Team.³⁵⁰

Officer Heckert's report reads:

When I arrived to Booking officer [sic] Blanchard advised that we were going to go in and take the piece of the wall that Inmate [G.A.] had broken off and were going to place him on the restraint board.³⁵¹

None of the reports provided by the jail stated G.A. was a threat to himself or others, or was jeopardizing jail security. Instead, references were made that G.A. was making verbal threats against officers, even though the jail's own policy states verbal threats in themselves are not justification for the restraint device. While the reports mention padding being torn from the wall, video of the cell entry and restraint board placement shows only some padding on the floor torn from the window area; much less than "extreme destruction to the cell" requirement provided in written policy.

³⁴⁹ Belligerent Inmate Report from Officer Blanchard (Sept. 3, 2006).

³⁵⁰ Belligerent Inmate Report from Officer Lewis (Sept. 3, 2006).

³⁵¹ Belligerent Inmate Report from Officer Heckert (Sept. 3, 2006).

The Ombudsman is also concerned about the use of the restraint board and chair as the first step to prevent further destruction of the cell. Iowa law allows use of four- and five-point restraints only after other restraints have proven ineffective. The Ombudsman interprets this provision to mean less restrictive alternatives to four- and five-point restraints must be employed and have failed before restraint chairs, boards, and beds can be used. Other than placement in a padded cell, there is no apparent attempt to use less restrictive restraints on G.A. The Ombudsman believes the analogies from *Management and Supervision of Jail Inmates with Mental Disorders*, addressing alternatives to the use of restraints, are on point in this case:

Consistent with the notion of using the least restrictive alternative, officials should consider whether an inmate simply can be placed in a cell out of earshot of other inmates prior to gagging. Similarly, if an inmate is tearing up a cell, is placing him in a strip cell, which contains nothing he can destroy, a less restrictive response than putting him in restraints?³⁵²

The Federal Bureau of Prisons has contemplated the use of less restrictive restraints before resorting to restraint devices. The federal policy incorporates the practice of progressive restraints, including the use of ambulatory restraints, which allow an inmate to eat, drink, and take care of basic needs without staff assistance.

Conclusion: The Ombudsman finds Woodbury County Jail violated its own policy and state law when it used the restraint board and chair on G.A. for only limited damage to his cell and making verbal threats to jail staff. The Ombudsman does not believe the jail complied with Iowa law when it did not attempt to employ less restrictive restraints before using the restraint board and chair.

The Ombudsman makes the following recommendations:

3. Woodbury County Jail should draft written policy that is consistent internally and with Iowa law. The policy should make clear that a restraint device should only be used if an inmate is a threat to self, others, or the security of the jail. The policy should also state that jail staff, when possible, should attempt less restrictive restraint before employing a four- or five-point restraint device. Minor cell damage and verbal abuse is not an appropriate basis for using a restraint device.

3. Type of Restraint Device Used

As indicated previously in this report, the Ombudsman has concerns regarding the restraint board as an effective tool for restraining inmates. This is due to the prone

³⁵² MARIN DRAPKIN ET AL., *MANAGEMENT AND SUPERVISION OF JAIL INMATES WITH MENTAL DISORDERS* 2-37 (2003).

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position that is required by the board. Several medical journals and professionals have detailed the risks associated with placing an inmate in a restrained prone position, which can restrict breathing and lead to adverse medical problems, including death.

The Woodbury County Jail has the option of choosing between the restraint chair and the restraint board. Its restraint chair is designed without straps crossing the chest or abdomen, reducing or eliminating the risk of positional asphyxiation. The jail transferred G.A. from the board to the chair on the two occasions reviewed by the Ombudsman because G.A. was able to loosen the board's restraining straps, but there was no apparent need to transfer him from the chair to any other device.

The Ombudsman also takes notice of one court's observations of restraint board use in another county jail in Iowa. The U.S. District Court for the Northern District of Iowa provided a commentary on the restraint board when it reviewed a case of an inmate's placement on the device: "This device is more than just uncomfortable. It is a restraint that should be used only for the amount of time necessary to restore order."³⁵³

The differences between a restraint chair and restraint board were discussed in unsettling detail in a post from a correctional officers forum:

Thread: Pro-Restraint Chairs?	
06-28-2006, 10:56 PM	#6
[username deleted] ³⁵⁴ Forum Member Join Date: May 2006 Location: sioux city iowa Posts: 18	We have one, we love it. Had it about 8 years now, use it probably 12-15 times a year. We also have a restrainer board. It's really just an over-sized piece of plywood. It has velcro straps that secure the head, scapular area, low back, tricep and wrist area, hamstring, calf and ankles. Works really great when the badboys are naked, those exposed bones pressed down to the board. It makes the tough ones beg.....

The Ombudsman became aware of this post while conducting Internet research for this case and subsequently learned it was written by an officer at the Woodbury County Jail. The jail acknowledged the forum comments came from one of their officers, but claimed an officer posted the comments under another officer's username. "We have a shared computer system, and we believe that [the officer] was visiting the police forum website and was called away before logging off the internet. Another officer went to the computer, saw the website that [the first officer] had visited, and posted the reply as a

³⁵³ *Ogden v. Johnson*, No. C00-0034, 2002 WL 32172301, at *3 (N.D. Iowa Sept. 5, 2002).

³⁵⁴ <http://forums.officer.com/forum.showthread.php?t=49486>. (last visited Oct. 30, 2008). Because the Ombudsman did not conduct an extensive investigation to substantiate the jail's claims and identify the officer who posted the comments, the username has been redacted.

joke.”³⁵⁵ Though the jail claimed the posting was a joke, it did not indicate it identified or spoke to the post’s author before reaching this conclusion.

Regardless of the writer’s intent, the Ombudsman believes the comments were inappropriate. At worst, it suggests a favorable view towards using the restraint board in a punitive manner and at best it shows insensitivity to an issue that should be and was the subject of a serious discussion on the forum. The post heightens one of the Ombudsman’s initial concerns from reviewing inmate complaints referenced in this report. Several inmates claimed the restraint devices were used for torture, that they were physically abused while in the devices, or that use of the devices was excessive to abate their behavior. The Ombudsman believes the use of restraint devices for punishment or to inflict pain constitutes an abuse of the restraint device, a violation of Iowa law, and a violation of an inmate’s Eighth Amendment rights.

Conclusion: The restraint board inherently carries a higher risk of injury or death compared to the restraint chair. For these reasons, the Ombudsman prefers the use of the restraint chair over the restraint board currently employed by the Woodbury County Jail.

The Ombudsman makes the following recommendations:

4. In all circumstances, when jail staff determine a four- or five-point restraint device is the only option to control an inmate, jail staff should use the restraint chair rather than the restraint board.

4. Medical Review of Inmate in Restraint Chair

G.A. was prescribed Seroquel on September 1, 2006, for depression and anxiety, and during the following two days, the jail had to employ two different restraint devices in response to his aggressive behavior. The jail was able to provide documentation that Dan Nettleton, RN, reviewed G.A.’s condition while in the restraint chair on September 2, 2006. On this date, G.A. was restrained for a total of three hours. In contrast, there is no documentation the jail’s medical staff reviewed G.A.’s condition while he was restrained for seven hours on September 3. Mr. Nettleton told the Ombudsman he was on-call that date, but did not recall reviewing G.A.’s condition or having any documentation of reviewing him during his restraint. Further, Mr. Nettleton told the Ombudsman he would have liked to have been notified.³⁵⁶

Woodbury County Jail uses a restraint chair manufactured by E.R.C. Inc. According to the manufacturer’s instruction manual, detainees should not be left in the restraint chair for more than two hours.³⁵⁷ The manufacturer told the Ombudsman that this time limit,

³⁵⁵ Letter from Robert Aspleaf, Assistant Chief Deputy, Woodbury County Sheriff Office, to Andy Teas, Assistant Ombudsman, Iowa Citizens’ Aide/Ombudsman (Oct. 10, 2008) (on file with author).

³⁵⁶ Telephone interview by Linda Brundies, Assistant Ombudsman, Iowa Citizens’ Aide/Ombudsman, with Dan Nettleton, Registered Nurse, Woodbury County Jail (Mar. 16, 2007).

³⁵⁷ E.R.C. Inc., EMERGENCY RESTRAINT CHAIR INSTRUCTIONS 12 (Feb. 10, 2001).

in part, allows the correctional facility to seek medical or psychological help for the detainee. The two-hour time limit may be extended only under direct medical supervision by a doctor or nurse. The NCCHC standards and the ACA standards require health services staff be notified immediately when a restraint device is used for the purpose of reviewing the inmate's medical record and monitoring the continued use of the restraint device.

Conclusion: Given the extensive time G.A. was left in the restraint chair, the Ombudsman finds that Woodbury County Jail should have contacted the nurse who was on-call immediately after G.A. was placed in the restraint chair on September 3. The minimal step the jail should have taken, in accordance with the restraint chair manufacturer's instructions, would be to contact medical staff when it determined the restraint chair was required beyond the initial two hours of use. Medical staff would thereafter monitor the continued use of the restraint chair until G.A.'s release. The jail does not currently have a policy requiring medical reviews of inmates placed in the restraint chair.

The Ombudsman makes the following recommendations:

5. Woodbury County Jail should incorporate language in its policy requiring medical staff be immediately notified when an inmate is placed in a restraint device. Written policy on restraint chair use should reflect the manufacturer's instructions by requiring direct medical supervision if an inmate must be restrained in the restraint chair for longer than two hours.

5. Notification of Mental Health Professional

On September 1, 2006, physician's assistant Dawn Nolan saw G.A. in response to his medical request submitted two months prior. Ms. Nolan prescribed him Seroquel® that day, a drug commonly prescribed for depression, bipolar disorder, and schizophrenia.³⁵⁸ G.A. spent three hours in the restraint chair on September 2 and seven hours on September 3. However, Ms. Nolan was not involved in the supervision of his placement on either date. Nor was any mental health professional or Siouxland, which provides mental health intake screening services for the jail, notified of his placement.

The DOJ's investigation of Black Hawk County Jail concluded that when restraints must be used on an inmate with a serious mental illness, the jail must ensure mental health personnel are involved in the decision to restrain the inmate.³⁵⁹ According to *Health Care Management Issues in Corrections*, when an inmate with a diagnosed or suspected mental illness is placed in restraints, staff should notify mental health personnel as soon

³⁵⁸ http://www.rxlist.com/script/main/srchcont_rxlist.asp?src=seroquel (last visited Oct. 30, 2008).

³⁵⁹ Letter from Bill Lann Lee, Acting Assistant Att'y Gen., Civil Rights Div., to Brian S. Quirk, Chair, Black Hawk County Bd. of Supervisors, at "Minimum Remedial Measures, Mental Health Care, recommendation 10" (Jan. 4, 1999), available at <http://www.usdoj.gov/crt/split/documents/bhfind.htm>.

as possible for clinical advice on the continuation of the restraint.³⁶⁰ The NCHC and the ACA require, pursuant to their policies, that medical personnel be notified if an inmate who has a suspected mental illness is placed in restraints. As mentioned above, the E.R.C. Inc. instruction manual states the two-hour time limit allows the correctional facility to seek medical or psychological help for the detainee. The manufacturer's Customer Letter repeats this policy by stating "[t]his time limit was established to allow . . . the correctional officer to seek medical or psychological (sic) help for the detainee."³⁶¹

Conclusion: The Ombudsman believes the jail had adequate knowledge that G.A.'s mental health condition could have played a part in his aggressive behavior. The Ombudsman finds Woodbury County Jail's failure to contact a mental health professional unreasonable, given the jail's existing relationship with Siouxland Mental Health, the jail's medical and mental health information from G.A.'s prior incarceration, and G.A.'s evaluation immediately prior to the restraint chair use.

The Ombudsman makes the following recommendations:

6. Woodbury County Jail should incorporate language in its written policy requiring a mental health review, conducted by a mental health professional, of any inmate with a known or suspected mental illness who is placed in a four- or five-point restraint device.

6. Written and Video Documentation

The jail was not able to provide documentation for either restraint occasion showing G.A. was periodically reviewed to determine whether he could be safely released from the restraint chair. It also could not provide documentation on the jail's rationale when it did release him. Written officer reports cover only the events leading up to the need for the restraints and end after G.A. was placed in the restraint chair. Aside from the cell entry and initial placement on the restraint board and the chair, the jail did not video record its use of the restraint chair. Only vague written logs recording when the straps were checked, tightened, or loosened recount the events during the restraint chair use.

Jail policy states restraint devices must not be used as punishment and only used when a prisoner is a threat to themselves or others, or jeopardizes jail security. The policy also explicitly states "[r]estraint devices (sic) shall not be applied for more time than is necessary to alleviate the condition requiring the use of the restraint device."³⁶² This policy reflects Iowa law, federal case law, and the manufacturer's policy. Cited throughout this report are federal district court cases, including two in Iowa, that have

³⁶⁰ KENNETH L. FAIVER, HEALTH CARE MANAGEMENT ISSUES IN CORRECTIONS 152 (1998).

³⁶¹ Letter from Thomas Hogan, President, E.R.C. Inc., to Customer (Jan. 17, 2001).

³⁶² WOODBURY COUNTY JAIL POLICIES AND PROCEDURES, JSOG 149 4.4.2 (2007).

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found correctional facilities liable for not being able to justify continued use of restraint devices, even while initial placement was deemed appropriate.³⁶³

The Ombudsman's concern with Woodbury County Jail is that the jail has no record or documentation that justifies or demonstrates the continued need for restraints. This left questions for the Ombudsman as to the need for the lengthy restraint and could expose the jail to liability if the inmate brought a claim. If the restraint chair is used for more time than was necessary to alleviate the condition requiring its use, questions arise whether the use constitutes punishment in violation of its policy, Iowa law, and Eighth and Fourteenth Amendment protections.

The Woodbury County Jail provided the Ombudsman with video of the cell extraction, restraint board placement, and the transfer from the restraint board to the restraint chair. However, the recordings end after G.A. was secured in the restraint devices. Along with a lack of written documentation, the jail cannot provide any supplementary video documentation showing G.A.'s behavior and need for continued restraint.

The Ombudsman strongly endorses the use and retention of video documentation for the inmate's duration in a restraint device. A recording provides an accurate account of the events leading up to and during restraint. It provides a resource for supervisors to review the actions of officers and make any necessary changes to procedures. It can also be used to identify actions that are contrary to policy that may require disciplinary action, or to rebut false allegations from inmates about officer abuse. All recordings of restraint device use should be kept for at least two years, the duration of Iowa's statute of limitations for tort actions.

Conclusion: The Ombudsman finds the jail's ability to provide only scant documentation addressing the restraint chair use was unreasonable. Without documentation drafted contemporaneously with the observation of the inmate's actions and disposition, the jail cannot show how the inmate remains a threat to self, others, or security at the facility. This leads to questions whether the jail is using the restraint device for legitimate purposes allowed under law or for punishment in violation of Iowa law and the inmate's constitutional rights. Absent clear documentation addressing the continued need for restraint device use, the Ombudsman must conclude that use is not justified.

The Ombudsman makes the following recommendations:

7. Woodbury County Jail needs to show continued use of the restraint chair is necessary and should do this by having staff document their observations either in reports or facility logs – preferably both.

³⁶³ *Sadler v. Young*, 325 F.Supp.2d 689 (W.D. Va. 2004); *Ogden v. Johnson*, No. C00-0034, 2002 WL 32172301 (N.D. Iowa Sept. 5, 2002); *Rogers v. Dunn*, No. C00-0188-PAZ, 2001 U.S. Dist. LEXIS 22710 (N.D. Iowa Nov. 27, 2001).

8. The jail should incorporate the practice of video recording the placement of an inmate in a restraint device, the duration of its use, and the release of the inmate. This practice should also be reflected in the jail's written policy as part of the procedures for restraint device use. Copies of each recording should be retained for a minimum of two years.

Appanoose County Jail – Findings, Conclusions, and Recommendations

A. Findings of Fact

T.F. wrote to the Ombudsman on February 3, 2007, claiming she was harassed by the Centerville Police Department on December 31, 2006. She described being held in a restraint chair for ten hours after her arrest. She claimed that when she was “hollering for someone to let me out so I could go to the bathroom” during her restraint, a female jailer came to the door with a male officer. The male officer told her if she didn’t shut up she would be “tazered” (sic) while holding the Taser in his hand.³⁶⁴ She claimed she defecated when officers left her in the chair.

1. Inmate Reception and Placement in Restraint Chair

An officer’s incident report states T.F. arrived at the jail at 7:00 p.m. and was aggressive from the beginning when she refused to get out of the patrol car.³⁶⁵ A video reviewed by the Ombudsman showed T.F. in handcuffs escorted into a small room by several officers. She appeared to be hyperventilating, not responding to questions, and unintelligible, except for repeating the words “get them off,” apparently referring to the handcuffs. An ambulance was called 15 minutes after T.F. arrived at the jail, but medical personnel could not find anything wrong with her. Soon after medical staff left, Officer Cairns’ report states T.F. jumped out of a chair and hid behind the booking counter. The report states T.F. began punching herself in the face, hitting her head against the wall, and jammed her thumbs in her eyes. She told officers if she stayed there, she would die. She was then placed in the restraint chair for the first of two occasions that night at 7:40 p.m. She soon calmed down and was released at 7:56 p.m.³⁶⁶

The video, referred to in an incident report as the “O.W.I. camera,” was used to record T.F.’s actions and the breath test. It was not intended to record or observe her placement in the restraint chair. When T.F. refused to participate in the breath test, the camera was shut off, approximately an hour after it started recording. Officer Cairns’ report stated T.F. tried to get her medications out of her purse after the breath test. When an officer tried to stop her, a struggle ensued. At 8:16 p.m., T.F. was placed in the restraint chair a second time and moved to a temporary cell, where she remained for the next ten hours.³⁶⁷

2. Restraint Chair Monitoring

Officer Cairns reported he checked on T.F. every 15 minutes and loosened the arm restraints twice. At one point, T.F. was able to get her head under a shoulder strap, trying to strangle herself with it.”³⁶⁸ Officer Cairns notified T.F. several times that if she

³⁶⁴ A Taser is a weapon that uses electrical impulses to cause neuromuscular incapacitation in a subject. <http://www.taser.com/research/technology/Pages/NeuromuscularIncapacitation.aspx>.

³⁶⁵ Incident Report from C.O. Mitch Cairns (Dec. 31, 2006).

³⁶⁶ *Id.*

³⁶⁷ The Jail’s restraint chair was purchased from E.R.C. Inc. in 2001.

³⁶⁸ Incident Report from C. O. Mitch Cairns (Dec. 31, 2006).

calmed down, he would remove her from the restraint chair. For the remainder of his shift, which ended at 11:00 p.m., T.F. continued to yell and curse at officers. When Officer Vicky Butler arrived at that time, she reported hearing an inmate yelling and threatening jail staff. Soon after her shift started, Officer Butler reported hearing T.F. yell, “I will kill you if you don’t get me out of this chair.”³⁶⁹ An hour-and-a-half later, T.F. yelled, “I will kick your ass when I get out of this chair.”³⁷⁰

T.F. remained verbally disruptive for the next five hours. Officer Butler’s report states at 5:35 a.m., T.F. began rocking the restraint chair in an attempt to tip it over. Officer Butler called additional officers to the jail. “Deputy Carter, Wayne Moore, and Rick Butler arrived in the jail. Deputy Carter advised T.F. to stop yelling and trying to tip the chair over or she would be Tased.”³⁷¹ According to T.F.’s letter to the Ombudsman, she was yelling because she needed to use the restroom, and defecated herself when officers refused to let her out. She was released from the restraint chair at 6:00 a.m.

The Ombudsman obtained a shift log indicating when T.F. was checked during Officer Butler’s shift and the incident reports from Officer Cairns and Officer Butler. However, Jail Administrator Deloris Beck stated no other officer wrote a report, including Officer Carter who threatened to use the Taser on T.F. While the Ombudsman was able to review the O.W.I. video, the jail could not provide a copy of the security tape that documented T.F. in the restraint chair because it had automatically been recorded over.

The jail has no in-house medical or mental health staff, and the jail does not routinely contact medical or mental health professionals during or after an inmate has been placed in the restraint chair. Nor does written policy require contact with medical or mental health staff. In its entirety, the Appanoose County Jail restraint chair policy and procedure states:

POLICY

The Emergency Restraint Chair (E.R.C.) is intended to help control combative, self destructive, or potentially violent inmates. All staff involved in the use of the Emergency Restraint Chair shall be trained in the proper usage of the chair.

PROCEDURES

1. When appropriate all detainees’ personal property shall be removed prior to placement in the ERC.
2. The detainee should be handcuffed and wearing leg irons when warranted.
3. Restraint straps are not to be placed around detainee’s chest, head, or neck.
4. Detainees placed in the Emergency Restraint Chair must be monitored continuously by CCTV. Personal observation will be every 15 minutes.

³⁶⁹ Incident Report from C.O. Vicki Butler (Dec. 31, 2006).

³⁷⁰ *Id.*

³⁷¹ *Id.*

5. Detainees are to be removed from the chair when it is believed that there is no longer a threat to self or others.
6. Detainees shall not be left in the Emergency Restraint Chair for more than two hours at a time. This time may be extended, but only under direct medical supervision. [*Second sentence added during June 26, 2007, revision.*]
7. Jail Administrator and/or Jail Supervisor shall be notified as soon as possible that a detainee has been placed in the Emergency Restraint Chair.

Administrator Beck stated in a letter to the Ombudsman dated March 12, 2008, that T.F. was the only inmate the jail has left in the restraint chair for more than two hours and did so because staff felt they were in danger since she was displaying aggressive behavior throughout the night.

B. Analysis, Conclusions, and Recommendations

The decision to place T.F. in a restraint chair arose soon after her arrival at the Appanoose County Jail. As such, the jail could not conduct a full medical and mental health background to determine her history and needs in these areas. Based on the documented physical aggression of T.F. and verbal threats, the Ombudsman believes the jail had sufficient security concerns to place her in the restraint chair. However, several areas of concern need to be addressed after her placement, including the periodic medical and mental health reviews of T.F., an officer's threat and the jail's policy of allowing the use of a Taser device on inmates in the restraint chair, and the lack of video documentation during the restraint chair use.

1. Medical and Mental Health Review During Restraint Chair Use

Before T.F.'s first 15-minute placement in the restraint chair, jail staff called for an ambulance to review her medical condition due to her hyperventilating. A brief review determined she did not require medical attention. Shortly after medical personnel left, staff placed her in the restraint chair when she began punching herself in the face, hitting her head against the wall, and jamming her thumbs in her eyes. She was placed in the restraint chair a second time when she tried to get medication from her purse and struggled with jail staff. The second placement lasted almost ten hours.

The jail uses a restraint chair manufactured by E.R.C. Inc. According to the manufacturer's instruction manual, an inmate is not to be left in the restraint chair for more than two hours – a policy the manufacturer repeats on its website, instructional video, and letter to customers. This time limit may only be extended after direct medical supervision by a doctor or nurse. The chair's manufacturer, Tom Hogan, explained to the Ombudsman that the initial two hours allows jail staff to observe any unusual behavior by the inmate and contact a medical or mental health professional as necessary. The NCCHC standards and the ACA standards recommend jail staff notify health services immediately when restraints are used in order to review the inmate's medical record and monitor the continued use of the restraint device.

According to Jail Administrator Deloris Beck, the jail does not routinely contact a medical or mental health professional during or after an inmate's placement in the restraint chair.³⁷² However, according to written policy, an inmate cannot be left in a restraint chair for longer than two hours unless under direct medical supervision. Administrator Beck also stated that the jail has no in-house medical or mental health personnel, and instead relies on a local hospital for emergency medical care. The local hospital was not consulted during or after T.F.'s placement, and no other medical professional reviewed her condition.

T.F.'s behavior before her placement and the length of time that was needed for the restraint chair use should have alerted staff of a potential mental illness. A suspected mental illness may come from responses to questions during the medical screen at admission, or it could come from the inmate's statements or behavior after admission. In this case, the video showed T.F. to be violent and incoherent, and officer reports stated she was hitting herself and trying to jam her thumbs in her eyes. This behavior should have raised concerns about the presence of a potential mental illness. A mental health professional would have been able to evaluate T.F. to determine if the aggressive actions were behavioral or the result of a mental illness. A mental health professional would also have been able to evaluate the inmate to determine whether the jail had the capacity to provide for her or whether she needed to be placed in another facility.

T.F. apparently was an exceptional case for the jail. Administrator Beck reported she was the only inmate the jail has left in the restraint chair for more than two hours. This provides additional evidence that medical staff and mental health professionals should have been contacted during the restraint chair use. This was not a normal circumstance where the device was used for a brief incident until an inmate calmed down. The exceptional use of the restraint chair on T.F. should have alerted jail personnel that there could have been a medical or psychological emergency causing T.F.'s aggressive action, as is contemplated by the manufacturer's instruction manual, instruction video, and Customer Letter.

Conclusion: The Ombudsman concludes the Appanoose County Jail acted contrary to its own policy when it failed to consult a medical professional. It is important a medical professional evaluates the inmate in-person to determine whether any medical needs must be addressed. The jail acted unreasonably when it failed to contact a mental health professional during T.F.'s restraint, given her aggressive behavior before and during the restraint.

The Ombudsman makes the following recommendations:

- 1. Appanoose County Jail should adopt written policy detailing when medical and mental health staff should be contacted during restraint device use.**

³⁷² Id.

a. Medical staff should be notified immediately when an inmate is placed in a restraint device. The written policy should reflect the manufacturer’s instructions requiring direct medical supervision if the restraint device is required beyond the initial two hours.

b. Written policy should require jail staff to contact a mental health professional in the event an inmate with a known or suspected mental illness needs to be placed in a restraint device. The jail should enter a formal relationship with a mental health professional to provide this service. The sheriff’s office should work with the county’s central point of coordination (CPC) to locate a mental health contact that can provide these services.

2. In the event that cost and the lack of local services is a prohibitive factor in obtaining mental health services, the jail should review the use of telemedicine to obtain these services outside the region.

2. Potential Use of Taser Device While in Restraint Chair

According to T.F.’s letter to the Ombudsman, she hollered at staff to let her out so she could go to the bathroom. A correctional officer threatened to “Taser” her if she did not shut up. An officer’s incident report states T.F. was rocking the restraint chair and trying to tip it over, at which time Deputy Carter told her to stop yelling and trying to tip the chair over, or she would be “Tased.” T.F. stopped yelling and claims she defecated while in the chair. Administrator Beck informed the Ombudsman there is no record of T.F. requesting to use the restroom and according to jail staff, she did not urinate or defecate while in the chair.³⁷³

Based on the Ombudsman’s review, there are no Iowa or Eighth Circuit cases involving the deployment of a Taser device on inmates who are also in a restraint device. However, the Ombudsman reviewed a federal district court case from Missouri that described a jail inmate suffering from the effects of narcotics who had to be placed in a restraint chair.³⁷⁴ When medical staff attempted to insert an IV to counter the effects of the narcotics, the inmate would make movements to dislodge the IV or cause it to reverse its flow. Jail staff then deployed the Taser against the inmate’s neck. The district court found the use of the Taser to be objectively reasonable since jail staff deployed it for the inmate’s safety to administer the IV, for officer safety to prevent the spread of communicable disease, to maintain control of the jail, and to gain the inmate’s compliance.³⁷⁵

The Ombudsman questions the rationale for the use of a Taser device on an inmate placed in a restraint chair. The restraint chair is used as a means to control a violent inmate who may be a threat to themselves or others. If the inmate continues to be a threat

³⁷³ *Id.*

³⁷⁴ *McBride v. Clark*, No. 04-03307-CV-S-REL, 2006 WL 581139 (W.D. Mo. Mar. 8, 2006).

³⁷⁵ *Id.* at *23.

to themselves or others after being placed in a restraint device and a Taser is needed for control, the usefulness of the restraint device to control an inmate is called into question. The Ombudsman spoke with Tom Hogan, who invented, manufactured, and marketed the restraint chair used by the Appanoose County Jail. When asked about the use of a Taser device, Mr. Hogan replied, “I cannot think of a circumstance where someone would use pepper spray, Taser, or stun gun on an inmate who is in the restraint chair.”³⁷⁶ According to Mr. Hogan, it is almost impossible to tip the restraint chair if the inmate is strapped in properly. Further, he suggested a simple solution of backing the restraint chair into a corner to minimize any possibility of tipping the restraint chair. Given the low likelihood the restraint chair could be tipped over, he contemplated that it may even be beneficial to let the inmate “bounce around” in the chair to use energy and hopefully calm down sooner.³⁷⁷

The Ombudsman observed a solution another county jail came up with to secure the restraint chair. The jail, which uses the same restraint chair as Appanoose County Jail, bolted a metal “lip” to the concrete floor that hooked on the foot plates of the chair. While it is not known whether this method is approved by Mr. Hogan, the Ombudsman believes it is a better alternative to deploying a Taser on an inmate to prevent the chair from tipping.

Conclusion: Although a Taser was not deployed in this incident, jail staff indicated it potentially could be used on the inmate in the restraint chair. The Ombudsman opposes the use of Taser devices while an inmate is in a restraint device unless absolutely necessary and other less restrictive options for reducing the threat to the inmate’s self are not available.

The Ombudsman makes the following recommendations:

3. Appanoose County Jail should draft a policy detailing the limited circumstance when a Taser device may be deployed on an inmate who is secured in a restraint device. The jail should explore alternatives that would reduce the likelihood of the restraint chair tipping due to an inmate’s aggressive behavior that do not include the use of a Taser.

3. Toilet Breaks

The Ombudsman cannot substantiate the inmate’s claim that she defecated while in the restraint chair when staff refused to let her use the toilet. Jail staff reported she did not defecate or urinate while in the chair, and no video documentation is available to substantiate either party’s claim. However, it is relevant to review procedures set forth by other organizations and agencies to determine what practices should be in place for county jails who restrain inmates for extended periods of time.

³⁷⁶ Telephone Interview with Tom Hogan, President, Emergency Restraint Chair, Inc. (June 11, 2008).

³⁷⁷ *Id.*

According to the APA's Resource Document, which addresses the use of restraint devices for mental health interventions in jails and prisons, nursing staff should perform a medical assessment of the inmate every two hours, which would include the need for toileting.³⁷⁸ Separate from the medical assessments, toileting of the patient should be provided at least every four hours and more often if necessary. In the event the toilet facilities are outside the restraint area and safety concerns suggest that release would be unnecessarily dangerous, a urinal or bed pan should be used with appropriate considerations of both privacy and safety.³⁷⁹

The Federal Bureau of Prisons' policy provides the use of the toilet at every two-hour review, "unless the inmate is continuing to actively resist or becomes violent while being released from the restraints for this purpose."³⁸⁰ While the policy places conditional language for the break, it contemplates providing a break even if the inmate is a present threat to himself or staff if released:

Based on the particular nature of the situation, the Lieutenant who has offered the inmate a bathroom break will determine how many staff are needed to release the inmate from restraints and provide the inmate a bathroom break. The Lieutenant will assemble the staff and visually observe and direct staff as they complete this task. The Lieutenant will determine what protective equipment is needed, if any, for the staff assisting with the inmates (sic) bathroom break.³⁸¹

Conclusion: The Ombudsman believes it is possible T.F. needed to use the toilet during her restraint, given the alleged event occurred nine hours after her restraint. To not allow for toilet breaks and force inmates to sit in feces or urine is both unsanitary and inhumane.

The Ombudsman makes the following recommendations:

4. Appanoose County Jail should develop written policy allowing for toilet breaks of restrained inmates, including time increments to offer such breaks and the number of staff members required to facilitate the breaks.

4. Video Documentation

The Appanoose County Jail provided the Ombudsman with video of T.F.'s initial admission to the jail for purposes of O.W.I. documentation. However, once the attempt

³⁷⁸ JEFFERY L. METZNER ET AL., COUNCIL ON PSYCHIATRY AND LAW, THE USE OF RESTRAINT AND SECLUSION IN CORRECTIONAL MENTAL HEALTH CARE 6 (2006).

³⁷⁹ *Id.*

³⁸⁰ FEDERAL BUREAU OF PRISONS, PROGRAM STATEMENT P5566.06(10)(e) (2005), http://www.bop.gov/policy/progstat/5566_006.pdf

³⁸¹ *Id.*

to administer the breath test was complete, the video was shut off. When the Ombudsman inquired about any additional video, Administrator Beck stated the jail did not have video of T.F. in the restraint chair because “[t]he time for us to copy T.F. in the restraint chair had been recorded over before we knew we would need the video.”³⁸² T.F. contacted the Ombudsman approximately one month after her December 31, 2006, placement in the restraint chair. The Ombudsman contacted the jail two weeks later, and formally requested video documentation from the jail two months after the incident.

Conclusion: The video could have provided helpful evidence to evaluate T.F.’s claim that she defecated in the chair, and verified whether her behavior and actions justified continued use of the restraint chair or even the threat of the Taser deployment.

The Ombudsman makes the following recommendations:

5. Appanoose County Jail should use and retain video documentation of the placement, duration of use, and release of an inmate in a restraint device. Such documentation should be retained for at least two years, the statute of limitations for tort actions in Iowa.

³⁸² Letter from Deloris Beck, Jail Adm’r, Appanoose County Sheriff’s Office, to Andy Teas, Assistant Ombudsman, Iowa Citizens’ Aide/Ombudsman (Mar. 12, 2008) (on file with author).

Wapello County Jail – Findings, Conclusions, and Recommendations

A. Findings of Fact

J.L. entered Wapello County Jail for public intoxication on May 20, 2007, at 7:25 p.m. He called the Ombudsman on May 24, 2007, saying the jail ignored his bronchitis when it claimed he was faking the condition. He asserted he was put in the restraint chair when he tried to get medical attention for his bronchitis. An officer reportedly jumped on his chest, jammed fingers under his rib cage, and pulled his hair while he was restrained. J.L. later told the Ombudsman he had a rib fracture, caused by an officer striking him in the middle of the chest repeatedly. J.L. also alleged the officer also tried to pull his ribs out.

Based on the accusations, the Ombudsman obtained the incident reports and videotape of the incident. Many of J.L.'s accusations could not be substantiated by the video. The Ombudsman had further questions about the severity of J.L.'s bronchitis considering he was arrested for being belligerent, yelling at a mother and daughter, and registering a .239 on a preliminary breath test.³⁸³ However, the Ombudsman did have concerns regarding language in an officer's report and an incident filmed on a CCTV camera that showed an officer struggling with J.L. and striking him while in the restraint chair.

1. Placement in Restraint Chair

Approximately ten minutes after J.L. arrived at the jail, officers began preparing the restraint chair to restrain him. According to Officer Travis Bates' report, J.L. began hitting his head against the cell's window. Officers decided to use the restraint chair for J.L.'s safety. The restraint chair was set outside of J.L.'s cell, out of the full view of the camera. Though partially obstructed by a wall, the video shows two officers placing J.L. in the restraint chair. However, the tape ends at approximately 7:37 p.m. before placement was complete.

The next tape begins prior to officers removing J.L. from the restraint chair at 9:44 p.m. The removal occurred outside of J.L.'s cell, and again, the camera view was partially blocked by a wall. J.L. told the officers he was fine and would cause no more trouble, but soon after being released, he began striking the cell's window again.³⁸⁴ Thirteen minutes after his first removal from the restraint chair, officers initiated a second placement in the restraint chair.

While the video shows two officers present – identified as Officer Jeremy McDowell and Officer Nicole Cassatt in supplemental reports – only Officer McDowell was actively involved in placing J.L. in the restraint chair. Again, the restraint chair was set outside J.L.'s cell, out of full view of the security camera. J.L. immediately began resisting McDowell's efforts and in the ensuing struggle pushed the restraint chair into full camera

³⁸³ Complaint & Affidavit, *Ottumwa v. [J.L.]*, OTSMSM024472 (Iowa Dist. Ct. Wapello County, May 20, 2007).

³⁸⁴ Correctional Officer's Supplemental Report from Jeremy McDowell (May 21, 2007).

view. Officer McDowell is seen struggling to place J.L. in the restraint chair while another security camera angle shows Officer Cassatt holding the cell door open. After strapping J.L.'s arms, shoulders, and waist into the chair, Officer McDowell's report described what happened next:

While getting this fastened he kicked me in the head with his right foot. He tried again a couple of times to kick me again and I instructed him to put his legs down and quit kicking me. When he didn't comply I struck him in the sternum and told him to put his legs down again and to quit resisting till I got control of his legs and had them fastened.³⁸⁵

After placing the lap belt around J.L.'s waist, the video shows Officer McDowell reach back in a striking pose. Due to the choppy nature of the video, it does not show the impact of the blow. It does show Officer McDowell's arm extended outward into J.L.'s chest area and the restraint chair moved back several inches. Immediately afterward, another officer approaches the restraint chair and helps secure J.L.'s legs.

2. Documentation of Restraint Chair Use

The CCTV video at the time of J.L.'s restraint was set to only capture action through still pictures and was not streaming. In addition, there was no video observing J.L. while he was restrained during each of his two-hour sessions in the restraint chair. The camera closest to the cell was placed on the opposite side of the reception area and did not capture enough detail to provide the Ombudsman with any useful information on what took place in the cell. Any type of video observation was rendered useless the second time J.L. was placed in the restraint chair because the lights in his cell had been turned off.

The Ombudsman received three officer reports explaining the rationale for J.L.'s placement in the restraint chair, as well as Administrator Weller's summary to our office of his review. As cited above, Officer McDowell's report states that he struck J.L. in the sternum when J.L. would not stop trying to kick him. Administrator Weller's account states that Officer McDowell struck J.L. with a "soft blow to the stomach area," while Officer Cassatt's report states he struck J.L. right below the ribs.³⁸⁶

The video and officer reports are the only documentation the jail provided to the Ombudsman. However, these sources did not document the events over the duration of restraint chair use. Though specifically requested, no 15-minute log of the restraint chair was provided by the jail. Written jail policy states a daily activity log must be maintained on the inmate after placement in the restraint chair, documenting observations and activity every 15 minutes. While written policy also stated the inmate should be

³⁸⁵ *Id.*

³⁸⁶ Letter from Jeremy Weller, Jail Adm'r, Wapello County Jail, to Ombudsman's Office (June 8, 2007); Use of Restraint Chair on Inmate J.L. from C.O. Nicole Cassatt (no date provided).

considered for removal at least hourly, no documentation was provided showing this was done, nor was any reason given for why J.L. remained in the restraint chair beyond the initial hour after placement.

B. Analysis, Conclusions, and Recommendations

The Ombudsman relied on the security videos, written documents, and conversations with Jail Administrator Jeremy Weller for its conclusions. The Ombudsman identified three areas of concern, including (1) the application of the restraint chair, (2) documentation of the use of force, and (3) video documentation of the use of force. A full understanding of policies and practices of the jail was impaired by a lack of responsiveness from the jail during the investigation.³⁸⁷ However, the Ombudsman obtained sufficient facts and information to arrive at the conclusions listed below.

1. Application of Restraints

J.L. was placed in the restraint chair on two occasions the night of May 20, 2007, with a 15-minute break in between.³⁸⁸ J.L. was placed in the restraint chair on the first occasion for his own safety when he began hitting his head against the window of his cell. Security video of the first restraint shows two officers placing him in the restraint chair. After approximately two hours, officers released J.L. from the restraint chair. J.L. said he was fine and would cause no more trouble; but soon after being released, he began breathing heavily, claiming he had asthma, and pretended to pass out on the cell floor.³⁸⁹ When officers ignored him, he began hitting the glass with his arms and banging his head against the cell floor. Officers then decided to place him in the restraint chair a second time.

According to Officer McDowell's supplemental report, he called for assistance to place J.L. in the restraint chair the second time. The report stated he and Officer Cassatt removed J.L. from the cell and placed him in the restraint chair, but video of the incident showed only Officer McDowell actually trying to place J.L. in the restraint chair. Officer Cassatt is seen holding the cell door open, even after J.L. was removed from the cell. Officer McDowell is seen struggling with J.L. in an attempt to place him in the restraint

³⁸⁷ After reviewing the videos, written policy, and officer reports, the Ombudsman sent Administrator Weller a list of written questions on February 28, 2008, relating to the May 20, 2007, use of force by jail staff. The Ombudsman received a call from Administrator Weller on March 4 stating he understood the Ombudsman previously concluded staff had done nothing wrong. The Ombudsman explained no such conclusion had been reached at that point and the investigation was still open, as represented by the letter. When the Ombudsman heard nothing further from Administrator Weller, he left three messages for Administrator Weller and one for Chief Deputy Mark Miller between April 15 and May 13. The Ombudsman never received a return call. Instead, the Ombudsman received a set of documents via fax on May 14, many of which were duplicates of documents already obtained by the Ombudsman. None of the enumerated questions were directly responded to, and the only document the Ombudsman requested, the 15-minute activity log, was not provided.

³⁸⁸ Wapello County Jail, Emergency Restraint Log (May 20, 2007).

³⁸⁹ Correctional Officer's Supplemental Report from Jeremy McDowell (May 21, 2007).

chair for over two minutes. During that time, Officer Cassatt never assisted Officer McDowell with the placement. Officer McDowell succeeded in applying the arm, shoulder, and waist straps, but when he attempted to apply the ankle straps, J.L. kicked him in the head. This was followed by Officer McDowell punching J.L. in the chest. After more than two minutes of struggling alone with J.L., Officer Cassatt and another officer approached and assisted Officer McDowell with applying the ankle straps.

The Ombudsman has not previously reviewed any cases presented to this office where a single officer is used to place an inmate in a restraint device. In fact, the Woodbury County Jail used five officers for its cell extraction, placement on a restraint board, and transfer to the restraint chair in one case reviewed by the Ombudsman. The Polk County Jail employed five officers in a restraint chair placement reviewed by the Ombudsman, with another two officers on hand. Five officers were used on at least one occasion by Jefferson County Jail during their placement of an inmate, and no fewer than three officers were actively involved in other restraint chair placements. While the restraint chair instruction manual does not provide a recommended number of officers to use the restraint chair, the instructor on the video informs the viewer, “Now, to do this properly, we should have a person on either side of the chair.”³⁹⁰ During an interview with the Ombudsman, E.R.C. Inc. President Tom Hogan confirmed he recommends at least two officers should be used to place an inmate in the restraint chair.³⁹¹

The Ombudsman believes the use of a single officer to actively place a resistant inmate in the restraint chair directly resulted in the officer getting kicked in the head. In addition, the subsequent punch by Officer McDowell occurred when J.L.’s arms, shoulders, and waist were restrained to the chair. The Ombudsman questioned whether this was the appropriate response from the officer when it appeared the officer had the opportunity to step away from the inmate, without the risk of a further attack from the inmate, until additional help could arrive. The Ombudsman did not receive any response to this written question from Administrator Weller.

Conclusion: Officer McDowell acted unreasonably when he attempted to place J.L. in the restraint chair by himself. The Wapello County Jail should ensure *at least* two officers are used to place an inmate in a restraint device. Using at least two officers means they would actively control and handle the inmate, not only observe the inmate’s placement in the restraint device. The number of officers recommended by the Ombudsman is based on the observations of the procedures employed by other county jails and the recommendation from the restraint chair instruction video. The use of at least two officers is necessary to prevent injury to the officers and the inmate.

Punching J.L. in the chest was not a reasonable response to being kicked in the head. The interest in gaining compliance at that moment did not outweigh the risk of serious injury or death that could have been caused by the punch to the chest. Officer McDowell had an

³⁹⁰ Videotape: Emergency Restraint Chair Instructions (E.R.C. Inc.)

³⁹¹ Telephone Interview with Tom Hogan, President, Emergency Restraint Chair, Inc. (June 1, 2008).

opportunity to step away from J.L. until another officer could arrive to help with the restraint. J.L. was restrained by his arms, shoulders, and waist, and he posed no further physical threat to staff if Officer McDowell had stepped away.

The Ombudsman makes the following recommendations:

- 1. The Wapello County Jail should include language in its written policy and training requiring at least two officers to actively place an inmate in the restraint device.**
- 2. The jail should adopt language in its policy that details what type of force may be used on inmates who are fully or partially restrained in a restraint device.**

2. Observation and Documentation

Iowa law requires 15-minute checks of the inmates and the restraint device as well as documentation of all decisions and actions.³⁹² The jail's written policy in effect at the time of J.L.'s placement in the restraint chair stated:

During the time period that the inmate is restrained in the chair, an activity log will be kept **with detailed entries being made every 15 minutes.**³⁹³ (emphasis added).

The Ombudsman requested, but never received, a log of the 15-minute checks on J.L. during each of his two-hour sessions in the restraint chair. Administrator Weller faxed documents on May 14, 2008, with the cover sheet stating “[h]ere are the documents you requested.” The Ombudsman must conclude that no logs exist documenting the 15-minute checks. In addition to Administrator Weller failing to provide an activity log with detailed entries of the 15-minute checks, the Ombudsman only received the portions of the security video pertaining to the placement and removal from the restraint chair. Therefore, the Ombudsman has no written or video evidence proving the 15-minute checks were conducted pursuant to Iowa law.

Wapello County Jail policy also requires the inmate “be considered for removal from the chair at least hourly.”³⁹⁴ Administrator Weller did not provide any documentation that J.L. was considered for removal hourly on either occasion he was restrained. While the officer reports detail the placement of each incident, they do not indicate an hourly check was conducted or a rationale for why J.L. was left in the chair each successive hour.

The Ombudsman has further concerns regarding the cell where J.L. was placed during the restraint chair use. The security video shows the room used during the restraint, along

³⁹² IOWA ADMIN. CODE r. 201—50.13(2)(f) (2008).

³⁹³ WAPELLO COUNTY JAIL POLICY AND PROCEDURE I-8A at 6 (2003).

³⁹⁴ *Id.*

with the other cells near it, had the lights turned off. As a result, it is impossible for the security camera to capture discernable events inside the cell where J.L. was restrained in the restraint chair. This creates a potentially dangerous situation if the inmate begins to have medical problems that require an immediate response and staff cannot see into the room, whether in-person or via the CCTV monitor. This also raises questions about how the jail would be able to comply with Iowa law requiring continuous observation if an officer cannot see the inmate in the darkened room.

Conclusion: The Wapello County Jail failed to provide evidence that 15-minute checks were conducted during the restraint chair use on J.L. The failure to keep an activity log with 15-minute entries is a violation of jail policy. The failure to conduct 15-minute checks is also contrary to the requirements of restraint device use under Iowa law. In addition, the jail did not follow its policy to conduct hourly checks of the inmate or document any decisions to keep the inmate in the restraint chair. The hourly checks serve to comply with Iowa law and inmates' constitutional rights that an inmate remain in the restraint device only for the amount of time the inmate remains a threat to self, others, or jail security.

The designated room for restraint chair use should be well-lit to enable staff to immediately determine if an inmate needs emergency attention. Turning the lights off in an observation room, when Iowa law requires continuous observation of an inmate in a restraint device, creates a dangerous situation for the inmate and potential liability for the jail.

The Ombudsman makes the following recommendations:

- 3. Wapello County Jail staff must conduct 15-minute checks of the inmate and restraint device application and maintain logs documenting the 15-minute checks of the inmate and the restraint device application.**
- 4. The jail should ensure lights in a cell holding the restrained inmate are always on, regardless of whether the jail uses in-person staff or CCTV to comply with the continuous observation requirement under Iowa law.**

3. Video Monitoring

The security video reviewed by the Ombudsman was motion-activated and recorded in a series of still shots. This made it difficult to accurately review the events from the video, including the exact moments when J.L. kicked Officer McDowell and Officer McDowell punched J.L. However, due to the time sequencing of the still shots, the Ombudsman was still able to discern these actions occurred. According to Administrator Weller, the jail has since switched to "streaming" video, so the action recorded is fluid.

The Ombudsman also had concerns about the placement of the security cameras. While it is difficult to determine the exact distance between the camera and the cell, it is

apparent they were on the opposite ends of a large booking area. The Ombudsman strongly endorses the use of video to record the placement and duration of restraint devices use, even if it is not required under Iowa law. The use of such video loses its relevance if the video does not capture any of the events it is intended to record. This issue is particularly relevant since the Iowa Administrative Code now allows continuous monitoring to be accomplished by CCTV.³⁹⁵ The distance between the camera and the subject and lighting of the area, as mentioned above, are two important considerations if video for documentation or continuous monitoring purposes is to be used.

In addition to the streaming video, Administrator Weller assured the Ombudsman the video camera has been placed in a position that clearly and accurately records the inmate in the restraint chair.

Conclusion: Video of the restraint chair use did not clearly and accurately capture the events that transpired while J.L. was restrained due to the distance between the security camera and the cell where J.L. was placed. The Ombudsman questions how jail staff could respond to an emergency if staff rely on the video for continuous monitoring but cannot clearly see the inmate on the video.

The Ombudsman makes the following recommendations:

5. The Wapello County Jail should ensure the video documenting the restraint chair use provides an accurate account of the events that transpire. This would include an unobstructed view of the placement and a clear, detailed image of the inmate during restraint use. Copies of each restraint video should be retained for a minimum of two years.

³⁹⁵ IOWA ADMIN. CODE r. 201—50.13(2)(f)(1) (2008).

Polk County Jail – Findings, Conclusions, and Recommendations

A. Findings of Fact

M.B. was placed in a restraint chair at Polk County Jail on December 21, 2007. An officer's Incident Report stated M.B. flooded his cell and covered the door window with toilet paper.³⁹⁶ When officers entered the cell to remove him, M.B. refused an order to turn around and kneel by his bunk and proceeded to come after staff in an aggressive manner. He was Tasered, removed from the cell, and placed in the restraint chair.³⁹⁷ M.B. contacted the Ombudsman claiming he was strangled by an officer while in the restraint chair and had bamboo sticks pushed under his finger nails.

The Ombudsman reviewed the incident reports and video of the placement and use of the restraint chair. The Ombudsman found no indication M.B. was strangled or had bamboo pushed under his fingernails. However, the Ombudsman did note potential violations of Iowa law and jail policy, including no apparent 15-minute checks of the inmate and the restraint as required under Iowa law, no hourly reviews to determine whether the inmate could be removed from the restraint chair as required under jail policy, and no medical review of the inmate after the initial two hours of restraint as recommended by the restraint chair manufacturer.

1. Inmate Monitoring During Restraint Chair Use

Approximately three minutes after officers entered his cell for the extraction, M.B. was placed in the restraint chair. Video of the restraint chair use recorded an officer ordering to staff "I want him facing the wall," before M.B. was placed in an observation cell. M.B. was placed in the cell at approximately 6:35 a.m. and was eventually released at 11:16 a.m. During this restraint, the Ombudsman only identified four potential checks before M.B. was released. Those checks, observed on the video, included:

- 6:40 Officer enters cell with medical staff to check inmate.
- 6:42 Officer enters cell to reposition chair after inmate rotates restraint chair.
- 8:14 Officer enters cell and appears to check inmate.
- 10:02 Officer speaks to inmate through door.
- 11:15 Staff begin releasing inmate from restraint chair.

According to Lt. Greg Peterman, the security tape "clearly shows staff walking past the restraint chair room."³⁹⁸ He explained that staff do not open the door to the cell to check inmates, but look through the window to observe them. The Ombudsman reviewed the video to look for any occasion where staff made a deliberate attempt to check the inmate, even if an officer did not stop to observe the inmate, talk to the inmate, or enter the inmate's cell. Counting these occasions, the Ombudsman observed:

³⁹⁶ Incident Report from Officer Susan Michalski (Dec. 21, 2007).

³⁹⁷ *Id.*

³⁹⁸ Letter from Lt. Greg Peterman, Polk County Sheriff's Office, Jail Div., to Andy Teas, Assistant Ombudsman, Iowa Citizens' Aide/Ombudsman (Apr. 8, 2008) (on file with author).

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- 6:40 Officer enters cell with medical staff to check inmate.
- 6:42 Officer enters cell to reposition chair after inmate rotates restraint chair.
- 6:46 Officer looks in cell.
- 6:57 Officer looks in cell.
- 7:32 Officer looks in cell.
- 7:36 Officer looks in cell.
- 8:14 Officer enters cell and appears to check inmate.
- 10:02 Officer speaks to inmate through door.
- 11:15 Staff begin releasing inmate from restraint chair.³⁹⁹

During the four additional occasions where officers appeared to make an attempt to check on M.B., he and the restraint chair were facing the wall opposite the cell door's window. The restraint chair has a high back in which photos taken of the inmate show the chair's back extending to the top of his head. Thus, the most an officer would be able to observe from behind is the back of the chair, the very top of the inmate's head, and the back of the inmate's arms.

The Ombudsman requested and received the special inmate supervision logs that documented the 15-minute checks. The logs appear to be entered by the same person for each 15-minute check, though the Ombudsman did not identify on the video a specific officer conducting the checks. The logs also show the checks were done exactly at 15 minutes on the hour, though the video showed irregular checks being conducted that did not match the logs. The jail did not respond to written questions inquiring about who specifically conducted the checks and if that person was the same who entered the checks in the logs.

In addition to the 15-minute checks, Polk County Jail policy requires the inmate be considered for removal from the chair at least hourly. This consideration is based on the inmate's immediate past behavior while restrained and the staff and supervisor's observations of the inmate. The Ombudsman inquired about these periodic hourly reviews of the inmate that were not apparent on the video, and no log or report indicated it was done. Lt. Peterman replied "[a]t one point in the video there was an officer who entered the room and physically checked [M.B.]."⁴⁰⁰ A review of the security video shows an officer entered the observation room at approximately 8:15 a.m., 90 minutes after the last physical check of the inmate. No other physical checks of the inmate were conducted during the next three hours of M.B.'s restraint, when he was released at 11:15 a.m.

Lt. Peterman did not explain why there was only one such review of the inmate when the jail's policy requires reviews to be conducted at least hourly. Further, for the one

³⁹⁹ Excluded from this list were occasions when officers were conducting other tasks, but looked in the cell, such as officers escorting prisoners through facility, transporting laundry carts past the cell, and washing their hands at a sink across the hall from the cell.

⁴⁰⁰ *Id.*

periodic review that was allegedly done, there is no documentation detailing what was observed or the rationale for keeping M.B. in the restraint chair after the review.

Polk County Jail policy requires the jail's health authority to be notified when an inmate is placed in the restraint chair:

[T]he health authority or designee on duty must be notified to assess the inmate's medical and mental health condition and to advise whether on the basis of serious danger to self or others, the inmate should be placed in a medical/mental health unit for emergency involuntary treatment with sedation and/or medical management as appropriate.⁴⁰¹

Approximately five minutes after M.B. had been placed in the restraint chair, the security video showed a staff member in a medical uniform enter the observation room with a correctional officer. The medical staff member stayed approximately one minute before exiting the cell. No documentation from this medical staff member was provided to the Ombudsman that detailed his observations or assessment of the inmate. So, it is not known what the medical staff member's conclusions were of M.B.'s medical and mental health condition, or what he conveyed to other correctional staff.

2. Documentation

According to Polk County Jail policy, when an inmate is restrained in the restraint chair, "an activity log will be kept with detailed entries being made every 15 minutes."⁴⁰² The activity log provided to the Ombudsman included a form with the date, time, inmate's activity, remarks, and the initials of the officer who entered the data. The inmate's activities documented on the form include a checklist of eight actions, including:

- ✓ Pacing
- ✓ Sleeping
- ✓ Sitting
- ✓ At Door
- ✓ Resting
- ✓ Reading
- ✓ Writing
- ✓ Watching TV

The activity log entries are hand-written precisely at 15-minute intervals for the times covering M.B.'s placement in the restraint chair and marked as "Sitting" each time for his activity. While 18 activities were documented on the activity log, only two entries were listed under "Remarks." At 6:35 a.m., the activity logs states "Placed into restraint chair," and at 11:20 a.m., it states "Removed From Chair."⁴⁰³ Therefore, based on

⁴⁰¹ POLK COUNTY SHERIFF'S OFFICE, JAIL DIVISION, SECURITY AND CONTROL, RESTRAINT CHAIR No. 6600.59(II)(A)(1) (2001).

⁴⁰² *Id.* at 6600.59(II)(A)(6).

⁴⁰³ Special Inmate Supervision Log for M.B. (Dec. 21, 2007).

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information provided by the activity log, a reviewer is informed M.B. was placed in the restraint chair, was sitting during its use, and was then released.

Missing from the activity log sheets is any documentation between 7:00 a.m. and 8:00 a.m. According to Lt. Peterman, this time period was during a shift change “and the log was probably over looked.” However, he states the video shows the inmate had eye-on contact during this time. The Ombudsman’s review of the video did not show the 15-minute checks being done.

B. Analysis, Conclusions, and Recommendations

The Ombudsman identified several areas raising concern about M.B.’s placement in the restraint chair, including 15-minute checks, periodic reviews, medical reviews, and documentation. The Ombudsman believes staff violated Iowa law and the jail’s written policy by failing to adequately observe M.B. throughout his placement and document each action and decision.

1. Fifteen-Minute Checks

The Activity Log maintained during M.B.’s restraint indicates checks were done at exactly 15-minuted intervals. This is not consistent with what the video documentation shows during the restraint session. The Ombudsman only noted five occasions during the almost five-hour restraint when it appeared staff made a deliberate effort to check on M.B. “Deliberate efforts” included only those occasions when staff entered the cell to check the inmate or had verbal contact with the inmate from outside the cell.

To determine what is required under Iowa law during the 15-minutes checks, the Ombudsman relied in part on statements made by a representative of the Iowa State Sheriffs and Deputies Association during a Legislative Administrative Rules Review Committee that addressed the jail rules. According to Linn County Sheriff Don Zeller, when asked by Representative Dave Heaton what was required during the 15-minute checks, the checks require staff “going in to look at the individual and checking the restraints that are placed on there”⁴⁰⁴ The Ombudsman shares the views Sheriff Zeller expressed to the Iowa legislators during the ARRC meeting. Jail staff must enter a cell and check the inmate and the restraints. This requires more than looking at the back of an inmate and restraint chair through a cell door window.

The Ombudsman must also consider a scenario posed by a commenter during the public comment period of the Centers for Medicare and Medicaid Services regulations on restraint and seclusion, which applies to most hospitals:

⁴⁰⁴ Proposed Amendments to Ch. 50 Update Jail Inspection Standards: Hearing on ARC 6641B Before the Admin. Rules Review Comm., 2008 Leg., 82nd Gen. Assem., 2nd Sess. (Iowa 2008) (Statement of Don Zeller, Linn County Sheriff).

Another commenter argued that there is no substitute for face-to-face monitoring with periodic checks of patient's vital signs. The commenter recounted two separate instances where patients died while in restraints and seclusion. In both instances, the paramedics were unable to ventilate the patients because they were unable to place a tube down the throat of the patient. The onset of rigor mortis demonstrated that these patients had been dead for several hours before hospital staff discovered them and called the paramedics. The nursing logs for both patients indicated that the patients had been checked every 15 minutes. **In these instances, "checked" meant looked at through the window into the seclusion room.**⁴⁰⁵ (emphasis added).

Giving wide latitude on what constitutes a "check," at one point during M.B.'s restraint almost two hours pass between checks by jail staff. According to the video, an officer entered the observation cell and appeared to check M.B. at 8:14 a.m. At 10:02 a.m., another officer stopped outside the cell and can be heard talking to M.B. The officer did not appear to be a jail correctional officer and does not actually enter the cell or check the restraints. If the Ombudsman were to not count this as a "check," a total of three hours would have passed between checks, the next being when M.B. was removed from the restraint chair at 11:15 a.m.

Conclusion: The Ombudsman concludes the Polk County Jail failed to conduct 15-minute checks in violation of Iowa law. The checks must be conducted every 15 minutes and include up-close, face-to-face checks on the welfare of the inmate and the application of the restraints to ensure restraint straps or other devices are not affecting the inmate's circulation.

The Ombudsman makes the following recommendations:

1. Polk County Jail must conduct 15-minute checks of the inmate and the restraint device application throughout the duration of the inmate's placement in a restraint device. The jail should immediately review this practice with staff and ensure it is addressed during regular training on restraint device use in the jail.

2. Periodic Review

The jail was not able to provide evidence justifying M.B.'s continued restraint for almost five hours. The 15-minute Activity Log provides no detail of M.B.'s behavior other than to describe him as "sitting." The security video does not indicate M.B. posed a continued threat, and the jail did not present any documentation or reports from jail staff detailing why M.B.'s continued restraint was required. The video offers some insight into why

⁴⁰⁵ Medicare and Medicaid Programs; Hospital Conditions of Participation: Patient's Rights, 71 Fed. Reg. 71,378, 71,414 (Dec. 8, 2006) (to be codified at 42 C.F.R. pt. 482).

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documentation of periodic reviews was not provided to the Ombudsman; there were no reviews conducted after 8:14 a.m. until his release three hours later.

The details of M.B.'s release raises further concerns about his disposition. No reviews of M.B.'s disposition were conducted in the immediate time period prior to his release. Instead, an officer is heard off-camera say "I'm going to take [M.B.] out of the chair," and staff immediately proceed to remove him from the chair without incident. Jail staff apparently determined M.B. no longer posed a threat to himself or others, or jeopardized jail security without entering his cell, talking to him, or otherwise observing his behavior.

The Ombudsman believes the jail's failure to provide evidence justifying the continued use of the restraint chair may violate M.B.'s constitutional rights to be free from punishment and Iowa law requiring the use of restraints for only the amount of time necessary to alleviate the condition causing the restraint. It also risks exposing the jail to civil liability. The U.S. District Court for the Northern District of Iowa found the five-hour restraint of a Linn County Jail inmate was unreasonable and constituted punishment where the need for restraints ended after an hour and 15 minutes.⁴⁰⁶ In a separate case, the court found the same jail was liable when it could not provide evidence – such as documentation of reviews and evaluations – justifying the eight-hour restraint of an inmate.⁴⁰⁷

The Polk County Jail also violated its own written policy on the use of the restraint chair, which states "[t]he inmate will be considered for removal from the chair at least hourly."⁴⁰⁸ Asked about this policy and its application to M.B., Lt. Peterman only replied that an officer at one point entered the room and physically checked M.B. Assuming the purpose of the officer's check was to determine whether M.B. could be removed from the restraint chair, it still does not explain why the required three additional checks are unaccounted for.

Conclusion: The Polk County Jail cannot provide evidence showing the continued use of the restraint chair was justified, even while the original placement may have been reasonable. The Ombudsman questions whether the extended use of the restraint chair was used for punishment as opposed to controlling an existing threat to the inmate's self, others, or jail security. The jail also failed to follow its own written policy requiring an inmate be considered for removal from the chair at least hourly.

The Ombudsman makes the following recommendations:

2. Polk County Jail should refrain from placing an inmate in a restraint device for a pre-determined time limit. Such placement could be considered punitive and

⁴⁰⁶ *Ogden v. Johnson*, No. C00-0034, 2002 WL 32172301 (N.D. Iowa Sept. 5, 2002).

⁴⁰⁷ *Rogers v. Dunn*, No. C00-0188-PAZ, 2001 U.S. Dist. LEXIS 22710 (N.D. Iowa Nov. 27, 2001).

⁴⁰⁸ POLK COUNTY SHERIFF'S OFFICE, JAIL DIVISION, SECURITY AND CONTROL, RESTRAINT CHAIR No. 6600.59(II)(A)(4)(a) (2001).

contrary to the inmate's constitutional rights and Iowa law, especially if that pre-determined time limit extends to periods when the inmate is no longer a threat to self, others, or jail security.

3. The jail should conduct periodic checks of the inmate's disposition and actions to determine whether the inmate may be released. The jail should train all staff who may be involved in restraint chair use on the jail's existing policy requiring "at least hourly" reviews of a restrained inmate to determine if the inmate may be released. If the inmate must remain in the restraint device, the jail must document the inmate's actions justifying continued restraint.

3. Medical Review

The security video shows a medical staff member checked M.B. five minutes after his placement in the restraint chair, though no written documentation states what was observed. During the next 4 hours and 35 minutes, medical staff did not review his condition. According to the jail's restraint chair manufacturer, E.R.C. Inc., an inmate may only be held in the restraint chair for two hours, which may only be extended under direct medical supervision. This policy is stressed in the instruction manual, the manufacturer's Customer Letter, and its instruction video.

Tom Hogan, President of E.R.C. Inc., informed the Ombudsman the initial two hours of restraint should be used to determine if the inmate's behavior has underlying medical or mental health causation, and make those services available to the inmate. The need to use restraints beyond the initial two hours may itself be an indication the aggressive behavior is medical or mental health-based.

Conclusion: The Polk County Jail incorporates a good practice of having medical staff review the inmate after initial placement in the restraint chair. However, the restraint chair instructions state the restraint chair is only to be used beyond the initial two-hour time limit under direct medical supervision by a doctor or nurse.

The Ombudsman makes the following recommendations:

4. Polk County Jail should follow the manufacturer's guidelines recommending direct medical supervision in the event the restraint chair must be used longer than the initial two hours, and incorporate this procedure in the written policy.

4. Written Documentation

The Ombudsman has concerns about Polk County Jail's documentation of the 15-minute checks, the periodic reviews to determine if an inmate can be removed from restraints, and the medical checks of inmates. Written documentation on each of these areas is scant or nonexistent.

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The jail's Activity Log states checks were done precisely at 15-minute intervals, though these checks were not reflected on the video showing the inmate and the area around his cell. The activity log also appears to be entered by the same person, though the Ombudsman could find no pattern of a single officer checking the inmate. The Ombudsman sent written interrogatories inquiring about who conducted the 15-minute checks and who marked the Activity Log, but they were never answered by the jail.⁴⁰⁹

While checks were marked every 15 minutes, a span of 1 hour is missing from the logs between 7:00 a.m. and 8:00 a.m. Lt. Peterman explained this was only an oversight by staff to mark the log during a shift change, but the checks were done on the inmate. The Ombudsman was not able to substantiate 15-minute checks were conducted during this time frame based on his review of the video.

Jail policy requires staff to consider restraint removal at least hourly, based on the inmate's behavior while restrained and the staff and supervisor's observations of the inmate. While Lt. Peterman cites to a single occasion when an officer entered the observation cell and checked on M.B., which the Ombudsman concludes occurred at 8:14 a.m., there is no written documentation detailing what the officer observed or why the officer determined M.B. should remain in the chair. Relying on the security video, a viewer is not informed what the purpose of the check was for, what discussion took place between the officer and M.B., or what the officer's conclusions were upon leaving the cell. Nor is there even documentation identifying who the officer was that performed the alleged review.

The Ombudsman cannot conclude an effective hourly check took place in accordance with the jail's policy requiring hourly reviews of the inmate. There is no video or written documentation detailing the check or the officer's observations that shows the officer reviewed M.B.'s behavior and disposition, nor is there any documentation showing how he posed a threat to himself, staff, or jail security. The Ombudsman believes the jail cannot justify the need for the continued restraint after the 8:14 a.m. review of the inmate, though M.B. was left in restraints until 11:15 a.m. Further, when an inmate is held in four- or five-point restraints, Iowa law requires correctional staff to document all decisions and actions.⁴¹⁰ The Ombudsman must conclude the jail did not follow this requirement during the check.

The Ombudsman was not able to determine the conclusions of the medical staff's checks as no written documentation was provided by the jail for this event. The security video showed a medical staff member entering M.B.'s cell with an officer and leaving soon after. However, the video cannot offer the verbal discussion that might have taken place or any concerns medical staff may have raised. The Ombudsman believes it is important

⁴⁰⁹ Letter from Andy Teas, Assistant Ombudsman, Iowa Citizens' Aide/Ombudsman, to Lt. Peterman, Polk County Sheriff's Office (May 5, 2008) (on file with author).

⁴¹⁰ IOWA ADMIN. CODE r. 201—50.13(2)(f)(4) (2008).

for any medical observations and conclusions reached about the inmate during restraint be documented in writing.

Conclusion: The Polk County Jail did not document actions and decisions in accordance with Iowa law for 15-minute checks, periodic reviews, or medical checks.

The Ombudsman makes the following recommendations:

5. Polk County Jail must document each action and decision addressing an inmate's four- or five-point restraint. It must ensure the checks are done and ensure the documentation is not "overlooked." Documenting all actions and decisions, under Iowa law, also includes the decision whether to release the inmate or continue restraint use after each hourly review that is required under jail policy. This applies to any medical reviews during and after the use of restraints on the inmate.

6. The jail should incorporate in its written policy the procedures for written documentation of all actions relating to restraint chair use.

5. Video Monitoring and Documentation

The Polk County Jail currently video records restraint chair use, and this standard procedure proved very useful during the Ombudsman's investigation to identify problems with procedures and policy, as well as rebut allegations of assault and abuse raised by the inmate. The Ombudsman did note some problems with the recording that should be addressed, including placement of the camera and retention of videos.

While the camera was able to capture many of the events involving the application of restraints and the events outside the observation cell, it was not as effective for determining what occurred inside the cell. This was due to the location of the camera and the position of the inmate within the cell. During most of the restraint, a door frame blocked a portion of the inmate's body. In addition, the inmate was facing away from the door, hindering the camera from capturing the inmate's torso, legs, and face. Soon after the initial placement, staff entered the cell twice to reposition the chair to face away from the door after M.B. was able to shift the chair to the side. Ironically, M.B.'s defiant action of shifting the chair a third time without correction by staff offered the least obstructed view of the inmate.

The Ombudsman believes an unobstructed camera view of the inmate is necessary to accurately review the events of the restraint application and use. The Iowa Department of Corrections recently added a provision to the Iowa Administrative Rules allowing the use of CCTV for continuous monitoring.⁴¹¹ This additional tool now available to the jails supports the importance of a clear, unobstructed view. In the event an inmate begins to have problems that require emergency medical attention, a view that is obstructed by a

⁴¹¹ IOWA ADMIN. CODE r. 201—50.13(2)(f)(1) (2008).

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door frame, or one that cannot see the inmate's face, torso, or limbs could result in missed signals of that emergency, leading to serious injury or death. As explained by CMS, in reply to a comment for additional information on the "close proximity" requirement for audio and video use, "the intent is to ensure that staff is immediately available to intervene and render appropriate interventions to meet the patient's needs."⁴¹²

In Polk County Jail, an obstructed view can be remedied by turning the inmate to face the cell door and the camera. If the inmate needs to face away from the door for security reasons, a camera inside the observation cell could accomplish the same goal. The Ombudsman has reviewed cases in Iowa county jails where the camera was located inside the observation cell with the restrained inmate, which recorded an accurate account of the events during restraint.

The Ombudsman was also informed that Polk County Jail only retains video of restraint incidents for 45 days. As mentioned above, video recording is an invaluable tool for identifying potential violations of jail policy and unreasonable actions by staff, enabling supervisors to update training or revise jail policy. It is also instrumental for refuting an inmate's false allegations of inappropriate or abusive behavior against staff. The Ombudsman believes the jail should retain copies of each restraint device incident for a minimum of two years, reflecting the statute of limitations for tort claims in Iowa.

Conclusion: The position of the CCTV and the holding cell created an obstructed view of the restrained inmate, thereby preventing a reviewer from accurately observing the events inside the cell. An obstructed view may prevent staff from responding immediately in the event an emergency arises inside the cell, which in turn creates an unreasonable risk of serious injury or death for the inmate.

The Ombudsman makes the following recommendations:

7. The Polk County Jail should ensure the video documenting the restraint device use provides an accurate account of the events that transpire. This would include an unobstructed view of the placement and use of the restraints. This is important for vivid documentation and necessary if used for continuous monitoring purposes. The jail should retain copies of videos for each restraint device use for at least two years.

⁴¹² Medicare and Medicaid Programs; Hospital Conditions of Participation: Patients' Rights, 71 Fed. Reg. 71,378, 71,415 (Dec. 8, 2006) (to be codified at 42 C.F.R. pt. 482).

Systemic Mental Health and Professional Resource Challenges

Two common themes the Ombudsman heard repeatedly during the course of this investigation were (1) the lack of a systemic mental health program to address the growing problems of mentally ill citizens receiving care before they enter the criminal justice system, and (2) the financial and resource constraints placed on jails who eventually must care for those inmates who did not receive care before incarceration. The situations may involve inmates whose criminal records consist of only minor crimes, but due to an untreated mental illness the crimes have escalated. They also often involve inmates released from prison who have received insufficient treatment during incarceration or after release. The lack of correctional, judicial, and community mental health services each contribute to the numbers of mentally ill inmates seen by a county jail, and many of whom eventually go to prison. As of December 2007, over 41 percent of Iowa prison inmates had a diagnosed mental illness.⁴¹³ Inmates with *serious, persistent* mental illness accounted for 30.4 percent of the total population.⁴¹⁴

These issues are systemic problems that go far beyond the walls of the county jail and cannot be properly addressed in this report. However, the Ombudsman believes a few programs merit consideration.

A. Iowa Department of Corrections Reentry Plans

Part of the cycle facing county jails involves inmates with mental illness who are released from prison without the proper post-incarceration services available to respond to their mental health needs. These former inmates often commit crimes, are arrested, and begin the legal and correctional process over again at a much higher rate than former inmates with no mental illness. In April 2007 the Durrant Group, Inc. issued the first phase (Phase I) of a systemic study of the Iowa correctional system on behalf of the State of Iowa and issued the second phase (Phase II) in April 2008. In addressing the issue of improving community corrections outcomes, the study looked at ways to reduce recidivism.⁴¹⁵ It found each of the eight judicial districts expressed the need for additional mental health and dual diagnosis services and funding for medications.⁴¹⁶

According to Phase II, 26 percent of male parolees and 55 percent of female parolees in 2005 were mentally ill.⁴¹⁷ Looking at the inmates released in 2003, the study found the number of inmates with mental illness comprised 27 percent of prison releases, but represented 39 percent of those returning to prison within three years.⁴¹⁸

⁴¹³ DURRANT GROUP INC. ET AL, STATE OF IOWA SYSTEMIC STUDY FOR THE STATE CORRECTIONAL SYSTEM, PHASE II 70 (2008).

⁴¹⁴ *Id.* at 69.

⁴¹⁵ *Id.* at 213-14.

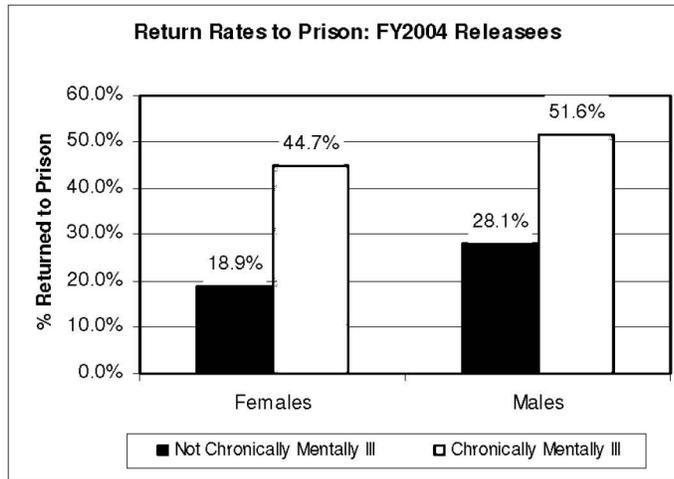
⁴¹⁶ “Dual diagnosis” refers to a situation where a person suffers from a diagnosed mental illness and a substance dependency or addiction.

⁴¹⁷ *Id.* at 214.

⁴¹⁸ DURRANT GROUP INC. ET AL, STATE OF IOWA SYSTEMIC STUDY FOR THE STATE CORRECTIONAL SYSTEM, PHASE I 50-52 (2007).

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Phase II compared the recidivism rate of chronically mentally ill male inmates and those with no mental illness for 2004 releasees. It found those with mental illness had a recidivism rate of 51.6 percent compared to 28.1 percent for those without a mental illness.⁴¹⁹ Among former female inmates, those with chronic mental illness had a recidivism rate of 44.7 percent compared to 18.9 percent for those with no chronic mental illness.⁴²⁰



Source: DOC: Prell, ICON Data

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Phase II further found the recidivism rates increase for each additional mental health diagnosis.

Chronic MI Diagnoses	Total Released	Total Returned	Recidivism Rate
None	2,388	654	27.4%
1	583	184	31.6%
2	285	170	59.6%
3	160	120	75.0%
4 or More	117	99	84.6%

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With the recidivism rate of mentally ill inmates being significantly higher than those without mental illness, the need for mental health services during parole or after an

⁴¹⁹ DURRANT GROUP, PHASE II at 71.

⁴²⁰ *Id.*

⁴²¹ *Id.* at 72, fig. IV-B-6.

⁴²² *Id.* at 74, fig. IV-B-10.

inmate discharges the sentence is apparent.⁴²³ Based on the figures provided by the Durrant Report, 40.7 percent of offenders in Community-Based Corrections (CBC) residential facilities and CBC field supervision who have mental illness and co-occurring disorders (substance abuse and at least one mental illness diagnosis) are not receiving treatment.⁴²⁴

The study recognized the need to respond to the mental health needs of offenders when released from prison through parole and work release. Offenders may be released with few well-grounded plans for community treatment and follow-up, and there can be a poor response from the community to providing treatment to offenders who may still be a part of the Department of Corrections system.⁴²⁵ The study also recognized that “[t]oo often these offenders serve the full term of their sentences in prison and are released directly into the communities without necessary supports in place.”⁴²⁶ It found a lack of special services throughout Iowa, including mental health courts, jail diversion, mobile crisis teams, and assertive community outreach teams.⁴²⁷

The study recommended a curriculum to meet the basic mental health training needs of all CBC probation and parole officers, as well as case managers.⁴²⁸ Advanced training programs should be developed for CBC staff that work primarily with offenders who have mental illnesses and co-occurring disorders. This training would include building community relationships, case management planning, and “using incentives and Recovery Model interventions to encourage treatment and correctional supervision compliance.”⁴²⁹ CBC “Reentry Coordinators” have recently been added to the eight judicial districts in Iowa, who screen potential resources in the communities and find the appropriate resource for offenders returning to the CBCs.⁴³⁰ The study recommended the Department of Corrections continue to work on building communication strategies needed for collaboration between the institution, the judicial districts, and the community providers to identify and meet the needs of offenders with mental health and co-occurring disorders.⁴³¹

B. Mental Health Courts

The Ombudsman believes a proposed pilot project for mental health courts like the one previously introduced by the Iowa Legislature could benefit Iowa counties.⁴³² Under the

⁴²³ According to Phase II, 66.6% of male and 17.3% of female special needs inmates expired their sentences in 2004. DURRANT GROUP, PHASE II at 71.

⁴²⁴ *Id.* at 86-88.

⁴²⁵ DURRANT GROUP, PHASE I at 66.

⁴²⁶ DURRANT GROUP, PHASE II at 57.

⁴²⁷ *Id.* at 92.

⁴²⁸ *Id.* at 108.

⁴²⁹ *Id.* at 109.

⁴³⁰ *Id.* at 37.

⁴³¹ *Id.* at 110.

⁴³² H.F. 613, 82d Gen Assem., 1 Sess. (Iowa 2007).

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proposed bill, three mental health courts would have been established and located in separate counties based on the county's size, and the project would be administered by the Iowa Judiciary. The courts would be available for nonviolent criminal offenders who suffer from mental illness.⁴³³

Several sheriffs, jail administrators, and corrections professionals have expressed frustration to the Ombudsman about what they describe as a revolving-door treatment system. A person with a mental illness may be civilly committed, but that person will have a short stay at a hospital or MHI only to be stabilized on medications and then be released with no follow-through. In many cases, the person will begin to digress because of little oversight or scarce community-based supervision. If the person quits taking their medication and no one is aware of it, mental health declines, legal trouble often ensues, and the person is taken to jail to face criminal charges. In cases where the charges are for non-violent crimes, the inmate may get little or no incarceration time and is released back into society with no structured mental health supervision. This can often lead to additional petty crimes or lead to more serious violent felonies.

In the case of T.H., the jail administrator and sheriff were very familiar with him based on continued run-ins in the community. Two months before T.H.'s incarceration in February 2007, he was civilly committed at University of Iowa Hospital and Clinics (UIHC), his ninth hospitalization since 2001. He was referred to UIHC by the county hospital due to his aggressive mental state after he was arrested for making threats against a convenience store. Upon his entry to UIHC, a psychiatrist noted T.H.'s high agitation level and uncooperativeness. After adjusting medication levels, T.H. was released from UIHC three weeks later. Medical notes report T.H.'s mania was resolved. He was cooperative, and there was no evidence of psychosis or thought disorder.

T.H. followed the typical pattern of behavior from petty offenses to much more serious charges. Four days after he was released from the hospital, T.H. was charged with drug possession. Eight days later, he was charged with trespass. One month later, he was arrested for robbing a bank. While it is impossible to know whether T.H. would have been a successful candidate for a mental health court, such a program may have proved beneficial in his case.

⁴³³ The Ombudsman corresponded with Rebecca Colton in her capacity as a lobbyist of the Judiciary-Iowa Supreme Court, when he noticed Ms. Colton was declared "Against" the proposed pilot project legislation. According to Ms. Colton, there are not enough treatment programs or other services available to accompany the mental health court. In addition, the mental health court would be far more labor-intensive than conventional court systems. The Ombudsman believes these are the issues a pilot project was meant to identify so further action can be taken by the Legislature to address those problems if needed. It is not known how the treatment programs and services were lacking, since the communities in which the pilot projects would be located had not been determined.

1. Woodbury County

The Ombudsman researched information about the only fully integrated mental health court in Iowa. Woodbury County first set up its mental health court in July 2001 with the cooperation of Siouxland Mental Health Center (Siouxland), the county jail administrator, the county sheriff, the county attorney, the county CPC, a public defender, and a judge willing to work the mental health court docket.⁴³⁴ Prior to the mental health court, Siouxland worked with Woodbury County Jail to identify inmates who needed services for mental illness, substance abuse, and co-occurring disorders, and would provide those services once the inmate was released from jail. That involvement provided the groundwork for the mental health court.

The concept of the mental health court came as a result of a survey that found 15 percent of inmates at Woodbury County Jail suffered from mental illness. According to Kim Fischer-Culver, Director of Community Services for Siouxland, the agency was involved in learning about the administration of a mental health court by visiting Broward County, Florida, one of the first mental health courts in the country.⁴³⁵ With the cooperation of law enforcement, the court system, and county administrative players, the services Siouxland were providing expanded into the mental health court currently operating in Woodbury County.

Through screening by Siouxland caseworkers, as well as referrals from other sources, inmates at Woodbury County Jail are identified as potential clients for the mental health court docket. The court only accepts defendants who are charged with misdemeanor crimes and must be approved by a caseworker after a 30-day trial period. If approved by Siouxland, the public defender, the county attorney, and the judge, the court will have authority to review the goals and service activities of the defendant and follow the client for the following year. The Siouxland case manager provides the judge with status reviews about the progress being made by the defendant. The judge, along with the case managers and attorneys, determines if the client will continue in the mental health court.

According to Ms. Fischer-Culver, funding for the court is entirely based on the county's mental health funds. The county CPC was instrumental in starting the mental health court because funding approval was needed from the county board of supervisors. No financial assistance comes from the state or federal programs. The board of supervisors approves funding for the court on a yearly basis.

Ms. Fischer-Culver described a positive working relationship with the other agencies involved with the court, and support is received from the county attorney, the jail, and the sheriff's office. A single judge, Judge Patrick McCormick, currently works the docket, and has since the mental health court's inception.

⁴³⁴ Telephone Interview by Andy Teas, Assistant Ombudsman, Iowa Citizens' Aide/Ombudsman, with Kim Fischer-Culver, Dir. of Cmty. Servs, Siouxland Mental Health Ctr. (May 14, 2008).

⁴³⁵ *Id.*

The most significant fact of the mental health court is its report rate of recidivism. According to the Third Judicial District's 2007 Annual Report, the program reported a 91.6 percent reduction in recidivism among those who participated in the court between July 2001 and June 2006.⁴³⁶ Siouxland also reported a 97 percent reduction in jail days among clients who participated in the mental health court, from 2,796 days to just 83 days.⁴³⁷ Ms. Fischer-Culver also noted the benefits among the community resources that reach beyond the mental health court, stating "[t]he outcomes of the program are positive in that there has been an increase in linkages to mental health services and resources in the community allowing for stability in the client's living environment."⁴³⁸

2. Rock Island County, Illinois

The mental health court system in Rock Island, Illinois, was the subject of two news articles published by the *Quad City Times* in January 2008. According to the articles, the mental health court in Rock Island was established by a county associate judge after he read about the suicide of a bipolar inmate at the Rock Island County Jail in 2006. The inmate had been deemed incompetent to stand trial and was awaiting transfer to a mental-health hospital. During his time in jail, the inmate spent five months with no medication, no treatment, and no mental health evaluation.⁴³⁹

Rock Island County Associate Judge Ray Conklin received support from the county attorney, local outpatient offices, fellow judges who volunteered to split cases, the county sheriff, and the jail administrator who "have complained for years that some inmates are too sick to be in jail. . . and that their problems are sometimes too much for correctional officers to deal with."⁴⁴⁰ According to the county attorney, "[k]eeping people locked up is probably the worst thing you can do with mental-health issues. Get them out, get them treatment and monitor them."⁴⁴¹

The court in Rock Island accepts referrals from family members, case workers, defense attorneys, prosecutors, and judges. The court is not available for all criminals and only allows few exceptions for those charged with felonies. It is voluntary and operates under recognizance bonds, with the condition that the defendant complies with the judge's orders. Orders can include taking medication, undergoing regular drug screenings, submitting to an evaluation, showing up on court dates, and meeting with case managers

⁴³⁶ THIRD JUDICIAL DISTRICT COURT OF IOWA, 2007 ANNUAL REPORT (2008), *available at* <http://www.judicial.state.ia.us/wfdata/frame6037-1511/File1.pdf>.

⁴³⁷ *Id.*

⁴³⁸ Letter from Kim Fischer-Culver, Director of Community Services, Project Compass, to Tom Mullins, Woodbury County Attorney (2006) (On file with author).

⁴³⁹ Barb Ickes, *Jail Suicide Inspires RI Judge to Start Mental Health Court*, Q.C. TIMES (Davenport, Iowa), Jan. 13, 2008, <http://www.qctimes.com/articles/2008/01/13/news/local/doc4789952685577227156651.txt>.

⁴⁴⁰ Barb Ickes, *Courting Justice: Mental Health Court Places Emphasis on Rehabilitation*, Q.C. TIMES (Davenport, Iowa), Jan. 14, 2008.

<http://www.qctimes.com/articles/2008/01/14/news/local/doc478af10a9908b739718165.txt>.

⁴⁴¹ *Id.*

and probation officers. Receiving medication and treatment is the alternative for being locked up in the county jail. The expected benefit for everyone is preventing misdemeanants from becoming felons.

Before and after T.H.'s commitment in December 2006, he was on probation through the Fairfield office. However, T.H. was not under a court ordered outpatient program for mental health. Any mental health services he sought would be voluntary. While his probation officer told the Ombudsman she encouraged T.H. to seek ongoing treatment, T.H. often refused to go, citing he did not like the psychiatrist who served the area. The Ombudsman is not in a position to say a mental health court would have prevented T.H. from robbing the bank and going to jail. However, the purpose of the mental health court is to address such circumstances as T.H.'s and intervene during petty offenses before a violent crime occurs.

Due to the concept of a mental health court still being in its infancy, experts on its form and function are few. After a year of operation, the Rock Island court is being visited by officials from other jurisdictions who want to see how the court functions.⁴⁴² Illinois has nine mental health courts in the state, out of 102 counties, and hosted its first seminar in summer 2008 addressing the issues of a mental health court.⁴⁴³ Ms. Fischer-Culver from Siouxland stated her office has provided limited training to other counties and is willing to share with other jurisdictions what it has learned about the mental health court process since its inception.

3. Essential Elements of a Mental Health Court

A report prepared by the Council of State Governments Justice Center (CSGJC) in 2007 for the U.S. Department of Justice, Bureau of Justice Assistance, reviewed ten elements necessary for a mental health court.⁴⁴⁴ Those elements include:

- 1) **Planning and Administration.** This element encourages the incorporation of a multidisciplinary planning committee, which would include, among others, law enforcement, judges, prosecutors, court administrators, and mental health providers and advocates.

⁴⁴² Barb Ickes, *Mental Health Court: Local Legal System Takes on Mental Health Issues*, Q.C. TIMES (Davenport, Iowa), Apr. 7, 2008, <http://www.qctimes.com/articles/2008/04/07/news/local/doc47f9a8c4834fe213543001.prt>.

⁴⁴³ *Id.*

⁴⁴⁴ The Council of State Governments Justice Center describes itself as a nonpartisan resource whose board of directors includes state legislative leaders, judges, corrections administrators, juvenile justice agency directors, and law enforcement professionals. The CSGJC provides technical assistance to the U.S. Department of Justice for mental health issues involving law enforcement, mental health courts, and corrections. Justice Center, Council of State Governments Homepage, http://justicecenter.csg.org/about_us/background (last visited June 30, 2008).

- 2) Target Population. The type of defendants who will be served by the court will be dependent on the resources in the community.
- 3) Timely Participant Identification and Linkage to Services. Participants are linked to community-based service providers as quickly as possible after being identified, referred, and accepted into mental health courts.
- 4) Terms of Participation. The terms of participation must be clear, promote public safety, provide positive legal outcome, and carry consequences for the defendant if not followed.
- 5) Informed Choice. Defendants are provided legal counsel and fully understand the program requirements.
- 6) Treatment Supports and Services. Mental health courts connect participants to comprehensive community treatment supports and services, dependent on their individual needs.
- 7) Confidentiality. Providers and representatives of the court must adhere to federal and state law protecting confidentiality.
- 8) Court Team. A team of criminal justice and mental health staff, and service and treatment providers, receive ongoing training to help achieve treatment and criminal justice goals by reviewing and revising the court process.
- 9) Monitoring Adherence to Court Requirements. The court must have up-to-date information through regular hearings on whether participants are taking medications, attending treatment sessions, abstaining from drugs and alcohol, and adhering to other supervision conditions.
- 10) Sustainability. Data describing the court's impact on individuals and systems should be collected and analyzed to demonstrate the impact of the mental health court.⁴⁴⁵

The elements listed above are meant to provide an overview and do not constitute an exhaustive review of the report. The Ombudsman encourages readers interested in mental health court projects to access the report themselves, available for no charge at the CSGJC website. CSGJC, through its Mental Health Consensus Project, provides many other resources on mental health courts and administrative issues addressed by local, state, and federal policy makers.

⁴⁴⁵ MICHAEL THOMPSON ET AL, IMPROVING RESPONSES TO PEOPLE WITH MENTAL ILLNESS: THE ESSENTIAL ELEMENTS OF A MENTAL HEALTH COURT 1-10 (2007), *available at* http://justicecenter.csg.org/resources/mental_health.

An extensive study issued in 2007 analyzed the recidivism rate of persons with mental illness who went through a mental health court, compared to persons in the same community with mental illness who did not participate in the program.⁴⁴⁶ The study, conducted by two psychiatry professors from the University of California, San Francisco, looked at any criminal charges after completing the program or being released from jail and charges involving violent crime.⁴⁴⁷ The authors hypothesized that those who participated in the mental health court, regardless of finishing the program, would not incur additional charges for a longer period of time for all crimes compared to nonparticipants, and those who “graduated” from the program would not incur additional charges for a longer time than those whose cases were adjudicated in regular court.⁴⁴⁸ After following 170 mental health court participants and 8,067 “treatment as usual” defendants, the authors’ hypothesis was provided documented support when the study found the mental health court graduates and participants went longer periods of time without incurring new charges, including violent crime charges.⁴⁴⁹

The more time that passed, the greater the difference between the two groups. At 18 months, mental health court participants were 26 percent less likely to be charged with a new crime than the treatment-as-usual group. The likelihood of a new violent crime charge during this time frame was 55 percent lower among the participants compared to nonparticipants.⁴⁵⁰

The study concluded its findings “provide evidence of the potential for mental health courts to achieve their goal of reducing recidivism among people with mental disorders who are in the criminal justice system.”⁴⁵¹ While most mental health courts in the country are not available to individuals charged with felonies, the results of the study found “it appears possible to expand the mental health court model beyond its original clientele of persons charged with nonviolent misdemeanors in a way that public safety is enhanced rather than compromised.”⁴⁵²

⁴⁴⁶ DALE E. MCNIEL & RENEE L. BINDER, *Effectiveness of a Mental Health Court in Reducing Criminal Recidivism and Violence*, 164 AM. J. PSYCHIATRY 1395 (2007).

⁴⁴⁷ *Id.* at 1395. At the time of the report, Dale McNiel was a professor of clinical psychology in the Department of Psychiatry at the University of California. Renee Binder was a professor in residence in the Psychiatry and the Law Program at the University of California, San Francisco. Aaron Levin, *Mental Health Courts: A Strategy That Works*, PSYCHIATRIC NEWS, Sept. 21, 2007, at 6.

⁴⁴⁸ McNiel, *supra*, at 1396.

⁴⁴⁹ *Id.* at 1396, 1401.

⁴⁵⁰ *Id.* at 1401.

⁴⁵¹ *Id.*

⁴⁵² *Id.* at 1401-02. For a review of the mental health court costs, the Council of State Governments sponsored an extensive study on the fiscal impact of mental health courts, conducted by the RAND Corporation, which analyzed the Allegheny County Mental Health Court in Pennsylvania. M. SUSAN RIDGELY ET AL, JUSTICE, TREATMENT, AND COST: AN EVALUATION OF THE FISCAL IMPACT OF ALLEGHENY COUNTY MENTAL HEALTH COURT (2007).

C. Multi-County Jails

The Ombudsman understands the financial and administrative pressures the recommendations contained in this report place on some smaller jails. Providing mental health services can be costly and difficult if there are no providers in the locale. The Ombudsman spoke with several county jail officials who expressed interest in combining resources with neighboring counties to broaden the tax base and pool resources for jail updates and services. The issue is not that the jails do not want to provide services for inmates who require them. A violent, mentally ill inmate creates more work and oversight for jail staff, and also creates a much more injury-prone environment for jail staff. Rather, the jail cannot provide the services to the inmate due to financial and administrative costs.

As part of its 2008 legislative priorities, the Iowa State Association of Counties (ISAC) provided its position on the development of multi-county jails. According to Dave Vestal, ISAC's legal counsel, ISAC receives input from county law enforcement officials when developing its legislative priorities. In addition, the Public Safety Division of ISAC that lays out its recommendation for multi-county jails is chaired by a county sheriff. ISAC endorses the concept of multi-county jails due to the costs of replacing old jails. Many counties are ready to band together to build new jails but cannot due to the lack of a statewide program to "encourage the planning, development and operation of multi-county jails."⁴⁵³ ISAC recommends the development of a state board, a process for counties to use in creating a commission to operate the jail, a state grant and loan process for jails, and other legislative and funding support. It also states that any multi-county jail, if constructed, should be under the control of the sheriffs of the counties serviced by the jail. The Ombudsman supports exploring proposals to create multi-county jails.

⁴⁵³ IOWA STATE ASS'N OF COUNTIES, 2008 LEGISLATIVE PRIORITIES: 82ND GENERAL ASSEMBLY, 2ND SESSION 29 (2008).

Glossary

- ACA** **American Correctional Association.** The ACA is a correctional association that provides certification, accreditation, and testing as well as issues standards and research publications in the field of corrections. <http://www.aca.org/>
- APA** **American Psychiatric Association.** Provides education and career development initiatives as well as publications in the field of psychiatry. <http://www.psych.org/>
- BJMHS** **Brief Jail Mental Health Screen.** A screening tool for use by jails to help identify the presence of potential mental illness in new inmates during intake. The screen was funded by the National Institute of Justice, a research arm of the U.S. Department of Justice. <http://gainscenter.samhsa.gov/pdfs/disorders/bjmhsform.pdf>
- CCTV** **Closed-Circuit Television.** The Iowa Department of Corrections adopted language in the Iowa Administrative Code in 2008 to allow continuous monitoring by CCTV of inmates placed in four- and five-point restraints.
- CMS** **Centers for Medicare and Medicaid Services.** A federal agency that regulates the administration of Medicare and Medicaid programs. CMS has authority to promulgate rules and regulations of facilities under its jurisdiction, including many health care facilities. This report cites rules and regulations covering the use of restraints by covered entities. <http://www.cms.hhs.gov/>
- CRIPA** **Civil Rights of Institutionalized Persons Act, 42 U.S.C. § 1997.** This act authorizes the U.S. Attorney General to conduct investigations and litigation relating to conditions of confinement in state or locally operated institutions. <http://www.usdoj.gov/crt/split/cripa.php>
- DOJ** **U.S. Department of Justice.** This report frequently refers to the DOJ's investigations of correctional facilities through its Civil Rights Division, with authority granted by CRIPA. <http://www.usdoj.gov/crt/>
- IBOM** **Iowa Board of Medicine.** A state agency that regulates the practice of medicine and medical doctors under Iowa administrative rules. <http://medicalboard.iowa.gov/>
- ILEA** **Iowa Law Enforcement Academy.** A state agency that provides broad training to law enforcement officers. <http://www.state.ia.us/ilea/>
- MHI** **Mental Health Institute.**

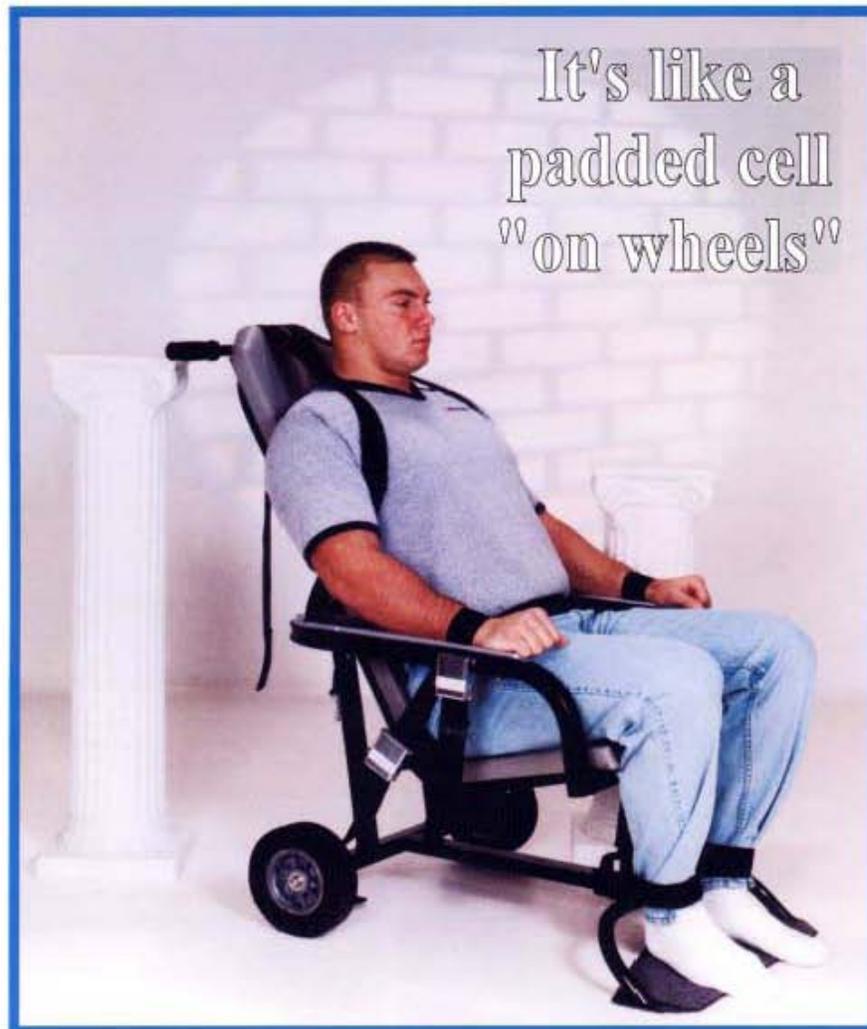
National GAINS Center A federal agency that serves as a locus for the collection and dissemination of information about effective mental health and substance abuse services for people with co-occurring disorders in contact with the justice system. <http://gainscenter.samhsa.gov/html/>

NCCHC **National Commission on Correctional Health Care.** The NCCHC provide standards for health services in correctional facilities, including prison, jails, and juvenile detention facilities. The NCCHC also provides accreditation to correctional facilities and issues publications. <http://www.ncchc.org/>

UIHC **University of Iowa Hospitals and Clinics.**

Appendix A: Emergency Restraint Chair

EMERGENCY RESTRAINT CHAIR



THE LATEST BREAK THROUGH IN SAFETY!

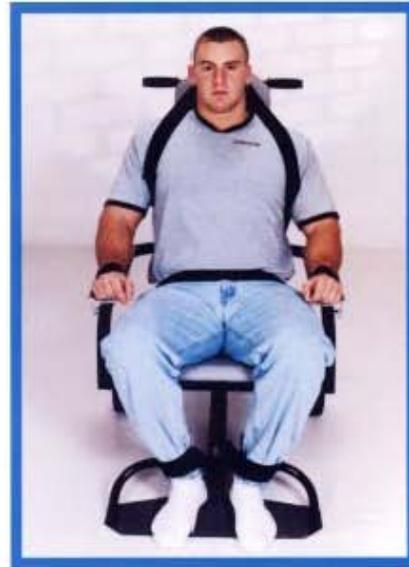
<http://www.restraintchair.com>

Appendix A: Emergency Restraint Chair



EMERGENCY RESTRAINT CHAIR

- * Safely restrains a combative or self destructive person
- * Allows for safe transportation to court / hospital
 - Does not restrict normal breathing
 - Secures an individual without injury
- * Protects your staff and the person being restrained



- * Completely mobile
- * Sturdy metal construction
- * Comfortable



- * Reduces the need for additional personnel
- * Reduces your liability
- * Easy to use and fully adjustable

You cannot afford to be without the
EMERGENCY RESTRAINT CHAIR

For more information call:

E.R.C. Inc.
P.O. Box 421
Denison, IA 51442
Phone: (712) 263-5291
Fax: (712) 263-4633

<http://www.restraintchair.com>

Appendix B: Organization Research Chart

Intake Screening			
NCCHC	ACA	Federal BOP	DOJ CRIPA Investigations
<p>Receiving screening is performed on all inmates immediately upon arrival at the intake facility. Person who are mentally unstable or otherwise urgently in need of medical attention are referred immediately for care. Reception personnel, using a health-authority-approved form, inquire about past and current mental illness, including hospitalizations. (J-E-02).</p> <p>All inmates must receive a mental health screen, separate from the receiving screen, conducted by a qualified mental health professional or mental health staff. The mental health screen should include, in part, inquiries into the history of psychiatric hospitalization and outpatient treatment, violent behavior and current status of psychotropic medications. (J-E-05).</p>	<p>The admission processes for a newly admitted inmate include medical, dental, and mental health screenings. (4-ADLF-2A-21).</p> <p>All inmates receive an initial mental health screening at the time of admission to the facility by a mental-health trained or qualified mental-health care personnel. The screening includes, in part, inquiries into the inmate's present medications, current mental health complaints, current treatment, and history of psychiatric treatment and substance abuse. The screening also includes observations of general appearance and behavior, and current symptoms of psychosis, depression, anxiety and/or aggression.</p>	<p>(Not relied on as a source for jail intake screening).</p>	<p><u>Black Hawk County Jail, Iowa:</u> The jail should not rely on inmate self reporting in group setting. The jail should establish a system of collecting mental health-related information that ensures confidentiality.</p> <p><u>Dallas County Jail, Texas:</u> The jail shall implement and comply with policies to provide adequate medical and mental health intake screening to all inmates. Newly admitted inmates who present current risk of acute mental health needs will be immediately referred for mental health evaluation by a mental health professional.</p> <p><u>Terrell County Jail, Georgia:</u> Jail shall appropriately screen all inmates upon arrival to identify serious medical and mental health conditions, including mental illness, suicide risk, and drug and/or alcohol withdrawal. Inmates who screen positively for any of these items shall be referred for immediate or prioritized screening by qualified health care staff. Initial screening should record inmate's mental health history, including health treatment, medication, and hospitalization.</p>

Appendix B: Organization Research Chart

Mental Health Assessment After Admission			
NCCHC	ACA	Federal BOP	DOJ CRIPA Investigations
<p>Inmates with a positive mental health screen must receive a mental health evaluation. Patients who require acute mental health services beyond those available at the facility are transferred to an appropriate facility. (J-E-05).</p>	<p>Inmates who are referred for assessment as a result of the mental health screen or by staff referral will receive a mental health appraisal by a qualified mental health person within 14 days of admission to the facility. (4-ADLF-4C-30).</p>	<p>(Not relied on as a source for jail inmate assessments).</p>	<p><u>Black Hawk County Jail, Iowa:</u> Provide an adequate and timely mental health evaluation, by a qualified and appropriately trained mental health professional, of inmates who screen positive for possible mental illness at intake and of inmates who exhibit symptoms of mental illness at any time during their incarceration.</p> <p><u>Terrell County Jail, Georgia:</u> The defendants shall develop and implement adequate policies, procedures, and practices consistent with generally accepted professional standards to ensure timely and appropriate mental health assessments by a qualified mental health professional for any inmate who becomes suicidal and those inmates whose mental health histories, whose responses to initial screening questions, or whose behavior indicate a need for such assessment.</p> <p><u>Dallas County Jail, Texas:</u> Defendants shall ensure timely access to a qualified mental health professional when presenting symptoms of mental illness require such care. Defendants shall provide adequate on-site psychiatrist coverage for inmates' serious mental health care needs and ensure that psychiatrists see inmates in a timely manner.</p>

Medical Staff Notification of and Reviews During Restraint Use			
NCCHC	ACA	Federal BOP	DOJ CRIPA Investigations
<p>When restraints are used by custody staff for security reasons, health services staff are notified immediately in order to: (1) review the health record for any contraindications or accommodations required which, if present, are immediately communicated to appropriate custody staff, and (2) initiate health monitoring, which continues at designate intervals as long as the inmate is restrained. (J-I-01).</p>	<p>When four/five-point restraints are used, the health authority or designee must be notified to assess the inmate’s medical condition, and to advise whether, on the basis of serious danger to self or others, the inmate should be in a medical unit for emergency involuntary treatment with sedation and/or other medical management, as appropriate. (4-ADLF-2B-03).</p>	<p>When the inmate is placed in four-point restraints, qualified health personnel shall initially assess the inmate to ensure appropriate breathing and response (physical and verbal). Staff shall also ensure that the restraints have not restricted or impaired the inmate’s circulation. When inmates are so restrained, qualified health personnel ordinarily are to visit the inmate at least twice during each eight-hour shift. Use of four-point restraint beyond eight hours requires the supervision of qualified health personnel. (P5566.06 (10)(f)).</p>	<p><u>Black Hawk County Jail, Iowa:</u> Absent exigent circumstances, a supervisor should be present when inmates are first placed in the restraint chair. Inmates in restraint must be checked by personnel with appropriate training every 15 minutes and by medical at appropriate intervals. Proper measures should be taken to ensure that inmates in restraints have their limbs exercised to avoid circulation problems, and adequate attention must be given to food, hydration, and bodily fluids.</p>

Appendix B: Organization Research Chart

Mental Health Professional Review During Restraint			
NCCHC	ACA	Federal BOP	DOJ CRIPA Investigations
<p>If the restrained inmate has a mental health condition, the physician is notified immediately so that appropriate orders can be given. (J-I-01).</p>	<p>When four/five-point restraints are used, the health authority or designee must be notified to assess the inmate’s medical and mental health condition, and to advise whether, on the basis of serious danger to self or others, the inmate should be in a mental health unit for emergency involuntary treatment with sedation and or medical management, as appropriate. (4-ADLF-2B-03).</p>	<p>Psychological services staff must examine an inmate once during every 24-hour period that the inmate is restrained. Examinations will include:</p> <ul style="list-style-type: none"> (1) a review of the inmate’s psychological history, (2) a description of the interview conducted with the inmate, (3) a review of the 15-minute, two-hour, and health services review logs, (4) a description of the inmate’s current mental health status, (5) recommendations, and (6) whether the inmate is being referred for mental health institution placement and an explanation. <p>(P5566.06 (10)(f)).</p>	<p><u>Black Hawk County Jail, Iowa:</u> Develop a comprehensive policy on the use of restraint and isolation on inmates with serious mental illnesses. Ensure that mental health personnel are involved in decisions to restrain or isolate mentally ill inmates, and in the monitoring of such inmates while restrained or isolated. Develop policies and procedures to ensure that inmates with acute psychiatric conditions, who cannot function long term in the general jail population, are transferred or committed to appropriate treatment facilities as expeditiously as possible.</p> <p><u>Shelby County Jail, Tennessee:</u> Policies should ensure that mental health professionals are consulted before any planned use of force or non-routine use of restraints on any inmate with a diagnosis of mental illness.</p>

Periodic Reviews to Determine Release From Restraints			
NCCHC	ACA	Federal BOP	DOJ CRIPA Investigations
(No regulation available)	(No regulation available)	<p>A review of the inmate’s placement in four-point restraints shall be made by a lieutenant every two hours to determine if the use of restraints has had the required calming effect and so that the inmate may be released from these restraints (completely or to lesser restraints) as soon as possible.</p> <p>The goal of the two-hour reviews is to determine, as soon as possible, that the inmate has regained self-control and may be placed in lesser restraints. Staff should look for a pattern of non-disruptive behavior over a period of time indicating the inmate has regained self-control and is no longer a disruptive threat.</p> <p>(P5566.06(10)(e)).</p>	(No regulation available)

Appendix C: Brief Jail Mental Health Screen

BRIEF JAIL MENTAL HEALTH SCREEN

Section 1

Name: _____ <small>First MI Last</small>	Detainee #: _____	Date: ____/____/____	Time: _____ AM PM
---	-------------------	----------------------	----------------------

Section 2

Questions	No	Yes	General Comments
1. Do you <i>currently</i> believe that someone can control your mind by putting thoughts into your head or taking thoughts out of your head?			
2. Do you <i>currently</i> feel that other people know your thoughts and can read your mind?			
3. Have you <i>currently</i> lost or gained as much as two pounds a week for several weeks without even trying?			
4. Have you or your family or friends noticed that you are <i>currently</i> much more active than you usually are?			
5. Do you <i>currently</i> feel like you have to talk or move more slowly than you usually do?			
6. Have there <i>currently</i> been a few weeks when you felt like you were useless or sinful?			
7. Are you <i>currently</i> taking any medication prescribed for you by a physician for any emotional or mental health problems?			
8. Have you <i>ever</i> been in a hospital for emotional or mental health problems?			

Section 3 (Optional)

Officer's Comments/Impressions (check <i>all</i> that apply):		
<input type="checkbox"/> Language barrier	<input type="checkbox"/> Under the influence of drugs/alcohol	<input type="checkbox"/> Non-cooperative
<input type="checkbox"/> Difficulty understanding questions		
<input type="checkbox"/> Other, specify: _____		

Referral Instructions: This detainee should be referred for further mental health evaluation if he/she answered:

- YES to item 7; OR
- YES to item 8; OR
- YES to at least 2 of items 1 through 6; OR
- If you feel it is necessary for any other reason

Not Referred

Referred on ____/____/____ to _____

Person completing screen _____

INSTRUCTIONS ON REVERSE

©2005 Policy Research Associates, Inc.

<http://gainscenter.samhsa.gov/pdfs/disorders/bjmhsform.pdf>

Appendix C: Brief Jail Mental Health Screen

INSTRUCTIONS FOR COMPLETING THE BRIEF JAIL MENTAL HEALTH SCREEN

GENERAL INFORMATION:

This Brief Jail Mental Health Screen (BJMHS) was developed by Policy Research Associates, Inc., with a grant from the National Institute of Justice. The BJMHS is an efficient mental health screen that will aid in the early identification of severe mental illnesses and other acute psychiatric problems during the intake process.

This screen should be administered by Correctional Officers during the jail's intake/booking process.

INSTRUCTIONS FOR SECTION 1:

NAME: Enter detainees name — first, middle initial, and last
DETAINEE#: Enter detainee number.
DATE: Enter today's month, day, and year.
TIME: Enter the current time and circle AM or PM.

INSTRUCTIONS FOR SECTION 2:

ITEMS 1-6:

Place a check mark in the appropriate column (for "NO" or "YES" response).

If the detainee REFUSES to answer the question or says that he/she DOES NOT KNOW the answer to the question, do not check "NO" or "YES." Instead, in the General Comments section, indicate REFUSED or DON'T KNOW and include information explaining why the detainee did not answer the question.

ITEMS 7-8:

ITEM 7: This refers to any *prescribed* medication for any emotional or mental health problems.

ITEM 8: Include any stay of one night or longer. Do NOT include contact with an Emergency Room if it did not lead to an admission to the hospital

If the detainee REFUSES to answer the question or says that he/she DOES NOT KNOW the answer to the question, do not check "NO" or "YES." Instead, in the General Comments section, indicate REFUSED or DON'T KNOW and include information explaining why the detainee did not answer the question.

General Comments Column:

As indicated above, if the detainee REFUSES to answer the question or says that he/she DOES NOT KNOW the answer to the question, do not check "NO" or "YES." Instead, in the General Comments section, indicate REFUSED or DON'T KNOW and include information explaining why the detainee did not answer the question.

All "YES" responses require a note in the General Comments section to document:

- (1) Information about the detainee that the officer feels relevant and important
- (2) Information specifically requested in question

If at any point during administration of the BJMHS the detainee experiences distress, he/she should follow the jails procedure for referral services.

INSTRUCTIONS FOR SECTION 3:

OFFICER'S COMMENTS: Check any one or more of the four problems listed if applicable to this screening. If any other problem(s) occurred, please check OTHER, and note what it was.

REFERRAL INSTRUCTIONS:

Any detainee answering YES to Item 7 or YES to Item 8 or YES to at least two of Items 1-6 should be referred for further mental health evaluation. If there is any other information or reason why the officer feels it is necessary for the detainee to have a mental health evaluation, the detainee should be referred. Please indicate whether or not the detainee was referred.

<http://gainscenter.samhsa.gov/pdfs/disorders/bjmhsform.pdf>

Jefferson County Jail's Reply

JEFFERSON COUNTY SHERIFF'S OFFICE



Office: (641) 472-4146
Fax: (641) 469-3353
E-mail: jeffcoso@kdsi.net

Sheriff
Jerry R. Droz

1200 W. Grimes • Fairfield, IA 52556

To Serve and Protect the People

Chief Deputy
Joe Smutz

Lieutenant
Randy Lewis

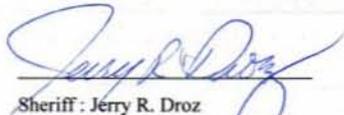
January 13, 2009

Mr. William Angrick,

We have attached Jefferson Counties' response from our Health Professionals. Please note that we are following our Health Professional's guidance at this time.

We would ask that you include both sides of this incident when publishing your findings to the general public. We want the public to know what was occurring to cause the excessive use of the Emergency Restraint Chair (ERC) and that we were NOT blatantly disregarding policies and procedures, and that we were indeed trying to keep Mr. Halley from harming himself or others at the time of the incidents. We feel it is very important and very fair that you publish both sides. Also, explain the fact that there were NO injuries to Mr. Halley from the use of the ERC.

We would further ask that when you publish these finding, that you get the names correct. It is Sheriff Jerry R. Droz and not Terry. This was relayed to Mr. Andy Teas in person to which he only replied "whatever".


Sheriff: Jerry R. Droz


Jail Administrator: Michael S. Simons

Cc: Tim Dille Jefferson County Attorney
Dr. Norman Johnson, AHC

Deputy: Tim Simmons
Deputy: Ryan Richardson

Deputy: Gregg Morton
Deputy: David Wyatt

Deputy: Jerry Marcellus
Secretary: Judi Robinson



December 16, 2008

Sheriff Jerry Droz
Jefferson County Correctional Facility
1200 West Grimes
Fairfield, IA 52556

Dear Sheriff Droz,

I am writing in regard to the investigation of restraint device use in Iowa's County jails from the state of Iowa Citizen's Aide/Ombudsman William P. Angrick, II, dated November 5, 2008.

After reviewing the executive summary, in paragraph 5 on page 1, there was a list of eight recommendations. I will take each of these in order to discuss our thoughts and recommendations.

- 1) Mental health screening of new inmates; Vice President of Quality Assurance & Risk Management sent you a copy of the recommendations on mental health screening from our mental health team. A copy is enclosed with this letter. You will note the recommended questionnaire is actually more comprehensive than the GAINS questionnaire recommended by the Ombudsman. I believe it is reasonable to incorporate these questions into your book-in screening sheet.
- 2) Follow up mental health assessment for inmates who screen positive for mental illness; Your physician has been trained to handle mental health issues according to NCCCHC (National Commission of Correctional Healthcare) standards. He has further support and training from our mental health team and has received special training from our team. It is my opinion that he is fully qualified to evaluate those people with mental health problems in your facility.
- 3) When to use restraint devices; I believe that your policy, 1-10, is well written and comprehensive. As long as your officers are trained in that policy, I see no need to change anything at this time.
- 4) What types of restraints are appropriate; it is my opinion, after reading your policies, 1-10 and 1-10A, which cover these types of restraints, given the situations that you face these policies appear to address the problem. I do not believe it is necessary to purchase further restraint devices, such as restraint bed. I don't believe any further protocols or policies are necessary.
- 5) Monitoring restrained inmates; Enclosed you will find a copy of the Jackson County, Missouri restraint monitoring policy. This is a very large facility and they do occasionally

find the need for chair restraints. This program has worked very well and has resulted in no injuries to the inmates. I believe it is reasonable to incorporate this monitoring system at your facility.

- 6) Medical and mental health reviews of inmates; I believe by extending the screening to include the mental health questions we have recommended and having your physician review the medical and mental health of the inmates, as you presently are doing, you will meet the recommendations of the Ombudsman. For an inmate who is placed in chair restraint, the officer should pull the medical record and alert the physician to any medical or mental health issues that may exist.
- 7) Documentation of restraint use; The documentation of the restraint use is two fold - first to document the reasons for the restraint, and second to document what is going on with the detainee while in the restraints. The second part of this is already handled in question number 5. The first part, documentation of the reasons, should be handled through your routine correctional officer's notes and documentation. I believe no further changes are necessary.
- 8) Time limits for restraint use; as discussed during the visit, we would recommend after a period of 2 hours the detainee should be released and allowed to stand up. If behaviors begin again he can be placed in restraints again for an additional 2 hour period. This will get past the issue of having a detainee in prolonged, 6 - 12 hour restraints. It will also get us past the need for medical review since the inmate is able to get out and move all extremities without difficulty.

If you have the ability to place the chair on video, I believe that would be an excellent way to document length of time and the procedures that the officers are using, as well as the combative behavior of the detainee.

At the present time, Advanced Correctional Healthcare is in the process of developing a video psychology and a video psychiatry program. It may be that the video psychology program on an as needed basis might work well in your facility. We are in the process of putting the elements together. As soon as this is completed we would let you know how it would work in your facility and what costs would be necessary to get it initiated.

Again, thank you for allowing us to assist you in this very important work. After reviewing these recommendations, let me know if we can assist you in any other way.

Respectfully,



Norman R. Johnson, MD
CEO, Advanced Correctional Healthcare
Cell (309) 648-3056

Woodbury County Jail's Reply



Andrea H. Buckley **
Timothy A. Clausen **+
René Charles Lapierre **+
William H. Larson **+
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December 31, 2008

Via E-Mail

William P. Angrick II
Citizens' Aide/Ombudsman
Ola Babcock Miller Building
1112 East Grand Avenue
Des Moines, IA 50319

Re: *Woodbury County Jail Investigation*

Dear Mr. Angrick:

I represent the Woodbury County Sheriff. In your letter of November 5, 2008, addressed to the Sheriff, you asked that he advise whether he will accept the recommendations contained in your investigative report issued on November 5, 2008. The purpose of this letter is to respond to that request.

1. *Recommendation regarding intake screening and response to medical requests* (p. 92). The Woodbury County Jail does provide a medical history screen, both at the time of booking, and in a more thorough assessment for detainees committed to general population. Both the screening and the assessment address current medical conditions, medications and mental health history. The forms used, questions asked and information gathered comply with the requirements of the current state jail standards. To the extent the Ombudsman is recommending that this procedure, or the forms currently in use be changed, that recommendation is rejected.

2. *Recommendation regarding responses to inmate requests for mental health care* (p. 92). The Jail does respond to inmate requests for mental health care, and rejects the suggestion that it did not respond in the case of G.A.

William P. Angrick II
Citizens' Aide/Ombudsman
December 31, 2008
Page 2

Re: *Woodbury County Jail Investigation*

3. *Recommendation regarding revisions to Jail Policy governing use of restraint devices* (p. 95). The Jail maintains that the applicable policies and guidelines comply with the requirements of state and federal law. The cases to which the Ombudsman refers are based upon facts that have no similarity to the allegations made by G.A. Jail staff are properly trained and understand that when force of any kind is used, they are always required to use the least amount of force necessary to accomplish their legitimate goals. The applicable policies and guidelines make it clear that in the case of cell damage, destruction must be "extreme." In the case of G.A., the officers that were present when the incident happened were convinced that restraints were appropriate. This recommendation is rejected.

4. *Recommendation regarding use of a restraint chair instead of a restraint board* (p. 97). No two incidents are alike. The circumstances of the individual incident and the availability of the particular device govern the choices that are made. From the standpoint of officer safety, a restraint chair is ordinarily easier to use than a board, and for that reason, the chair is often preferred. To the extent that the Ombudsman is recommending that the Jail *never* use a restraint board, however, that recommendation is rejected.

5. *Recommendation requiring notification of medical staff and direct medical supervision* (p. 98). While the factual basis for this recommendation is disputed, the Jail accepts the recommendation that medical staff be notified when a restraint device is used. The Jail rejects the recommendation that direct medical supervision be required in cases where use of a restraint chair exceeds two hours.

6. *Recommendation regarding mental health review* (p. 99). Mental health services are provided in accordance with the medical needs and legal rights of detainees. The Jail rejects this recommendation.

7 and 8. *Recommendations regarding documentation and video taping of use* (p. 100). The current policy and practice meet the requirements of the applicable state jail standards. This recommendation is rejected.

William P. Angrick II
Citizens' Aide/Ombudsman

December 31, 2008

Page 3

Re: *Woodbury County Jail Investigation*

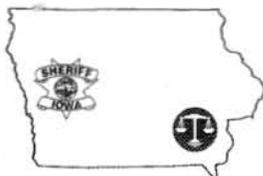
Sincerely,

A handwritten signature in black ink, appearing to read "Douglas L. Phillips". The signature is written in a cursive style with a prominent initial "D".

Douglas L. Phillips

cc: Glenn Parrett
Greg Logan
Robert Aspleaf
Lynette Redden

Appanoose And Wapello County Jails' Reply



SOUTH IOWA AREA CRIME COMMISSION
P.O. Box 943
FAIRFIELD, IOWA 52556

January 9, 2009

Mr. William P. Angrick, II
Citizens' Aide/Ombudsman
Ola Babcock Miller Building
1112 East Grand Avenue
Des Moines, Iowa 50319

RE: Use of Restraint Chairs

Dear Mr. Angrick:

This letter acknowledges the receipt of your letters to Sheriff Gary D. Anderson and Donald Kirkendall dated November 5, 2008. Both Appanoose and Wapello Counties are members of the South Iowa Area Crime Commission. Sheriffs Anderson and Kirkendall have requested that we prepare a response on behalf of both counties as well as on behalf of all fifteen Crime Commission member counties.

The Crime Commission assists member counties in risk management issues, lawsuit prevention, preparation and implementation of jail policy and procedure manuals and training. Most of the Crime Commission members have small rural jails with budgetary limitations and shortages in medical and mental health services. Most of our jails have less than a 25 bed capacity. Because of the diverse nature of each facility across the state, the age and condition of each facility, the financial and administrative pressures in each county and the lack of services available in many of our rural areas, it is not possible to deal universally with the issues you have identified.

In defense of the specific allegations against Wapello and Appanoose Counties, we will address those separately. However, both counties initially responded to investigations started by your office. Both Jail Administrators provided the information requested with one exception that will be addressed. Both Jail Administrators were told by the initial investigators that the investigations were completed. They were shocked when months later they were told by a different investigator that the investigations were not completed and these counties had not been cleared.

-1-

Regarding the incident with inmate J.L. who was arrested for public intoxication on May 20, 2007 and booked into the Wapello County Jail, please note that he registered a .239 on the preliminary breath test nearly three times the legal limit. Jail staff appropriately determined that the use of the restraint chair was necessary because J.L. was hitting his head against the cell window. The policies in place had been prepared by the former Jail Planner when the new jail was built. At the time, Iowa Jail Standards did not require constant CCTV surveillance on the restraint chair. The jail's policy required 15 minute in-person checks and consideration for removal on an hourly basis. However, this exceeded the Iowa Jail Standard, which did not require those checks. Documentation was required. Although jail staff claims that documentation was done, the Jail Administrator has been unable to find that documentation.

Additional training has occurred at the Wapello County Jail to address some of the concerns raised. Streaming video equipment has been purchased. The restraint chair has been moved to ensure 24/7 observation and proper lighting. Two correctional officers are now required to secure an inmate in a restraint chair. Documentation of the 15-minute checks will be preserved in an appropriate format for any future need or reference.

The real issue here is the fact that the officer, when kicked in the head by the inmate, reacted instinctively and defensively, by striking the inmate. While this was a reactive movement, it did not occur without provocation by the inmate. This was not punitive; it was reactive and defensive in nature. The policies in place were in compliance with the Iowa Jail Standards.

Concerning the Appanoose County Jail incident, jail personnel acted appropriately throughout the night when dealing with the inmate in question. She was abusive, assaultive, and self-injurious. She was examined by medical providers upon admission to the jail. These providers found no medical problem in need of treatment. She was provided many opportunities to cooperate with staff but chose to act in a violent manner.

Furthermore, there was no place to take this inmate. Appanoose County has an extremely difficult time getting any type of mental health commitment. Even if a commitment is approved, there are no medical facilities which will take these inmates. The safest place for this inmate, whether she was mentally ill or not, was in the jail.

-2-

The policy in effect did provide for direct medical supervision. The Crime Commission is recommending that this policy be changed since the Iowa Jail Standards do not require direct supervision by a medical provider or limit the hours needed for restraint. Clearly, this inmate needed to be in the restraint chair for the time indicated for her safety as well as the safety of staff. As soon as she settled down, she was released from the chair.

This inmate was not tased. Staff are trained that it is permissible, but not recommended, to tase a restrained arrestee if the circumstances warrant it. However, it is recommended that extreme caution be used under these circumstances. This inmate did stop rocking the restraint chair after she was advised of the possibility of being tased. It was not long after this that she started to behave and was removed from the chair. She was drunk, not mentally ill. Her behavior after that point suggested no mental illness.

There is absolutely no evidence that the inmate urinated or defecated in the chair. Staff must be given discretion to determine if it is safe enough to release the inmate. The Appanoose County Jail is an extremely small facility with few officers. They do not have the same manpower as the Federal Prisons. Therefore, the Federal Bureau of Prisons' policy is a luxury a small town jail cannot afford.

And finally, Appanoose County was not contacted about this incident until after the tape had been taped over. This is a common practice in jails across the country, because of the cost in replacing tapes frequently. Furthermore, Jail Administrator Beck was told by the investigating ombudsman that the incident had been reviewed and the county was not found at fault.

The list of recommendations provided in your report is laudable, but far from attainable due to budget shortages not only in Iowa Jails but in the mental health arena. Even if it is clear that the inmate is mentally ill, either staff cannot get the inmate committed because of a lack of cooperation by some judicial officials or medical providers refuse to verify the need. Medical providers and judges have said the safest place for these inmates and the public is in a county jail. And, even if a commitment is successful, there are no hospital beds for inmates with aggravated misdemeanor or felony charges. It takes months for a bed to open up at Oakdale for inmates with these charges. Where are these inmates supposed to go?

Most of our jails are small, in rural areas with little to no mental health services provided. The Jail Standards require that all inmates are screened for mental health. However assessment by a mental health professional is not an easy task not only because of budgetary constraints but also because of the absence of mental health professionals in these areas. Telemedicine may be a useful tool in the future, but currently it is out of reach for small, economically stressed rural counties. The cost may only be \$750 for the equipment, but the cost for the service cannot be billed to the inmate (even if the inmate were capable of paying) as it is to the patient as suggested by the hospital example given in the report.

In the review of when to use restraint chairs, it is clear that the policies are in place to use these devices when needed. However, do we wait until the inmate seriously injures himself, staff or other inmates before we intervene by using the device? This is reactive behavior and not proactive behavior which results in litigation. Correctional officers must be given discretion in the need for the device during an emergency situation. It is difficult to review these incidents in hindsight and judge whether the officer's decision was necessary. During an emergency situation, an officer must look at the totality of circumstances in determining the need for the restraint device. For instance, a threat upon the officer may be adequate cause for restraint rather than waiting for the assault to occur. Many of these inmates are well-known by the jail staff and their propensity for violence is well-known. A threat by an inmate with a known history of serious assault may be adequate for the use of the restraint device.

Often it is difficult to judge whether the use of the restraint device was punitive or not. What may be viewed as punitive to one person may be seen as in the best interest of another person. The lines between safety and security can often be blurred and viewed as punitive by the inmate. Verbal abuse and threats made by the inmate against staff or other inmates can be sufficient to justify use of the restraint device. If an officer waits until the inmate carries out the abuse, it is too late to protect the safety and security of the inmate(s) and staff.

Medical review of restraint chair use simply is not practical or realistic in our jails. Besides the issue of money, even if mental health professionals are available, it is difficult to hire a medical provider to come to the jail usually at odd hours of the day or night to deal with the criminal element.

We acknowledge that there may be times that a mentally ill inmate may be placed in a restraint chair. However, that is often the only mechanism immediately available to jail staff to ensure the safety of the inmate, other inmates and staff.

Camera usage is required pursuant to the Iowa Jail Standards. However, video feed is recorded over after a period of time. If the Jail does not receive notice of a reason to preserve the tape, it is simply recorded over. That does not mean the Jail does not comply with the Standards. If video feed is required to be preserved after every incident that occurs in the jail, there could be a potential storage problem as well as added operating expense to already stressed jails. The problem is further compounded by the lack of medical providers, the lack of medical beds and local funds to provide the mental health services you have suggested.

Our counties try to hire the best staff available. However, employment as a correctional officer in a small town jail is not the most glamorous or sought after position. Often, these officers work long hours, with low pay, being subjected to physical and verbal abuse by inmates on a daily basis. These employees are also subjected to bloodborne and airborne pathogens that can be potentially deadly. It is difficult to pay these officers what they are really worth. Policies are developed and training is provided. The majority of our officers are conscientious, dedicated employees who try to provide the best care for inmates as possible in spite of the abuse they receive in return. However, even a good employee can react instinctively and defensively to an assault by an inmate. Employees are taught defensive tactics routinely at jail schools to allow them to defend themselves during an assault.

The report details the need for mental health courts, and an overhaul in the mental health system in the State of Iowa. Other suggestions include regional jails. In many of our counties, bond issues for new jails have failed repeatedly because taxpayers do not want to fund new state of the art facilities. The funds are simply not available to pay the cost for these jails.

Regarding the recommendations made on pages 6 and 7 of the report, we would provide the following responses:

1. Mental health Screening forms may be a useful tool incorporated into our current Medical Screening Forms. However, it does not solve the budgetary and mental health issues due to lack of money, few mental health resources, refusal to commit by judicial officials and/or doctors, and refusal by mental health facilities to accept commitments of difficult inmates, who may be charged with a felony or aggravated misdemeanor.
2. The same arguments can be made regarding your recommendation for further assessment. Again, where do we transfer these inmates?
3. Our policies restrict when restraint devices may be used. However, we request that you do not second guess the use of a restraint device during emergency situations. Officers do not know when a verbal threat can escalate to actual assault. If an assault occurs after we know of the verbal abuse or threat, our litigation liability and risk increases.
4. Our policies require that the least restrictive means of force is used to control the inmate. Our officers are continually trained on this. Any use of force in excess of the minimum force necessary is excessive. Our officers are trained to use their best judgment under extenuating circumstances.
5. Video equipment is used. Depending on the Jail facilities and the equipment that can be afforded, video tape may be of good quality or it may be marginal as experienced in Wapello County. Our jails are constantly striving to update and improve equipment based upon budgetary restrictions.
6. Personal, visual observation is required by the Iowa Jail Standards. Our policies also require this.
7. Officers are actually trained to determine whether an inmate can be removed every 15 minutes, but at least hourly. Some officers are better at documenting specifics than others.
8. Medical review is simply not in the budget. The State of Iowa has increased the amount of time an inmate can serve in our county jails. This was to take the stress off the state system. County Jails were initially intended for short term incarcerations. Now, inmates can serve up to a year in jail. However, this increase in the use of our jails did not come with an increase in funding by the State.

9. Again, direct in-person medical reviews may be desirable, but they are not practical with restricted money and few mental health resources.

10. The Crime Commission respectfully disagrees that the employment of a licensed medical professional by the Jail is a potential conflict of interest. If the County has the luxury to hire staff medical personnel, those individuals should be allowed to review the use of a restraint device. This is a possibility if the Jail can afford to do so. However, most of our jails do not have the money to hire on-staff medical providers.

11. We would respond essentially as above regarding the need to contact medical providers every time a restraint device is used or if it is needed beyond two hours. We will be updating our restraint chair policies for our counties in the future, removing reference to the requirement that a medical provider has to be contacted, and removing reference to an automatic limitation on the time used for these chairs.

12. Again, documentation is required on the use of all restraint devices. Officers are trained on this and strongly encouraged to be specific in their documentation. While ILEA may or may not specifically train on the use of restraint devices, the Crime Commission has conducted familiarization training on the restraint chair and has annually conducted a review of legal cases around the country involving these devices, documentation and excessive force cases.

13. We have addressed repeatedly the issue of video use. However, retaining and preserving a tape to be kept for two years is simply not practical in light of the high number of incidents that occur in county jails. It would be up to each individual jail to determine whether these tapes could be maintained.

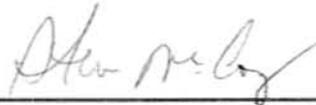
While the report does document ongoing mental health problems in the state's correctional system, the recommendations provided assume that minor changes can be made with minimal financial impact. These recommendations do not fully consider all the underlying causes and assume that the Jails have total control of these issues. That is clearly not the case. Mandating these recommendations without the funds or resources to do so is not in the best interest of the State. The financial impact could bankrupt many of our counties.

The Crime Commission will be reviewing its restraint chair policies for our member counties and will recommend some changes suggested by your report. We are always looking for ways we can improve the operation of our jails. However, based upon our review of the use of restraint chairs in our area, we believe that they are a valuable tool to assist our jails in controlling inmates and preventing injury to the inmate(s) and staff. Implementing all of the recommendations in your report would be virtually impossible due to budget restrictions and lack of mental health resources.

We would also like to request that the names of the jail personnel involved remain confidential, just as the inmate names remain confidential.

Thank you for your consideration.

Respectfully submitted,



Steve McCoy, Director
The South Iowa Area Crime Commission

Polk County Jail's Reply

POLK COUNTY SHERIFF'S OFFICE

SHERIFF DENNIS W. ANDERSON

Polk County Jail
1985 NE 51st Place
Des Moines, IA 50313-2517



www.co.polk.ia.us/departments/sheriff
Office (515) 286-3800
Fax (515) 323-5473

William P. Angrick II
Citizens' Aide/Ombudsman
Ola Babcock Miller Building
112 East Grand Avenue
Des Moines, Iowa 50319

Dear Mr. Angrick:

Thank you for the opportunity to reply to your report. The Polk County Sheriff's Office appreciates the analysis, conclusions and recommendations from your agency. We take this report very seriously and will take the corrective measures you have put forth in order to comply with all constitutional rights, Iowa laws and the restraint chair manufacture's recommendations.

The Polk County Sheriff's Office agrees to the general recommendations for jails made on page #65 of the report. The Polk County Sheriff's Office General Orders now reflect compliance to the recommendations and a copy of our revised General Order on the use of the restraint chair accompanies this response. Staff will be advised of the updated policy through roll calls, online training on the new General Order and through annual in-service training. All new hires are shown the restraint chair manufacture's (E.R.C. Inc.) usage video during basic jail school. A copy of the video used for restraint chair training also accompanies this response.

We have also addressed the issues presented in your report specifically addressed to Polk County which are pages 116 to 125.

1. Page #120 – Polk County must conduct 15-minute checks of the inmate and the restraint device application throughout the duration of the inmate's placement in a restraint device. The jail should immediately review this practice with staff and ensure it is addressed during regular training on restraint device use in the jail.

Response: The Polk County Sheriff's Office General Order # 6600.59 has been updated to reflect the mandate of 15 minute checks. Please refer to Page #2 of the attached General Order Procedure Section F 4(a-f). The updated General Order will immediately be reviewed with staff in the manner I have described above.



Accredited by the American Correctional Association

2. Page# 121 – Polk County Jail should refrain from placing an inmate in a restraint device for a pre-determined time limit. Such placement could be considered punitive and contrary to the inmate’s constitutional rights and Iowa law, especially if that pre-determined time limit extends to periods when the inmate is no longer a threat to self, others, or jail security.

Response: The Polk County Sheriff’s Office General Order # 6600.59 has been written to clearly state; restraint devices such as the restraint chair, shall not be applied as punishment. Please refer to the attached General Order Policy description as well as the General Order Procedure Sections G through J. The updated General Order will immediately be reviewed with staff in the manner I have described above.

3. Page #121/122 – The jail should conduct periodic checks of the inmate’s disposition and actions to determine whether the inmate may be released. The jail should train all staff who may be involved in restraint chair use on the jail’s existing policy requiring “at least hourly” reviews of a restrained inmate to determine if the inmate may be released. If the inmate must remain in the restraint device, the jail must document the inmate’s actions justifying continued restraint.

Response: The Polk County Sheriff’s Office General Order # 6600.59 has been written ensure that staff conducts regular 15 minute checks and consideration is given to the inmate for removal from the restraint chair at least hourly. Also; the General Orders have been updated to reflect the requirement to document the reasons for continued restraint at least hourly. Please refer to the attached General Order Procedure Section G. The updated General Order will immediately be reviewed with staff in the manner I have described above.

4. Page#122 – Polk County Jail should follow the manufacturer’s guidelines recommending direct medical supervision in the event the restraint chair must be used longer than the initial two hours, and incorporate this procedure in the written policy.

Response: The Polk County Sheriff’s Office General Order #6600.59 has been updated to include the restraint chair manufactures recommendation of maximum confinement. The General Order update also requires Health Services to inspect and review the inmate’s condition, as soon as possible after the inmate is placed into the restraint chair, at least hourly while in the restraint chair. Mental Health staff will also be notified if the inmate is known or believed to have a mental illness. Please refer to the attached General Order Procedure Sections D, H, I, K and L. The updated General Order will immediately be reviewed with jail and medical staff in the manner I have described above. The Emergency Restraint Chair Demonstration Video will be shown during our annual in-service training.

5. Page#123 – Polk County Jail must document each action and decision addressing an inmate’s four or five point restraint. It must ensure the checks are done and ensure the documentation is not “overlooked.” Documenting all actions and decisions, under Iowa law, also includes the decision whether to release the inmate or continue restraint use after each hourly review that is required under jail policy. This applies to any medical reviews during and after the use of the restraints on the inmate.

Response: The Polk County Sheriff’s Office General Order # 6600.59 has been updated to reflect the mandate requiring staff to physically check the restraints on inmates in the restraint chair every 15 minutes and to document their observations accurately. The Health Services Administrator Tania Porter has been advised documentation of medical observations for inmates in the restraint chair must be made for their records. Please refer to the attached General Order Procedure Section F 4(a-f) and G. The updated General Order will immediately be reviewed with staff in the manner I have described above.

6. Page#124 – The jail should incorporate in its written policy the procedures for written documentation of all actions relating to restraint chair use.

Response: The Polk County Sheriff’s Office General Order # 6600.59 Procedures Section F (1-5), has been updated to reflect all necessary documentation relating to the restraint chair use.

7. Page#125 - The Polk County Jail should ensure the video documenting the restraint device use provides an accurate account of the events that transpire. This would include an unobstructed view of the placement and use of the restraints. This is important for vivid documentation and necessary if used for continuous monitoring purposes. The jail should retain copies for at least two years.

Response: The Polk County Sheriff’s Office General Order # 6600.59 has been updated to include inmate placement for digital recording documentation and addresses digital recording retention requirements. Please refer to the attached General Order Procedure Section B, C and N. The updated General Order will immediately be reviewed with staff in the manner I have described above.

Thank you again for allowing the Polk County Sheriff’s Office an opportunity to respond to your report. We look forward to working with you as we continue to advance into our new jail facility.

Respectfully;

Chief L. Shoemaker

Ombudsman Comment

The Ombudsman is required by law to consult with the agencies involved in an investigative report and attach their written replies to the report.

The Ombudsman received a variety of responses, ranging from Polk County's acceptance of all the recommendations – including a redrafting of their restraint chair policy – to Woodbury County's outright rejection of all recommendations. The South Iowa Area Crime Commission (SIACC) provided arguments to many of the recommendations on behalf of Appanoose County, as well as the other counties it represents, which were not the subject of the Ombudsman's report. The Ombudsman's Comment will address the counties' responses.

Polk County Jail

The Ombudsman commends the Polk County Jail for its responsiveness to the report and recommendations. The jail assured the Ombudsman that it took the report very seriously, accepted each recommendation, and re-drafted its policy to comply with all constitutional rights, Iowa laws, and its restraint chair manufacturer's recommendations. The Ombudsman has reviewed the new policy and is very satisfied with the language.

Jefferson County Jail

Jefferson County Jail's original response did not address the recommendations set out in the report. The letter from Advanced Correctional Healthcare, on behalf of Jefferson County Jail, only responded to the general issues presented in the Executive Summary section of the report. However, a subsequent correspondence with Jail Administrator Michael Simons yielded the response that the jail accepted each of the Ombudsman's recommendations.

It is also important to point out that the jail began incorporating significant changes even before the report was issued, including consulting with an outside agency to review medical and mental health treatment for inmates.

The only fact dispute raised in Jefferson County's reply is the mistaken reference to Sheriff Jerry R. Droz's first name, identified as "Terry" in the draft report. The county's reply stated, "This was relayed to Mr. Andy Teas in person to which he only replied 'whatever'."

There was no in-person conversation between Sheriff Droz and Mr. Teas about the mistake. Mr. Teas became aware of the error on November 14, 2008, when Sheriff Droz informed the receptionist about the mistaken reference to his first name. The error has been corrected for the final version of the report.

Woodbury County Jail

The Woodbury County Jail rejected all of the Ombudsman's recommendations, the product of extensive research based on professional recommendations and industry standards. The Ombudsman is disappointed that the jail has failed to take the opportunity to improve its policies and practices on restraint device use. Of particular concern is the jail's decision to ignore the restraint chair manufacturer's own recommendation that owners of its chair employ direct medical supervision in cases where an inmate restraint exceeds two hours.

Each argument rejecting the recommendations merits a response from the Ombudsman:

1. The Woodbury County Jail rejected the Ombudsman's recommendation to incorporate an intake screen that addresses an inmate's medical and mental health history and needs. The jail argues it already has a screen in place. However, no records of any such screen were provided to the Ombudsman for G.A.'s admission to the jail on June 25, 2006. If the jail already has a screen it uses for newly admitted inmates, it needs to ensure it is used and retained for each inmate entering the jail.
2. The jail rejected the suggestion that it did not respond to G.A.'s request for mental health care. The Ombudsman did not make any such suggestion. The concern in G.A.'s case was that the jail did not respond *in a reasonable amount of time*. Based on documents provided by the jail, it took more than two months for G.A. to be seen by medical staff after he had submitted a medical request for depression and anxiety. The day after he was finally seen, he was placed both on a restraint board and in a restraint chair.

The Ombudsman believes an unreasonable delay to medical care may violate an inmate's Eighth Amendment rights and places the jail at risk of legal liability.

3. The jail rejected the Ombudsman's recommendation to revise the jail's policies on the use of restraint devices. The jail implies that the destruction G.A. caused to the cell was extreme. The Ombudsman stands by the facts presented in the report.

The jail's response does not address the Ombudsman's concerns regarding the apparent inconsistencies within the policy, which provides varying reasons for which a restraint device may be used. A clear policy is necessary to notify officers and jail staff when certain force is authorized and what kind of force is prohibited. In 2002, four former Woodbury County jailers sued the county for slander when the sheriff publicly stated that the jailers violated policy by their use of force on an inmate. The jailers later were able to show that there was no language in policy that prohibited their use of force against the inmate, which included kneeling the inmate, slamming his head against a counter, punching him in the ribs, and elbowing him in the back.

4. The jail rejected the recommendation that staff should use the restraint chair rather than the restraint board. The Ombudsman believes the use of the restraint chair is preferable to the restraint board whenever possible for the reasons detailed in the report.
5. The jail rejected the recommendation calling for direct medical supervision of inmates where the use of the restraint chair exceeds two hours. The recommendation is derived from the chair manufacturer's recommended use. By rejecting the Ombudsman's recommendation to provide direct medical supervision, the jail is putting the inmate at greater risk of serious injury or death, and potentially subjecting the county to legal liability.
6. The jail rejected the recommendation to incorporate language in its written policy requiring a mental health review of any inmate with a known or suspected mental illness who is placed in a restraint device. The jail argues it already meets the medical needs and legal rights of inmates.

The facts presented in the report speak for themselves. A medical or mental health professional was never contacted when G.A. was placed in the restraint devices on September 3, 2006. This is a practice recommended by the NCCHC, the ACA, the restraint chair manufacturer, and the U.S. DOJ's investigation of Black Hawk County Jail. Placing these procedures in written policies helps prevent inconsistent practices by jail personnel.

7. and 8. The jail rejected the recommendation to have staff document the need for continued restraint device use in its reports and logs. It also rejected the recommendation to video record the duration of the restraint device use. The jail argues its policy and practice meets the legal requirements under Iowa law.

The Ombudsman does not believe the jail's response to these recommendations reflect the best practice for restraint device use and further exposes the jail to liability, as detailed in the report.

This report cited examples from other jails where use of video provided instrumental evidence to substantiate or reject inmate claims of abuse. Woodbury County Jail's officials, in particular, relied heavily on the use of video when it disciplined four officers accused of beating an inmate in 2002. Without those tapes, it is difficult to say where the case would have gone if the only evidence came from the inmate's allegations.

The Ombudsman agrees with Woodbury County Jail that the jail's current policies and practices meet the basic requirements of the applicable jail standards. However, complying with existing law or rules is not sufficient. Clarification of jail policies, following industry standards, and conforming to manufacturer guidelines is as important for inmate and staff safety as following the minimum requirements of the law. The Ombudsman is convinced that continued monitoring for violations of Iowa law, jail policy, and industry standards at the jail is required for the health and safety of Iowans.

Appanoose County Jail

The South Iowa Area Crime Commission (SIACC) replied to our report on behalf of the Appanoose and Wapello county jails, as well as on behalf of 13 other counties it represents. In its representation of the Appanoose County Jail, the SIACC raised its concerns about how the county could access and afford medical reviews and mental health care services, the use of Tasers on restrained inmates, and the circumstances under which a restraint chair may be used.

SIACC requested that the name of jail personnel remain confidential, just as the inmates' names remained confidential. The Ombudsman redacted the inmates' names due to the sensitive medical and mental health issues detailed in the report. The same concerns do exist for jail personnel. In the spirit of transparency and accountability, the names of jail personnel will remain in the report.

Medical and Mental Health

Our report recommended consultation with a mental health professional in the event an inmate screens positive for a potential mental illness. The SIACC acknowledged that Iowa law requires all inmates be screened for mental health, but stressed the difficulty many counties have with the cost of mental health professionals' assessments. SIACC argued that even telemedicine does not solve the problem of paying for the services of a mental health professional to review inmates.

While the Ombudsman sympathizes with the fiscal constraints faced by small counties, failure to provide mental health care offers a more dire consequence than the financial strain it places on a county. If an inmate does screen positive for a potential mental illness in a county that cannot afford a mental health professional, what will happen to the inmate? Will the jail ignore the inmate's medical needs?

Refusing to contact a mental health professional for an inmate's serious mental health needs is an unacceptable response. It invokes a "snake pit" mentality towards mental health treatment. The costs of seeking treatment for an inmate's mental illness will pale in comparison to the litigation costs of ignoring an illness if the inmate is injured or dies. The Ombudsman hopes it is not also at the cost of human life or dignity.

The SIACC's reply also argues about smaller jails' ability to access mental health care, citing resistant judges, a lack of mental health beds, and a refusal by hospitals to accept inmates. The Ombudsman is well aware of these arguments by county officials.

The same arguments were raised by Jefferson County Jail when it restrained an inmate with a serious mental illness on several occasions. Despite arguments that the magistrate was known to decline civil commitment requests, the Ombudsman encouraged the county officials to pursue an order. If the order failed, it would not be the fault of the jail or county attorney. After the jail and county attorney agreed to the Ombudsman's request, the order was approved four days later.

The Ombudsman then worked with Jefferson County's Central Point of Coordination administrator (CPC) when a concern about placement was raised. Much like the argument raised by the SIACC, the county believed it would not find a bed for the inmate, who was facing charges of robbing a bank and had a history of violent behavior. The CPC eventually contacted 14 mental health institutes and private hospitals, requesting to be placed on their waiting lists. Instead of taking "months for a bed to open up," as argued by the SIACC, within one day a bed became available at University of Iowa Hospitals and Clinics.

The Ombudsman questions the SIACC's generalized statements that mental health care is unaffordable or inaccessible for its 15 member counties. The Ombudsman recently conducted a state-wide survey of county CPC's in Iowa, of which over half of the SIACC represented counties responded. Questions included the willingness of magistrates to commit inmates and the CPC's experience with successful placement of those inmates. The responses we received were not consistent with SIACC's blanket statement that its member counties cannot afford or access mental health care for inmates. The variety of responses we received could be summarized by a CPC who represents five counties:

It varies - one county seems to commit everyone – one county won't commit even if it seems obvious it's needed – the other 3 are good in their evaluations and judgement of who needs commitment.

Counties should not assume or over-generalize a lack of availability in the civil commitment process. Even those counties that have experienced problems committing inmates should not give up. Not dealing with the problem does not make it go away. Rather, counties should continue to work with parties involved to find solutions on individual cases and system wide.

The SIACC seems to raise a factual dispute when it stated T.F. "was drunk, not mentally ill. Her behavior after that point suggested no mental illness." The Ombudsman questions how the SIACC arrived at this conclusion. According to officer reports, T.F. was punching herself in the face, banging her head against the wall, and jamming her thumbs in her eyes. The Ombudsman believes it is risky for the SIACC and the jail to make conclusions about the absence of any mental health diagnosis without first consulting a mental health professional.

Use of Taser Devices on Restrained Inmates

Long ago men tried to shock the insane back into sanity by throwing them into a snake pit -- a drastic treatment which by its sudden terror was sometimes successful. Modern methods, though superficially more civilized, often rely on the same brutal shock to achieve their results.

Mary Jane Ward, *THE SNAKE PIT*, dust jacket (Random House 1946).

The SIACC points out that a Taser device was never used on T.F., just threatened to be used. The SIACC justifies the threat by pointing out that the desired effect was reached; the inmate stopped rocking the restraint chair. The Ombudsman has concerns with this argument, both for its premise and its acceptance of “shocking” the inmate with a potential mental illness into compliance.

The Ombudsman believes it is relevant that T.F. was in the restraint chair for over nine hours when the correctional officer threatened to use a Taser device on her. Until this point, she was highly agitated. If the Ombudsman were to entertain the idea that the threat of using a Taser device on inmates was an acceptable response - even where the actual use of a Taser device would not be justified - the Ombudsman questions why the jail waited over nine hours to employ this technique.

The Ombudsman stands by his recommendation that the jail consider non-aggressive alternatives before escalating to force against inmates. The primary concern of the jail should have been the inmate’s potential harm to herself by trying to tip over the chair. The readily available, less aggressive alternative offered by the chair’s manufacturer would have been to back the chair into the corner of the room to mitigate any tipping hazard.

When to Use

The SIACC takes the bold stance that a restraint chair can and should be used when inmates make verbal threats against jail staff. While the report did not criticize Appanoose County Jail for the basis of its restraint chair use, the jail’s reply provides an opportunity for the Ombudsman to reiterate its caution against such use.

The restraint chair must only be used when an inmate is a threat to self or others or jeopardizes jail security. The Ombudsman believes that verbal abuse by itself, even when the inmate has a history of violence, is insufficient reason to place an inmate in a restraint chair. However, if an inmate displays signs of imminent violence and the circumstance provides the inmate an opportunity to exact violence on others, the Ombudsman could see a justification for restraint device use.

The SIACC should consider non-aggressive alternatives like placing an inmate in a cell by himself to cool off, or avoiding contact between staff and an inmate during periods of inmate aggression. Both of those responses would avoid harm to staff and use of a restraint device. In the event a restraint device is necessary, staff should be able to articulate and document why the restraint device was required, and why less restrictive alternatives were not available.

The SIACC argues that proactively placing an inmate in restraints before an inmate acts out is an appropriate response, and the reactive response of waiting for an inmate to act out leads to litigation. The Ombudsman disagrees. Litigation can arise, and has arisen, when a jail places inmates in restraint devices based only on verbal threats.

Videotaping

The SIACC asserts that the jail's use of video comports with Iowa's jail standards. It argues against the recommendation that jails retain restraint chair use videos for two years, stating there could be a potential storage problem and added operating expense. The SIACC also states that retention would be impractical due to the "high number of incidents" that occur in county jails.

The SIACC did not identify what jail would be faced with a storage problem when rejecting the Ombudsman's recommendation. Unless specific storage problems are identified after an attempt to retain the recordings, the Ombudsman stands by its recommendation.

It is the Ombudsman's impression that restraint devices are rarely used by smaller counties like those the SIACC represents. It is not known how often Appanoose County Jail uses the restraint chair each year, but it told the Ombudsman that T.F. was the only inmate it used the restraint chair on for more than two hours. Jefferson County estimated that it uses its restraint chair less than five times a year. Muscatine County told the Ombudsman it used their restraint chair two to three times a year.

The highest number of restraint chair incidents the Ombudsman knows of came from Polk County with 193 incidents in 2007. The Polk County Jail incorporated language in its written policy to retain recordings for a minimum of two years in response to our report. The Ombudsman stands by his recommendation that jails retain video copies of all restraint device incidents for a minimum of two years.

Conclusion

The Ombudsman believes the SIACC has taken this opportunity to defend controversial positions on the treatment of jail inmates and the use of restraint devices based on budget restrictions and lack of mental health resources. It has offered no ideas on alternative responses to inmate mental illness or inmate aggression that are less restrictive.

It has even taken steps to weaken its own policy and place inmates at further risk of serious injury. Prior to the Ombudsman's investigation, the Appanoose County Jail went beyond the requirements of Iowa law in its jail policy by requiring direct medical supervision of inmates restrained for longer than two hours. This was consistent with the manufacturer's recommendations on restraint chair use. As a result of the Ombudsman's investigation, the SIACC reply stated:

The policy in effect did provide for direct medical supervision. The Crime Commission is recommending that this policy be changed since the Iowa Jail Standards do not require direct medical supervision by a medical provider or limit the hours needed for restraint.

The Ombudsman urges the Appanoose County Jail resist SIACC's advice to ignore the manufacturer's recommendation aimed at averting risk of harm to inmates.

Wapello County Jail

The SIACC also replied on behalf of Wapello County Jail. The Ombudsman appreciates the following steps Wapello County Jail has taken to address some of the concerns raised in this report, including:

- Utilizing two officers to secure an inmate in a restraint chair.
- Use of streaming video (change made after initiation of investigation and before issuance of report).
- Placement of chair to ensure 24/7 observation and proper lighting.
- Preservation of 15-minute check documentation.

The SIACC identified the officer's striking of an inmate as the real issue. The jail claims that the officer who struck the restrained inmate "reacted instinctively and defensively." The Ombudsman believes the real issue lies with the procedures taken to place the inmate in the restraint chair. Nevertheless, it appears the additional training includes the use of two correctional officers to secure an inmate in a restraint chair, which should help minimize the chances of an inmate causing harm to a correctional officer during placement.