

REPORT OF

A REVIEW OF THE MENTAL HEALTH TREATMENT, RESTRAINT AND DEATH OF WILLIAM JAMES OWENS IN THE OREGON CORRECTIONAL SYSTEM

OREGON ADVOCACY CENTER

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I. INTRODUCTION

This report presents Oregon Advocacy Center's (OAC's) review of the April 29, 2002 death of William James Owens, a former Snake River Correctional Institute (SRCI) resident. Mr. Owens was a forty-five year-old man with multiple disabilities, including a long history of serious mental illness. He died on his seventieth day in disciplinary segregation. The determination was made that Mr. Owens was not breathing after he had been extracted from his cell, which included being subjected to chemical and physical restraint.

OAC is an independent, private, nonprofit agency that protects and advocates for the rights of persons with disabilities. Under federal and state law, OAC has the authority to investigate incidents of abuse and neglect of persons with mental disabilities. Protection and Advocacy for Individuals with Mental Illness Act of 1991 (PAIMI Act), 42 U.S.C. section 10801 *et seq.*; ORS 179.505(16) and 192.517.

OAC's inquiry into Mr. Owens' death included:

- § Reviewing Mr. Owens' medical records, including mental health records from SRCI.
- § Reviewing a videotape taken of the incidents surrounding Mr. Owens' death.
- § Reviewing Mr. Owens' mental health records from Oregon State Penitentiary.
- § Reviewing Mr. Owens' mental health records from Oregon State Hospital.
- § Reviewing Department of Corrections' Administrative Rules regarding seclusion and restraint, mental health treatment and other applicable inmate care policies, procedures and directives.

- § Reviewing SRCI's internal policies regarding seclusion and restraint, mental health treatment, Emergency Abatement form records and other applicable inmate care policies, procedures and directives.
- § Reviewing the Oregon State Medical Examiner's autopsy and related documentary evidence.
- § Reviewing Department of Correction's documents related to its internal investigations of Mr. Owens' death.
- § Reviewing staff of SRCI's complaint to the Occupational Health and Safety Administration related to the events surrounding to Mr. Owens' death.
- § Reviewing Oregon State Police's investigative report.
- § Review of telephone conversations with two of Mr. Owens' siblings and of correspondence from a third sibling.
- § Reviewing documents, including correspondence from inmates, provided by the Oregon Judicial Watch¹ organization.

II. EXECUTIVE SUMMARY

On April 29, 2002, William James Owens died at Snake River Correctional Institute (SRCI). SRCI is one of twelve prisons in the state of Oregon run by the Department of Corrections (DOC). Mr. Owens had an extensive history of serious mental health problems.

Mr. Owens died at forty-five years of age and had been incarcerated for over a dozen years. He spent a significant amount of time in the prison's Special Management Unit (SMU) as well at the DOC ward at the Oregon State Hospital due to his serious mental illness.

Throughout his incarceration, Mr. Owens was plagued with paranoid thoughts that his family was being tortured or was dead. His delusional thoughts included auditory hallucinations where he heard his family members screaming and crying. Mr. Owens "acted out" behaviorally in response to being tormented by his paranoid delusional thinking. Although his "acting out" behavior was a direct result of his serious mental illness, Mr. Owens was sanctioned to disciplinary segregation which clearly exacerbated his symptoms.

Mr. Owens died on his seventieth day in disciplinary segregation having completed just less than one-half of his one hundred forty-five (145) day sanction. He died after being extracted from his cell and restrained, both chemically and physically. Prior to being restrained, Mr. Owens was observed in

¹ The Oregon Judicial Watch brought concerns regarding the circumstances surrounding Mr. Owens' death to OAC's attention.

his solitary cell poking himself in the neck with a broken pen. He appeared agitated and out of touch with reality.

During the events leading to his death, Mr. Owens was sprayed with pepper mace three times, restrained with a shield by five fully suited guards, restrained by both his wrists and legs, forcibly removed from his cell, forced to walk, held facing a wall, shoved and held in a wrist restraint against the wall, taken down to the floor and restrained in a prone position. He then stopped breathing and was not revived.

The final autopsy report states the probable cause of Mr. Owens' death as: "Restraint syndrome with preterminal positional asphyxiation" and/ or "restraint asphyxiation in excited delirium". The manner of death is stated to be an accident. Chronic schizophrenia was specified in the autopsy report as another significant condition contributing to Mr. Owens' death.

The Oregon State Police and the Department of Corrections investigated Mr. Owens' death and reviewed a videotape of Mr. Owens' last minutes of life. A resulting DOC internal investigation report raises important concerns about the incident including whether appropriate force and medical emergency procedures were used.

OAC reviewed the facts and circumstances surrounding Mr. Owens' death to determine what occurred and if policies or practices could be improved that would prevent this sort of tragedy from occurring in the future. We identify deficiencies and recommend changes that would, we believe, promote more therapeutic treatment and care of DOC's residents who have serious mental illness. OAC also identifies deficiencies and corrective actions that, in our judgment, can more effectively protect DOC's residents from inappropriate use of physical and chemical restraints.

OAC recommends that Oregon lawmakers follow states that have taken positive steps toward reform in this area, including Vermont's policy of stringently screening persons with serious mental illness when considering any disciplinary segregation sanction, and Pennsylvania's policy of reducing the use of seclusion and restraint and philosophically viewing its use as a treatment failure rather than treatment.

FINDINGS AND CONCLUSIONS

A. Inadequate mental health treatment and care at SRCI.

Mr. Owens had a long history of serious mental illness. While incarcerated, he periodically exhibited psychotic symptoms including delusional thinking and, as a result, spent substantial amounts of time in the prison Special Management Unit as well as in the Oregon State Hospital. He was also sanctioned to disciplinary

segregation for behaviors that appear to be a direct result of his mental illness. Punishing psychotic behavior with segregation is inhumane, unjust, and ineffective.

On the day of his death, Mr. Owens was serving his seventieth consecutive day in disciplinary segregation. He had refused to take medications, kicked his cell door and stabbed himself with a pen. In response to these actions, staff did not make a timely referral and assessment of his mental health condition but, instead, extracted Mr. Owens from his cell and subjected him to chemical and physical restraint. Because symptoms of serious mental illness may be exacerbated by experiencing disciplinary segregation, alternatives to segregation should be considered for inmates with mental illness. If no alternative to disciplinary segregation exists, then the sanction should be limited to a maximum of fifteen days and mental health care should be carefully monitored.

B. Failure to avoid using a prone restraint/ containment technique in a psychiatric/ medical emergency circumstance.

Immediately prior to his death, Mr. Owens was alone in a cell, stabbing himself in the neck with a pen in a state of excited delirium. This was a psychiatric/ medical emergency. Instead of treating the situation as such, Mr. Owens was blasted with pepper spray three times and taken to the ground into a prone position. After being removed from the cell, Mr. Owens was again taken to the ground by five staff and held in a prone position. Close in time to this second “take down”, Mr. Owens was found to not be breathing. The autopsy report states his cause of death as schizophrenia with probable excited delirium and terminal restraint asphyxia. The circumstances surrounding Mr. Owens’ death have common elements of the prone restraint syndrome, including: pressure on the upper torso, handcuffing, leg restraint, acute psychosis and agitation, physical exertion and struggle and obesity. The use of prone restraint is dangerous and should be avoided particularly when a person is exhibiting psychotic or delirious behavior.

C. Inadequate care and monitoring during the use of chemical and physical restraints.

Mr. Owens died from restraint asphyxiation after being extracted from his cell, and chemically and physically restrained. He appeared “out of it” and agitated when staff applied three blasts of pepper spray. No independent assessment appeared to be made of Mr. Owens’ wellbeing after any of these blasts. Shortly after being removed from his cell and taken to the ground for a second time, he was found to not be breathing. Following this discovery, significant amounts of time passed before Mr. Owens was removed from restraints, a mask was made available, a first rescue breath was administered, and an ambulance was called. Nobody appeared to be in charge of this emergency situation.

RECOMMENDATIONS

A. Improving mental health treatment and care for residents at DOC facilities.

It is inhumane and counterproductive for a prison to punish an inmate for behavior that is symptomatic of serious mental illness. Clinically appropriate mental health treatment should, instead, be offered. All DOC staff should receive comprehensive training in identifying symptoms of emotional and mental disorders. Oregon should adopt more stringent and specific policies restricting the use of disciplinary segregation for persons with serious mental illness using Vermont's policy as a starting point. The new policies should require thorough evaluation of contraindications to disciplinary segregation; due process procedures; evaluation of the relationship between an inmate's behavior and mental illness; consideration of all alternatives to disciplinary segregation; a cap of fifteen days of disciplinary segregation; provision of appropriate mental health treatment to inmates in disciplinary segregation.

B. Avoiding prone restraint/ prone containment of inmates.

DOC rules should be changed to prohibit prone restraint. Prone containment should also be prohibited except as a last resort. There is increasing evidence that the use of prone restraint can be lethal. DOC staff training should include recognition of the hazards of prone restraint and factors that put potential restrained individuals at greater risk of death. DOC should follow Pennsylvania's comprehensive reforms which recognize that use of seclusion and restraint is not an effective treatment intervention but indicative of a treatment failure. If prone restraint is used, rules should require that the inmate's well being be carefully monitored.

C. Improving seclusion and restraint care and monitoring practices.

Because chemical and physical restraints are intrusive and potentially dangerous, their use requires close monitoring and supervision to reduce risks. DOC should adopt policies that aim to reduce or eliminate the use of restraints on inmates with serious mental illness. DOC policy should, at least, restrict the use of chemical and physical restraint on persons with serious mental illness to circumstances in which other less invasive measures have been considered or there is no alternative. Soft restraints and padded rooms should be used to help reduce pain which can increase an inmate's agitation and frustration. Disciplinary and medical staff should be trained in emergency techniques, such as cardiopulmonary resuscitation (CPR), to ensure that the inmate receives the most effective teamwork and best practices for care.

III. CIRCUMSTANCES SURROUNDING THE DEATH OF WILLIAM JAMES OWENS

- A. Background**
- B. History of Mental Health Treatment in Corrections**
- C. History of Seclusion and Restraint in Corrections**
- D. Mr. Owens' death**

A. Background

In order for you to understand the circumstances of William James Owens' death, it is important that you know about his background. William was born on March 30, 1957 in Oakland, California. He was the fifth oldest in a family with eleven children. He had six sisters and four brothers, including an identical twin. When William was approximately six years old, his parents were separated after his mother had a "nervous breakdown".²

William then went to live with his aunt and uncle where he was the victim of serious physical abuse.³ He began having nightmares about his father abusing him when he was six years old. These persisted throughout his adulthood. After years of abuse, William was placed in a foster home. He did not reveal this childhood abuse until he was incarcerated even though he first saw a mental health professional at age seven while he was in foster care.

William attended school through the 10th grade⁴, although he dropped out for a period of time after eighth grade. In his early teenage years, he began using drugs⁵. As an adult, Mr. Owens tested⁶ in the borderline range of intellectual functioning and was also described as having low-average intelligence.⁷ Brain damage was also suspected.

During his early twenties, Mr. Owens had court-ordered substance abuse treatment, mental health treatment and experienced a head trauma. The head injury was the result of his being hit on the head with a baseball bat and caused him to have difficulty hearing with his right ear.

² William's mother was institutionalized for approximately three years. While in foster care, William was lead to believe that his mother was dead. His relationship with his mother was rekindled after finding out that she was still alive. Mr. Owens was depressed after learning that his mother had died while he was in custody in April of 1989.

³ This abuse included being tortured with electricity, bull whipped and hit with a 2 x 4. Additionally, Mr. Owens and other siblings were witness to a sister's rape.

⁴ At different points in the records, it states that Mr. Owens went to school through 8th, 9th or 11th grade.

⁵ Drugs of choice were IV methamphetamines, heroin and crack cocaine as well as alcohol.

⁶ Mr. Owens took the Wechsler Adult Intelligence scale evaluation while at OSH in 1992.

⁷ Stated in a Mental Health Evaluation dated May 22, 1991, quoting Dr. Grulert's statement after a mental health-screening interview of Mr. Owens.

As a young adult, Mr. Owens was employed on a fairly regular basis, usually working as a carpenter and doing other odd jobs such as roofing. He attended vocational training in carpentry. In his leisure time, Mr. Owens enjoyed playing sports, in particular baseball and football. He also enjoyed gardening, fishing, swimming and hunting.

Mr. Owens had a girlfriend for fifteen to twenty years, who was the mother of his two daughters⁸. They separated at some point prior to or during his period of incarceration.

In 1987, Mr. Owens was charged with two counts of attempted murder. While in jail awaiting trial, he attempted suicide by cutting his right wrist on glass. Mr. Owens stated that he was having paranoid delusions and hearing voices at that time. Subsequently, he was sent to Oregon State Hospital (OSH) for approximately six months because the court determined that he was mentally unfit to proceed on the criminal charges.

Mr. Owens was eventually convicted of attempted murder in 1988 and was sentenced to twenty years in prison. His grandmother and his brother were the victims of his crime. He described his relationship with these family members as being very close and his criminal behavior as the result of “bad drugs” (amphetamines). He evidently believed that some evil intruder inhabited his grandmother’s body and that he had to free his grandmother by killing the evil intruder. His brother had intervened to protect their grandmother. Members of Mr. Owens’ family corroborated that he appeared to be hallucinating at and around the time of the crime.

Mr. Owens began his prison time at Oregon State Penitentiary (OSP) in 1988. During his time at OSP, he was transferred to the Oregon State Hospital (OSH) on four separate occasions. He was described as obese or overweight throughout his period of incarceration. At the time of his death, he weighed 270 pounds and was 5’ 8” tall.⁹ His breathing was noisy and he needed to expend much effort even for small movements.¹⁰

In 1992, Mr. Owens was paroled to live in Grants Pass with a family member¹¹ and to be given mental health treatment and services by Josephine County

⁸ On September 18, 1995, Mr. Owens stated that his daughters were ten and seventeen years old.

⁹ The Autopsy report stated that Mr. Owens was “moderately obese” and listed these measurements in its gross autopsy findings, external examination section.

¹⁰ In a 1992 OSH neuropsychological screening, the behavioral observation was made that, “[Mr. Owens’] breathing is noisy and gives an impression of effort even for small movements such as drawing pictures”.

¹¹ In some records, the family member is stated to be Mr. Owens’ sister; in others it is stated to be his twin brother.

Mental Health. While on parole, he had surgery to replace a disk in his back¹² and was in an automobile accident in which he broke three ribs, hurt his knee, broke some teeth and exacerbated his back injury.

In 1994, Mr. Owens was returned to prison due to a parole violation. He violated parole by using alcohol and methamphetamines. He spent more time in OSP as well as at OSH, participated in the Challenge of Prison Experience (COPE) program at the Eastern Oregon Correctional Institute, and was incarcerated in Oregon State Correctional Institute as well as in Snake River Correctional Institute (SRCI). He died during a use of force incident while at SRCI, as described more fully below.

B. History of Mental Health Treatment in Corrections

Throughout his incarceration, Mr. Owens had a re-occurring psychosis wherein he believed that his family was being tortured, was being killed or was dead. He experienced visual and auditory hallucinations along with paranoid delusional thinking. Mr. Owens heard screaming and crying that he believed to be from his family members. His thoughts raced. He experienced agitation, restlessness and sleeplessness. He became internally pre-occupied, had extended lapses in his speech and appeared confused and disheveled. He had a flat affect, decreased energy and appeared depressed. While psychotic, he sometimes refused meals, medications and showers.¹³

When actively psychotic, Mr. Owens became convinced that there was a conspiracy/ plot against his family and loved ones. He was considered to have exceedingly dangerous paranoid delusions.¹⁴ He believed that staff or other inmates were part of a conspiracy or plot against his family. He heard the television, inmates and staff talking about plans to harm or torture his family. He became angry and anxious. He confronted and accused other inmates of harming his family. He acted out in dramatic ways in an attempt to deflect the perceived threat away from his family and onto himself. He, for example, requested that staff kill him to assure his family's safety. He reportedly told his family members that "they better load their guns."¹⁵ Clearly, Mr. Owens experienced extreme personal torment.

Mr. Owens acknowledged that he "acted out" when he was psychotic and agreed to take various medications to help him with these symptoms.¹⁶ At times he took unusually high doses of anti-psychotic medications such as Haldol and at times

¹² In March 1992, Mr. Owens had an incident with Security Guards that caused Mr. Owens to strain his back. The records do not provide further detail regarding the nature of this incident.

¹³ Mental health records from OSP, SRCI and OSH.

¹⁴ Dr. Dale Mortimer provided this description in an "Interoffice Memo" dated March 11, 1992.

¹⁵ Mental health records from OSP, SRCI and OSH.

¹⁶ For example, on October 10, 2000, Mr. Owens signed an informed consent form to take Seroquel for "voices", on January 16, 2001, Mr. Owens signed informed consent form for Paxil for "depression".

took no medication. There are notations throughout his medical records that he agreed to take his medication that was offered to him.

When he was actively mentally ill, Mr. Owens tended to refuse to take showers, to eat and/ or to take his medications. On the day Mr. Owens died, he did not take a shower and had not taken his medication for three days. This included his prescription for high dosages of psychotropic medication¹⁷ as well as for his blood pressure medication.

The Special Management Unit (SMU) is a cell block in OSP that provides enhanced mental health care to inmates. Mr. Owens had at least thirteen admissions¹⁸ to SMU during his incarceration. He was in prison only four or five days when he was first admitted. Mr. Owens' last stay at the SMU was for close to one year, from September 26, 2000 until August 13, 2001. This stay was interrupted by two stays at the Disciplinary Segregation Unit (DSU) for acting out behaviors.¹⁹ He also spent over eighteen months on transfer to Oregon State Hospital for treatment of delusional, paranoid thinking, potential for violence against others, potential for self-directed violence, social isolation and other mental health symptom management.

Mr. Owens participated in the Challenge of Prison Experience (COPE) program at Eastern Oregon Correction Institution from approximately September of 1998 until April of 1999. This program provides day treatment services to inmates who are struggling to function in the general prison population, but who do not need the intensive treatment level provided at the SMU. Mr. Owens stated that the goal he wanted to accomplish through the COPE program was, "Get my head together better so I can understand if voices are real or not."²⁰

When Mr. Owens entered the corrections system, he was given an Axis I diagnosis of "Multiple substance dependent". Over the next few years, psychotic depressive reaction and paranoia were added diagnoses.²¹ By 1991, he was diagnosed with chronic schizophrenia. From 1994 to 1999 he was diagnosed as

¹⁷ See DOC internal investigation memorandum from, Dr. Steve Shelton who was the Health Services Medical director for the DOC, to Stoune John L dated May 24, 2002. Dr. Shelton states, "I reviewed [Mr. Owens'] medical record. He was on very high dose[s] of MH [sic/ mental health] meds [sic/ medications]."

¹⁸ It is unclear from the records whether Mr. Owens was in the SMU thirteen times during the course of his second period of incarceration, beginning in 1994 or thirteen times total.

¹⁹ J. Todd Foster, of *The Oregonian* staff stated: "General population provides the most freedoms and privileges; the special management unit is the equivalent of a mental hospital; disciplinary segregation is the jail." J. Todd Foster, "State Prison Back On Track A Year After Abuse Scandal", *The Oregonian* (July 7, 1998).

²⁰ As quoted on page 2 of the Initial Assessment for the COPE program, dated September 23, 1997.

²¹ Dr. Wesley Weissert was Mr. Owens' medical doctor and recorded these diagnoses in progress notes.

having bipolar disorder.²² From 2000 until the time of his death, he was given the diagnosis of schizoaffective disorder as well as antisocial personality disorder.

Mr. Owens had several incidents of self-harm and attempted suicide. In addition to the suicide attempt while awaiting trial, he attempted to hang himself with coveralls and sheets while in disciplinary segregation at OSP in 1994, and was found lying face down in his cell with smears of blood on the wall and floor near his head three months prior to his death.

C. History of Seclusion and Restraint in Corrections

Mr. Owens spent time in the Disciplinary Segregation Unit (DSU) for his “acting out” behavior, as described below.

In 1989, Mr. Owens was transferred from SMU to DSU for nine months as punishment for an assault on staff. This incident was close in time to his learning that his mother had died. The prison psychiatrist, Dr. Weissert, stated that the issue of whether Mr. Owens should be held responsible for his aggressive behavior or whether he was totally psychotic during the incident would be addressed only when Mr. Owens became suitable for release from SMU.²³

Mr. Owens was in DSU for approximately one week in 1996 because a razor blade²⁴ was found in the cell that he shared with his brother.²⁵ In 2000, he was sent to DSU for getting into an altercation with his cellmate while in the General Population. At that time, he had a flat affect, sad mood, and poor eye contact. He was transferred to SMU where he broke some windows by throwing a table resulting in his return to DSU. He also went to DSU for nine days in January 2001 for attacking his cellmate.

D. Mr. Owens' death

On February 18, 2002, Mr. Owens began his final sanction to disciplinary segregation: a term of one hundred forty-five days. This long-term sanction (any sentence longer than thirty days constitutes long-term status.²⁶) resulted from an

²² Other Axis I diagnoses during this time frame were “Rule out schizoaffective disorder”; Schizophrenia, paranoid type, polysubstance abuse by history.

²³ I did not find any evaluation, determination or other information in the records regarding whether or not Mr. Owens should be held responsible for this assault on staff.

²⁴ Mr. Owens was upset about this incident because he stated that it was not his razor blade.

²⁵ Mr. Owens and his brother were cellmates for a period of time, until Mr. Owens' brother was released. Mr. Owens' brother evidently would assist Mr. Owens by questioning the factual basis of his paranoid delusional thoughts.

²⁶ According to OAR 291-011-0010 (6), any sanction and confinement in disciplinary segregation for 30 or more consecutive days is deemed long-term. N.B., The records received by OAC did not disclose the purpose for Mr. Owens' stay at DSU nor did they indicate the results of the assessments, which are required each 30 days by OAR 291-011-0030(3).

altercation with his cellmate. Mr. Owens stated that he got into this altercation because he was hearing voices.

On the day before his death, Mr. Owens was found at 7:33 p.m. punching his cell window with his fist such that his knuckles were bloodied. He refused medical attention. He reportedly kicked his cell door throughout that evening. SRCI staff did not immediately remove him from disciplinary segregation and thoroughly assess his mental health status.

The next morning, at 9:15 a.m., he stated "O.K." in response to staff telling him that they were going to take him to the shower. A staff person asked Mr. Owens to put on his shower shoes for escort. He reportedly glared at the officers, put on his shower shoes and walked to the cell door. When he reportedly continued to glare at staff, a staff person asked him if he was going to cause any trouble during the escort. Mr. Owens nodded his head, signifying yes. Staff then informed him that he was being refused a shower because he affirmed that he planned to cause a problem for staff. Mr. Owens sat down on his bunk.

He refused food later that morning. At 11:00 a.m., when lunch was being served, he was asked if he was going to eat and he shook his head in a manner that was taken to mean, "No".

At 1:10 p.m. (more than seventeen hours after Mr. Owens was found punching his cell window, approximately four hours after he had been denied a shower, and more than two hours after he had refused to eat) two escort officers arrived at his cell with the intent to move him to close supervision status²⁷. Mr. Owens was found in his cell lying face down on the floor with his hands beneath him. Blood smears were observed on the wall and floor of his cell.

Mr. Owens did not respond to the officers' orders to show his hands although some movement was noted. His glasses, which were broken, were observed near his head. An officer verbally commanded Mr. Owens to show his hands. He did not respond. The officer noted that he was breathing. An extraction team was therefore organized to subdue Mr. Owens and to remove him from his cell.²⁸

The Shift Lieutenant and the Nurse attempted to get a response from Mr. Owens by calling out his name and knocking on the cell door. He was not immediately responsive but then he stood up. Blood was observed on his face and forehead. What appeared to be a broken pen was observed in his right hand. He began to stab himself in the right side of his neck with the pen. The shift Lieutenant had

²⁷ According to OAR 291-011-0010 (1), close supervision status is the "Placement of an inmate so that he/she is more restricted than other inmates in disciplinary segregation status. This status is designated for inmates whose actions disrupt the safe and orderly operation of disciplinary segregation."

²⁸ This information is pieced together from viewing the videotape as well as from reading the critical incident reports from the participating SRCI staff persons.

OC Spray or pepper spray brought to the cell. The specific chemical agent brought was "Freeze Plus P". The shift Lieutenant requested that Mr. Owens stop stabbing himself, drop the weapon and back up to be restrained. He did not follow these instructions and continued to stab himself in the neck. Mr. Owens was then sprayed with pepper spray for approximately four seconds.²⁹ Afterwards, he stopped stabbing himself and sat on his bunk.

An extraction team then assembled outside the cell. The team consisted of five men who were in full SWAT gear, including helmets, face shields, respirators, latex gloves, and boots.³⁰ Mr. Owens again began stabbing himself in the right side of his neck with a broken pen. He appeared to be out of touch with reality. The response team leader sprayed Mr. Owens with a second dose of pepper spray for approximately four seconds. He stopped stabbing himself with the broken pen briefly, but then recommenced. At this point, Mr. Owens was sprayed with pepper spray for a third time for approximately two seconds.

The pepper spray was clearly potent. A nurse who later attempted to treat Mr. Owens and was not in or near the cell had to be relieved, evidently due to second-hand inhalation of pepper spray.³¹ Likewise, a SRCI officer was affected by the spray and had to step outside to breathe more freely.

After being sprayed, Mr. Owens was physically restrained. The extraction team rushed into his cell and took him down to the floor. The five staff struck him with the shield and pushed him to the far wall and floor of the cell, trapping him with the shield. The team member who evidently forced Mr. Owens to drop the pen appears to have used his foot or knee to strike Mr. Owens approximately six times. Mr. Owens was held in a prone position on the ground when SRCI staff restrained him in wrist and leg cuffs.³² The videotape showed that he coughed at this point.

He was then forced to stand up and was ordered "to walk out on [his] own power".³³ He walked to the intake portion of the DSU with guards holding his

²⁹ Chemical agents may be used to prevent death, serious injury, or substantial destruction of property and to effect cell extractions or involuntary forced moves of inmates. OAR 291-013-0030(1).

³⁰ At this point, the video camera began recording this incident. This information is included in the OR-Occupational Health and Safety Association's follow up to the SRCI staff's complaint filed by its union representatives. The extraction of Mr. Owens from his cell was a planned use of force, which is defined by DOC rules as "the use of force in situations where time and circumstances allow for consultation with, and approval by, higher ranking employees, and where there is some opportunity to plan the actual use of force." OAR 291-013-0010(12).

³¹ Documents attached to the OR-OSHA report note that the first nurse to the scene was overcome by and coughing due to the pepper spray.

³² Security restraints are defined as handcuffs, temporary cuffs, leg irons and other similar equipment designed to restrict and control a person's movement from injuring himself, others, and escape. OAR 291-013-0010(17).

³³ Physical force, under DOC rules, is defined as including the use of hands, other parts of the body, chemical devices or other physical methods used to restrain, subdue, control, intimidate or

arms and applying what SRCI staff described as painful pressure to force him to walk. He was ordered by staff to not lean back. His breathing appeared to be labored while he was walking.

Throughout this incident, guards shouted commands at him such as “stop resisting”. The guards did not specify how Mr. Owens was resisting. There were essentially no attempts to engage him in any dialogue. Mr. Owens seemed “out of it”, his movements were slow and unsteady and he seemed disoriented and frenzied. He never spoke nor acknowledged staff directives.

In the DSU intake area, staff considered Mr. Owens to be resisting. He was put into a wrist restraint mechanism attached to the wall and guards were holding him on either side. A staff person ordered Mr. Owens with a sharp, mean tone to face the wall. His face appeared bloody at this time. His forehead was forcefully shoved against the cinder block wall for no apparent reason.

He was taken down to the ground by the five guards. Staff directed Mr. Owens to settle down to stop resisting, to cool down, to think, and to follow staff directives at this point. While on the ground, he began spitting up blood.

A nurse later stated that when she arrived at the DSU intake room, Mr. Owens was face down (i.e., in a prone position) on the floor with his hands handcuffed behind his back with several officers kneeling around him. At this time, a SRCI staff person stated that Mr. Owens was not breathing.

Staff moved him onto his side and removed him from the wall restraint prior to moving him to the center of the room. He was positioned on his back. Staff inquired about a CPR mask.

From the moment Mr. Owens was found not to be breathing:

- § Approximately two minutes passed before staff, with a nurse present, removed Mr. Owens from the wrist restraints that bound his hands behind his back.
- § Over four minutes passed before CPR was commenced: the first “rescue breath” was given after over four minutes of delay and the first chest compression was administered after an additional one-half minute delay.
- § Over four minutes passed before an ambulance was contacted.
- § Nearly twenty minutes passed before an ambulance arrived.

to compel persons to act in a particular way, or to stop acting in a particular way. OAR 291-013-0010(11). DOC staff is required to use reasonable force—to use physical force to achieve a legitimate correctional objective, where the type and amount of force are consistent with the situation and the objective to be achieved; and alternatives to physical force are unavailable or ineffective; and where the force used is the minimum necessary to control the situation. OAR 291-013-0010(14).

SRCI staff were not able to revive Mr. Owens and he was pronounced dead.

During the revival efforts, there were many security and medical staff present but no-one appeared to be in charge of the situation. No-one instructed staff to immediately begin CPR. There appeared to be hesitancy to begin CPR, which began only after discussion and locating of a mask. In addition, SRCI staff engaged in totally unrelated and inappropriate conversation and behavior. As Mr. Owens lie dying, SRCI staff members engaged in laughter, unrelated conversation, a kiss, and other unrelated banter.

IV. FOLLOW-UP INVESTIGATIONS OF DEATH

- A. Autopsy by Oregon Medical Examiner**
- B. Oregon State Police Report**
- C. Department of Corrections' Internal Investigation**

A. Autopsy by Oregon Medical Examiner

On April 31, 2002, Dr. David Brauer with the Oregon State Medical Examiner's Office stated that the results of the autopsy were inconclusive and that he would seek further information from other medical professionals.³⁴

In the Oregon State Medical Examiner Report dated May 3, 2002, Dr. Brauer states as cause of death: "Restraint syndrome with preterminal positional asphyxia."³⁵ Another significant condition was chronic schizophrenia."

The autopsy relates the circumstances of Mr. Owens' death as follows:

"Schizophrenic individual died in jail³⁶ following a struggle and restraint by officers. He had not taken his medication³⁷ in about three days, was acting bizarrely and stabbing himself in the neck

³⁴ N.B., SRCI's Emergency Abatement forms, under section I (b), describe the nature of emergency as "Inmate Suicide/ Death". Similarly, on the form entitled "Emergency Plan Criminal Evidence Handling", "Suicide" is initialed as occurring at 2:00 with the weapon sued being stated as "Pen/ Glasses".

³⁵ Positional asphyxia occurs when the body position interferes with respiration, resulting in asphyxia. Granfield, Onnen and Petty, "Pepper Spray and In-Custody Deaths", *International Association of Chiefs of Police*, March 1994 citing Reay, D.T., C.L. Fligner, A.D. Stilwell and J. Arnold, "Positional Asphyxia During Law Enforcement Transport," *The American Journal of Forensic Medicine and Pathology* 1992; 13(2): 90-97.

³⁶ Actually, Mr. Owens did not die in jail but rather in prison.

³⁷ Mr. Owens' medications included Zyprexa 20 mg b.i.d., Lorazepam, Amitriptyline, Trazodone, Zantac and Inderal according to the Autopsy.

with a BIC pen. He died suddenly while handcuffed and leg cuffed in a face-down position following restraint.”

The pathologist, Dr. Evelina G. Amparo, stated that one of the final anatomic diagnoses was: “Schizophrenia with probable excited delirium and terminal restraint asphyxia”.³⁸ Mr. Owens was stated to have history of hypertension. No gross, microscopic or toxicological findings accounted for Mr. Owens’ death.³⁹

Although the death was deemed to be an accident, the autopsy report commented on the mechanism of death in cases of restraint asphyxiation in excited delirium:

O’Halloran and Lewman⁴⁰ conclude that the mechanism of death appears to be a sudden fatal cardiac dysrhythmia or respiratory arrest induced by at least three factors relating to increased oxygen demand and decreased oxygen delivery. First, the psychiatric or drug-induced state of agitated delirium in conjunction with police confrontation places catecholamine stress on the heart. Second, the hyperactivity associated with the state of agitated delirium coupled with struggling against police and restraints increases the oxygen delivery demands on the heart and lungs. Finally, the hog-tied position impairs breathing in situations of high oxygen demand by inhibiting chest wall and diaphragmatic movement. The subjects in these cases suffer a category of positional asphyxiation.

The autopsy report cites this article by O’Halloran and Lewman⁴¹ as well as an article by O’Halloran and Frank⁴² regarding asphyxial death during prone restraint.

B. Oregon State Police Report

The Oregon State Police (OSP) report determined that Mr. Owens’ death was an accident, with the cause being Restraint Syndrome. Mr. Eric Newman, the reporting officer for the OSP, arrived at SRCI approximately two and one-half

³⁸ This final anatomic diagnosis was included in the autopsy report dated September 6, 2002 and was not included as final anatomic diagnoses in the autopsy report dated May 2, 2002.

³⁹The internal examination of the gross autopsy findings determined that Mr. Owens’ 7th and 8th ribs were fractured along the anterolateral region with only a small amount of associated hemorrhage. Additionally, the microscopic examination found sections of the foci of hemorrhage in the lungs revealed acute interstitial and intraalveolar hemorrhage associated with focal edema. There was no discussion as to whether these findings resulted from Mr. Owens being restrained.

⁴⁰ The autopsy report cites to O’Halloran RL and Lewman LV, “Restraint Asphyxiation in Excited Delirium”; *American Journal of Forensic Medicine and Pathology* 1993; 14: 289-295.

⁴¹ O’Halloran RL and Lewman LV, “Restraint Asphyxiation in Excited Delirium”; *American Journal of Forensic Medicine and Pathology* 1993; 14: 289-295

⁴² O’Halloran RL and Frank JG, “Asphyxial Death During Prone Restraint Revisited, A Report of 21 Cases”, *American Journal of Forensic Medicine and Pathology* 2000; 21: 39-52.

hours after the stated time of Mr. Owens' death. At that time, medical equipment and supplies were still in the area and attached to the body.

The OSP report details the events shown on SRCI's videotape as follows: Mr. Owens was in his cell injuring himself with a broken piece of ink pen; after staff commanded him to stop several times, an entry team entered his cell, restrained and removed him; Mr. Owens was able to walk under his power to the intake area; he continued to resist staff at the intake area; Mr. Owens was taken down to the floor; he began to spit up blood and to have difficulty breathing approximately one minute after having been taken down to the floor.

Mr. Owens' wounds were observed and recorded but the suspected cause of the wounds was not stated. The report notes several shallow wounds to the right side of Owens' neck and some lacerations to his forehead. "Bruising around the area⁴³ in which [Mr. Owens] was restrained" is also mentioned. The report concludes that none of these injuries appeared severe enough to cause his death and observes that no suicide note was found.

OSP referred the matter to the Malheur County District Attorney's Office. That office decided not to prosecute the case for the stated reason that, "Death was not caused by a criminal act".

C. Department Of Corrections' Internal Investigations

DOC conducted an internal investigation and completed a Critical Incident Review (CIR). This investigation included review of staff memoranda (describing their role in the circumstances surrounding Mr. Owens' death) and the videotape of the incident. Its stated goals were to address concerns regarding compliance with DOC policy and potential inadequacies in DOC staff training and to determine necessary lessons to be learned.

The CIR raised concerns regarding compliance with DOC rules regarding use of force. The staff person who removed the pen from Mr. Owens did not accurately document that incident. The staff person appeared to strike Mr. Owens multiple times and only documented placing his knee on his shoulder and pushing his head down. The statements by staff were vague and did not define how Mr. Owens was resisting prior to the second take down. The staff did not clarify the nature of the resistance that required his take down, despite his being secured by a wall restraint. The concern was raised that there was not a correctional objective for using pepper spray on Mr. Owens, who was unresponsive.

The CIR observes that if there was a long period in which Mr. Owens did not speak or otherwise communicate, it should have been documented on his Green Card so that his welfare could be assessed.

⁴³ No area is specified.

Delays in providing emergency health care were highlighted in the CIR, including: the two minutes before Mr. Owens' handcuffs were removed with a nurse present; the delay and apparent hesitation to begin CPR; the approximately four minutes that transpired before an ambulance was called. Concern was also raised that Mr. Owens' airway was not checked for blockage or fluid before initial administration of "rescue breaths" and that the initial nurse did not take charge of the situation.

The CIR cited concerns regarding professionalism. Items cited were the carrying on of unrelated conversation, laughter, a kiss from a nurse to an officer and a staff person who asked for a round of applause and ensuing laughter while Mr. Owens was undergoing CPR.

In addition, DOC subsequently reviewed a draft of this OAC report as well as the underlying records on which it is based. The conclusions that DOC reached after reviewing a draft of this OAC report are attached as Addendum "D".

V. FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

A. Ineffective monitoring of mental health treatment.

FINDINGS AND CONCLUSIONS

The DOC knew that while Mr. Owens was in its custody he had a serious mental illness including re-occurring paranoid delusions that his family was being tortured or murdered with the collusion of those around him. He was housed in various settings due to his mental health disorder, including at least thirteen stays in SMU⁴⁴ and four hospitalizations at OSH⁴⁵. At the time of his death, Mr. Owens had been sanctioned to DSU for "acting out" behaviors and had served one hundred forty-five days.

⁴⁴ The Special Management Unit (SMU) is designated for persons who, due to a mental illness, are unable to satisfactorily adjust in the general inmate population. OAR 291-048-0100(2). (N.B., persons with severe emotional disturbance are included as well as persons with mental illness.) SMU's purpose is to provide an environment oriented to mental health treatment for inmates who because of mental illness and severe emotional disturbance are behaving in such a way as to endanger themselves or others or are unable to provide for their basic needs. OAR 291-048-0100 (3). The SMU is designed to provide short-term psychiatric crisis services for stabilization, diagnosis, or medication adjustment as well as longer term psychosocial rehabilitation for persons with severe mentally illness. See: <http://www.doc.state.or.us/programs/cts.shtml?smu>. Additionally, inmates in an acute phase of mental or emotional disorder could be assigned to the SMU. OAR 291-048-0120.

⁴⁵ For persons with who cannot reasonably be treated in a prison setting, such as the SMU, OSH provides limited beds. See: http://www.doc.state.or.us/programs/cts.shtml?other_programs

According to DOC administrative rules, any stay in the DSU for longer than thirty days is deemed long term.⁴⁶ DOC policy further directs that inmates with mental illness be housed in a facility most appropriate for their treatment needs after their initial screening for the presence of mental disorders.⁴⁷ It also requires that inmates be assigned to segregation for the shortest amount of time necessary to achieve the purpose of the assignment. The records reviewed do not indicate the purpose for Mr. Owens' sanction to disciplinary segregation.

Imposing segregation on inmates with serious mental illness poses unique challenges in a correctional facility setting. These inmates experience symptoms that may be exacerbated by restricted movement, isolation from other people, limited access to programs, and fewer amenities. Suicidal ideation and behavior may increase.⁴⁸

Mr. Owens' was sanctioned to DSU in this instance because of an altercation with a peer. He said that his behavior was caused by his mental health disorder. If this was case, as seems reasonably likely given his history, he should not have been sanctioned to disciplinary segregation.

If there were no alternatives to placing Mr. Owens into disciplinary segregation, his need for appropriate mental health treatment should have been factored into determining the amount of time and the level of monitoring he received while there.⁴⁹ DOC policy required that Mr. Owens have direct access to health care personnel to ensure that his placement was not contraindicated based on medical and mental health concerns. Health care personnel were to conduct an initial and daily evaluation and make referrals for health and mental health services as clinically indicated.⁵⁰ His length of stay and conditions of confinement seem to contradict the intent of these policies.

All reports indicate that Mr. Owens was exhibiting psychotic behavior on the day before his death. DOC policy⁵¹ requires that upon identification of these symptoms, steps be taken to provide timely examination, assessment, and treatment by scheduling an appointment with the appropriate practitioner.⁵² Had DOC policy been followed, a referral to Counseling Treatment Services would have been made.⁵³ Given that this was a Sunday, an emergency referral should have been made paging Dr. Susan Bennett, Mental Health Services Supervisor,

⁴⁶ See OAR 291-011-0010(6).

⁴⁷ See DOC Health Services Division Policy and Procedure #E 5-0.

⁴⁸ Vermont Department of Corrections' Policy 370, Policy Section attached as Addendum "A".

⁴⁹ A stated DOC goal is to provide quality health services at a reasonable cost to inmates in segregation. OAR 291-124-005(3)(b); see also OAR 291-011-0030

⁵⁰ See DOC Health Services Division Policy and Procedure #E 9-0.

⁵¹ See DOC Health Services Division Procedure #E 9-0 (D)

⁵² See DOC Health Services Division Procedure #E 9-0 (G)

⁵³ See DOC Health Services Division Policy and Procedure #E 9-0 (B.)(2.)(c.)

in order to obtain, and document the need for, emergency mental health consultation.⁵⁴

The staff attempt to move Mr. Owens from his cell occurred more than seventeen hours after he had punched his cell window with his fists, bloodied his knuckles, and refused medical attention. He had kicked his cell door throughout the night of the prior evening, had refused to take medication for the three days preceding his death and had refused medications on two additional days within the past month. Had Mr. Owens been referred for mental health services upon his initial refusal to take medication, his suffering and death would likely have been avoided.

RECOMMENDATIONS

OAC recognizes that DOC policies address the need to provide mental health services to inmates. However, the circumstances leading to Mr. Owens' death suggest that additional steps need to be taken to accommodate persons with mental health disorders,⁵⁵ provide them with appropriate and humane treatment⁵⁶ and avoid inappropriate use of disciplinary segregation.⁵⁷

Specifically, DOC policy should require training of all staff at orientation in the identification of individuals with possible emotional and mental disorders. This training should include: (1) recognition of signs and symptoms of mental and emotional disorders prevalent in the inmate population; (2) recognition of signs of chemical dependence and the symptoms of drug and alcohol intoxication and withdrawal; (3) recognition of adverse reactions to psychotropic medications; (4) recognition of signs of developmental disability, especially mental retardation; (5) recognition of potential mental health emergencies and instruction in appropriate action in crisis situations; (6) identification of medical problems of inmates housed in mental health units and proper referral for care; (7) suicide prevention; (8) instruction in the procedures for referring an inmate to mental health services

⁵⁴ Susan Bennett, Mental Health Services Supervisor, per her memorandum regarding, "Availability for Consultation", Attachment 2 to the P & P E 5-0.

⁵⁵ According to the American Public Health Association (APHA), sixteen percent of persons in prisons have psychological problems and that research has shown that the harsh prison environment exacerbates psychological disorders. See http://www.apha.org/news/press/2003/PrisonHealth_Care_book.htm. APHA is the oldest and largest organization of public health professionals in the world.

⁵⁶ The U.S. General Accounting Office Report, "Mental Health: Improper Restraint and Seclusion Use Places People At Risk" (September 1999) at page 22 concludes: "*People with mental illness . . . in residential settings are among the most vulnerable members of our society. Protecting them from abuse and injury in a responsibility of the federal government, the states, treatment facilities, and the P & A system. However, the safeguards currently in place are not comprehensive and fail to fully ensure the rights and safety of these individuals . . .*" (Italics added to the original).

⁵⁷ See Grondahl, Paul, "Locked in The Box", Albany Times (October 21, 2002).

for immediate evaluation⁵⁸; and (9) recognition of the risks of disciplinary and administrative segregation for inmates with serious mental illness. Hearings Officers and members of disciplinary committees should likewise be trained, because they play a key role in the discipline of inmates who have serious mental illnesses.⁵⁹

DOC should also adopt a policy⁶⁰ for the use of disciplinary segregation or administrative segregation for inmates with serious mental health disorders. The Vermont Department of Corrections' Policy Number 370 (attached as Addendum "A") is a useful example of such a policy. Another resource is the Commonwealth of Pennsylvania Department of Public Welfare's policy that seclusion shall not be used for patients who exhibit suicidal or self-injurious behaviors should be seriously considered⁶¹ (attached as Addendum "B").

Specifically, OAC suggests that segregation not be imposed when it is either contraindicated or alternatives exist. A Qualified Mental Health Professional (QMHP) should determine if segregation is contraindicated. All alternatives to segregation should be considered and documented. Possible alternatives include loss of privileges, early lock-in, restriction to living unit, change in living unit, temporary loss of the use of personal property, work project related to offensive behavior, reprimand, apology, written essay, monetary restitution, SMU placement, OSH placement or intermittent segregation.

Due to the heightened risk of suffering and harm caused by inappropriate segregation of an inmate with the serious mental illness, such individuals should be afforded due process prior to placement in segregation, including the right to an attorney.⁶² The Hearings Officer should not sustain the use of disciplinary action in response to behavior that is a direct result of the person's mental

⁵⁸ In American Psychiatric Association, "Psychiatric Services in Jails and Prisons", 2000 at page 17, it states that "Referrals should be time constrained—that is, a maximum time for response to each referral, suitable to the situation, should be set out in the facility's operating standards. Timely referral and response should be designated as indicators of quality of care."

⁵⁹ See Addendum "A", Letter from Vermont Prisoner's Rights Office to Dr. Thomas Powell of the Vermont DOC dated November 19, 2001 regarding, at that time, proposed Policy 370.

⁶⁰ This could be either a DOC policy or adopted as an Oregon Administrative Rule.

⁶¹ See Commonwealth of Pennsylvania Department of Public Welfare Policy No. SMH-01-02, effective July 1, 2001, Section "VI. C. Contraindications", attached as Addendum "B". This policy has eliminated the use of seclusion in the state hospital.

⁶² Currently, the Ninth Circuit has not held that a hearing and right to an attorney to inmates with serious mental illness being transferred to disciplinary segregation. Instead, the court has followed the U.S. Supreme Court's test for determining the existence of a protected liberty interest in prison cases addressed in *Sandin v. Conner*, 515 U.S. 472, 115 S.Ct. 2293 (1995), which states that the existence of a protected liberty interest depends upon whether the restriction "imposes atypical and significant hardship on the inmate in relation to the ordinary incidents of prison life." Therefore, the Ninth Circuit looks to whether the difference between conditions in the inmate's current prison population compared with in the segregated population are sufficiently great to trigger a right to a hearing. Factors that are reviewed include whether the transfer will affect the inmate's sentence duration and the duration of the transfer. *Keenan v. Hall*, 83 F.3d 1083 (Ninth Cir. 1996).

illness. The American Psychiatric Association has stated: "In jails and prisons without adequate mental health services, inmates with mental illness often find their way into segregation housing quite unnecessarily, when their mental illness prevents them from understanding or adhering to correctional rules."⁶³

Testimony to the U.S. State House of Representatives on offenders with mental illness in the criminal justice system emphasize that an inmate's mental condition should be taken into account at the disciplinary hearing, not as an excuse but in order to fashion a disposition that comports with both security and treatment needs:

For both security and health care reasons, we need to know whether [inmates] are demonstrating purposeful, negative behavior as opposed to those who are 'acting out' because of a mental illness. Mental health professionals working closely with security professionals assist in this task, but we can do a better job. For many years, the clashing of treatment and clinical professionals with security staff has created difficult management issues. The signs now point to significant reduction in this type of friction. . . . Some [inmates] with mental illness may also suffer from the distorted belief that staff intends to harm, rather than help them. This makes it difficult for these inmates to follow prison rules and procedures.... prevention and amelioration of mental health related problems, from an administrative and clinical perspective, must be a conscious, ongoing mission.⁶⁴

If no alternative to segregation exists and if the person's behavior was not directly caused by his mental illness, disciplinary segregation should not exceed fifteen continuous days and administrative segregation should not exceed thirty continuous days. Mental health professionals should monitor the segregation including any use of any chemical or physical restraint. QMHP's should conduct regular mental health rounds to insure that the inmates receive appropriate mental health services and that symptoms are detected and treated in a timely manner.

DOC should continue in its efforts to provide an adequate therapeutic milieu for all inmates. According to the American Psychiatric Association, this requires: a sanitary and humane environment, written procedures and adequate staffing to permit adequate observation, adequate allocation of resources for the prevention of suicide and assault, medical and mental health staff that are available to provide adequate treatment and supervision, social interactions that foster

⁶³ American Psychiatric Association, "Psychiatric Services in Jails and Prisons", 2000.

⁶⁴ See Reginald A. Wilkinson, "Summary Testimony on Offenders with Mental Illness in the Criminal Justice System" submitted to the U.S. House of Representatives House Judiciary Subcommittee on Crime (September 21, 2000).

recovery, and transfer to an appropriate mental health facility when these conditions are not able to be met. As safety and security allow, self-help and peer support programs or activities contribute to the overall goals of the mental health services and should be promoted and encouraged by the clinical professional staff.⁶⁵

In addition to being humane and helpful to the specific inmate needing mental health treatment, more effective mental health treatment engenders safer and easier to manage prisons. An inmate can better control his behavior when receiving appropriate treatment for his illness.⁶⁶

B. Inappropriate use of prone restraint/containment.

FINDINGS AND CONCLUSIONS

SRCI violated Mr. Owens' fundamental right to be free from excessive bodily restraints. While having a psychiatric/medical emergency, Mr. Owens was pepper sprayed three times and taken to the floor twice by five staff. He was restrained/contained in a prone position to apply wrist and leg cuffs. Shortly after the second take down and restraint in a prone position, Mr. Owens stopped breathing.

DOC staff members are permitted to use force when there is a legitimate correctional objective.⁶⁷ Preventing an individual from injuring or killing himself or other persons is specified as a legitimate correctional objective.⁶⁸ Staff appear to have complied with DOC rules in this instance.

The autopsy report stated that the cause of Mr. Owens' death was due to schizophrenia with probable excited delirium and terminal restraint asphyxia. Events leading to the death and autopsy findings support the conclusion that Mr. Owens succumbed to prone restraint syndrome. Common elements of the syndrome are pressure on the upper torso, handcuffing, leg restraint, acute psychosis and agitation, physical exertion and struggle, and obesity.⁶⁹ All of these elements appear to have been present in this case.

It seems both humane and prudent to develop some safer means of control and protection, given the increased knowledge and understanding of the potential lethality of prone restraint in excited, delirious people.⁷⁰

⁶⁵ American Psychiatric Association, "Psychiatric Services in Jails and Prisons", 2000 at page 36.

⁶⁶ See footnote number 56, *supra*.

⁶⁷ OAR 291-013-0005 and OAR 291-013-0065(1).

⁶⁸ OAR 291-013-0065(1)(b)(B).

⁶⁹ See O'Halloran RL and Frank JG, *supra*.

⁷⁰ See O'Halloran RL and Lewman LV, *supra* at 295.

RECOMMENDATIONS

DOC rules should be changed to prohibit prone restraint/containment. At the very least, prone containment should never be used for persons at risk for positional asphyxiation, including those with obesity and those in an agitated, excited state. Acute excited states and patient aggression should be regarded as a psychiatric emergency when the inmate has been diagnosed with a psychiatric disorder. Temporary prone containment should only be used when other techniques of intervention have been tried and failed.

Investigations have found a direct link between the use of prone restraints and death.⁷¹ For example, the California Protection and Advocacy Institute (PAI) issued a report tying the use of prone restraint with death by asphyxiation.⁷²

During prone restraint, death can occur from a sudden cardiac arrhythmia or respiratory arrest due to a combination of factors causing decreased oxygen delivery at a time of increased oxygen demand.⁷³ Breathing requires movement of the ribs by the intercostals muscles and movement of the diaphragm.⁷⁴ When a person is restrained or contained in a prone position, her ability to breathe is compromised due to these factors:

1. There is restriction to the movement of the ribs limiting the individual's ability to expand his chest cavity and breathe; and
2. The abdominal organs may be pushed up, restricting movement of the diaphragm and further limiting the available space for the lungs to expand.⁷⁵

The risk of causing respiratory compromise when subduing and restraining a person is increased when the person's demand for oxygen is increased by agitation or aggressive struggle. Struggle also increases the potential for further compression and restriction of the chest by those executing the restraint. As noted in the American Journal of Emergency Medicine:

Restraint asphyxia is a term that expands the concept of positional asphyxia to include the process of subduing and restraining an

⁷¹ Leslie Morrison, "The Lethal Hazard of Prone Restraint: Positional Asphyxiation", Protection & Advocacy, Inc. (April 2002, Publication #7018.01)

⁷² A copy of California's Report by Leslie Morrison, "The Lethal Hazard of Prone Restraint: Positional Asphyxiation", Protection & Advocacy, Inc. (April 2002, Publication #7018.01) is attached and identified as Addendum "C".

⁷³ Leslie Morrison, Addendum "C".

⁷⁴ Leslie Morrison, Addendum "C" at 17, *citing* Parkes, 2000, p. 40; Reay, Fligner, Stilwell, & Arnold, 1992, p. 94.

⁷⁵ Leslie Morrison, Addendum "C" at 17.

individual. In the out-of-hospital setting, the process of restraining a victim of excited delirium usually involves “take down” where the individual is forced to the ground and the wrists bound behind the back. During this phase there is a struggle by the individual with the potential for compression and restriction of the chest by placement of pressure (usually a knee or hand) on the back of the thorax with the individual in prone position while being subdued and initially restrained. . . . The entire process of subduing and restraining an uncooperative individual may have high risk for causing ventilation compromise.⁷⁶

DOC staff should be trained to avoid the use of prone restraint and to recognize persons at risk for positional asphyxiation. Indicators include bizarre/ violent activity, obesity (especially “big bellies”), drug or alcohol involvement and apparent ineffectiveness of pepper spray.⁷⁷ The California legislature has recently passed a bill prohibiting the use of prone mechanical restraint on a person at risk for positional asphyxiation as a result of any one of the seven listed risk factors, including obesity, agitated delirium or excited delirium syndrome, and exposure to pepper spray in mental health and developmental disability facilities.⁷⁸ While a corrections setting presents additional challenges, alternative restraint methods should be mandated or, at least, encouraged whenever feasible.

Practices developed in Pennsylvania may be instructive in development of a new DOC restraint policy for individuals with mental illness. Pennsylvania reformed its policies regarding the use of seclusion and behavioral restraints in nine state hospitals in 1997. Those policies regard the use of seclusion and restraint as a treatment failure rather than a treatment intervention.⁷⁹ Pennsylvania reduced the use of seclusion and restraints by 74% and the duration of time patients spent in seclusion and restraints by 96% over three years. Injuries to staff as

⁷⁶ Stratton SJ, Rogers C, Bricket K, Gruzinski G, “Factors Associated With Sudden Death of Individuals Requiring Restraint for Excited Delirium”, 19 American Journal of Emergency Medicine, No. 3, pages 187-191 (May, 2001).

⁷⁷ Granfield, Onnen and Petty, “Pepper Spray and In-Custody deaths”, in International Association of Chiefs of Police Science and Technology (March 1994); See California Proposed Senate Bill No. 130 introduced by Senator Chesbro, Amended in Senate, April 29, 2003 stating in section 11.80.3(2)(c) that the facilities covered by the proposed bill “may not use prone mechanical restraint on a patient at risk for positional asphyxiation as a result of one of the following known risk factors: (1) *Obesity*. (2) *Pregnancy*. (3) *Agitated delirium or excited delirium syndromes*. (4) *Cocaine, methamphetamine, or alcohol intoxication*. (5) *Exposure to pepper spray*. (6) *Preexisting heart disease, including, but not limited to, an enlarged heart and other cardiovascular disorders*. (7) *Respiratory conditions, including emphysema, bronchitis, or asthma*.” (Emphasis added to the original.)

⁷⁸ The bill is attached hereto as Addendum “E”.

⁷⁹ The Commonwealth of Pennsylvania’s Department of Public Welfare’s policy SMH-01-02, effective July 1, 2001, on the use of restraints, seclusion and exclusion in the State Mental Hospitals and Restoration Center supports this philosophy.

well as to patients were reduced.⁸⁰ The components for staff training set forth in these policies may be of particular assistance to DOC.⁸¹

DOC policy should assure that if prone restraint cannot be entirely prevented, its use must be closely and continuously monitored.⁸² A staff person should be designated to observe the inmate for any signs of physical duress throughout the episode. Staff should ensure that the inmate's body is turned on the side or to an upright position as soon as possible and that he is not exhibiting signs of lack of oxygen.

C. Inadequate care and monitoring during the use of chemical and physical restraint.

FINDINGS AND CONCLUSIONS

Preparations to remove Mr. Owens from his cell were not made under emergency conditions.⁸³ Numerous security and medical SRCI staff were present and yet no-one appeared to be responsible for ensuring Mr. Owens' health and well being while he was subjected to restraints. No-one was designated to be apart from the restraint activity and responsible for monitoring Mr. Owens' health, condition and well-being. Mr. Owens' vital signs and medical health were not checked after he was pepper sprayed or after he was found to have stopped breathing. A mental health specialist was not present to monitor Mr. Owens' mental health status or condition.

SRCI staff failed to respond to clear signs of an impending medical crisis. Inattention to Mr. Owens' condition by nursing and medical staff while he was pepper sprayed and physically restrained constituted neglect of a dependent adult, exposing him to significant danger.

1. Chemical restraints not adequately monitored

The use of Oleoresin Capsicum (also known as "OC spray" or "pepper spray") presents unique challenges for seriously mentally ill inmates whose behavior is assaultive or disruptive.⁸⁴ When the agent is inhaled, the respiratory tract is

⁸⁰ See California Senate Bill No. 130 introduced by Senator Chesbro, enrolled on September 15, 2003 (*citing* that in October 2000, Pennsylvania's reform project was awarded the Harvard University Innovations in American Government Award), attached hereto as Addendum "E".

⁸¹ See Commonwealth of Pennsylvania Department of Public Welfare's Policy SMH-01-02, effective July 1, 2001, Section III on "Staff Training", attached hereto as Addendum "B".

⁸² Granfield, Onnen and Petty, "Pepper Spray and In-Custody deaths", in International Association of Chiefs of Police Science and Technology (March 1994).

⁸³ Note that on the Emergency Checklist form states, "Not declared an institutional emergency".

⁸⁴ See Vermont DOC' Policy Number 370, Addendum "A".

inflamed, and breathing is too restricted to support high levels of physical activity such as fighting with officers.⁸⁵

DOC rules set out requirements for the use of force in applying a chemical restraint.⁸⁶ While chemical restraints may be used to affect cell extractions,⁸⁷ the amount used should not exceed that which is necessary to overcome resistance.⁸⁸ Mr. Owens was pepper sprayed three times while he was in a very agitated state. He was not responding to staff directives and did not appear capable of complying. The amount of pepper spray used was sufficient to cause a serious reaction in an SRCI nurse who was not in Mr. Owens' cell at the time of the spraying. The nature of the correctional objective for the use of, the amount of, pepper spray was not clear from the records reviewed.

After being chemically restrained, an inmate is supposed to be examined by health care professionals as soon as feasible.⁸⁹ Instead of being immediately monitored by medical personnel, Mr. Owens was forced to walk to the intake unit of the DSU.

2. Physical restraints not adequately monitored.

As related above, five men with a shield took down Mr. Owens after he had been chemically restrained. One man used his knee or foot to strike Mr. Owens approximately six times for the stated reason of gaining control of the pen that Mr. Owens was holding. Mr. Owens was forced to walk after being placed in what appeared to be metal wrist and leg restraints. What may have been Mr. Owens' difficulty with ambulating was treated as non-compliance and resistance. He was again taken to the ground and contained in a prone position with several guards holding him down. When he was discovered not to be breathing, there were significant delays prior to removing Mr. Owens' wrist restraints, accessing a mask, beginning CPR, and contacting an ambulance.

According to DOC policy, each unit manager is required to maintain an adequate number of correctional and other employees trained to respond to life threatening situations within four minutes.⁹⁰ Removal of Mr. Owens from his cell was a planned use of force that required contacting health care professionals in advance to ensure that medical assistance would be ready if necessary.⁹¹

⁸⁵ See Granfield, Onnen and Petty, "Pepper Spray and In-Custody Deaths", International Association of Chiefs of Police, March 1994 at http://www.zarc.com/English/other_sprays/reports/iacp_oc_death_1994.html.

⁸⁶ OAR 291-011-0020.

⁸⁷ OAR 291-013-0030(1).

⁸⁸ OAR 291-013-0065(1)(b)(D)(9).

⁸⁹ OAR 291-013-0090(3)(i).

⁹⁰ OAR 291-241-0035.

⁹¹ OAR 291-013-0070(3).

Approximately fifteen SRCI employees filed grievances through their Union Representative, which was presented to a management representative on May 30, 2002. The employees raised concerns, including exposure to blood born pathogens (BBP)⁹² during the extraction of Mr. Owens and administering of subsequent assistance to him; denial of an opportunity to clean-up after exposure to BBP; and failure to have been offered the option to take administrative leave following the death of Mr. Owens. The Management Representative, after investigating staff grievances, determined that no contract violations had occurred.

Additionally, the grievance resulted in a complaint being issued to Oregon-Occupational Health and Safety Association (OR-OSHA). OR-OSHA conducted an inspection based on the complaint and determined that the staff appeared knowledgeable regarding blood born pathogens and found that the complaint was unsubstantiated. OR-OSHA determined that SRCI was doing a thorough job of implementing all applicable safety and health standards in the work environment regarding blood born pathogens.⁹³

RECOMMENDATIONS

Restraint is an intrusive and potentially dangerous procedure that requires close monitoring and supervision. Floor restraint poses heightened risks and should be avoided whenever possible. When restraint is being considered for an inmate with a serious mental illness, DOC policy should assure that it is not employed for punitive purposes and that chemical restraint such as pepper spray is used only as a last resort and with medical monitoring. DOC should also consider the applicability of the restraint policies adopted for hospitals in Pennsylvania that are discussed above.

Mr. Owens' death may have been avoided if clinical considerations been paramount in planning his transport. Staff must have been aware that Mr. Owens might resist and that pain could escalate his agitation and frustration. And yet force, aggression and infliction of pain were central to the procedures used. He could, instead, have been taken to a padded room for his own protection. Metal restraints were used to control his movements.⁹⁴ Instead, soft restraints, such as soft Velcro or leather could have been used so as to not exacerbate the inmate's physical and psychological distress.

In responding to medical emergencies it is essential that staff's roles during CPR are understood and that staff can function as an effective team. Staff should be trained on how to ensure that an inmate's airway is clear and body positioning

⁹² Note that the OR-OSHA inspectors noted that Mr. Owens had no medical history of any blood borne diseases.

⁹³ The OR-OSHA inspectors noted that SRCI spent several thousand dollars on new mouthpieces and bought 600 additional mouth guards after the death of Mr. Owens.

⁹⁴ See Addendum "B".

strategies. Medical and disciplinary staff should be trained to work together in a way that follows best practices for inmate care. Additionally, SRCI should have had CPR masks easily accessible and available such that life needed care is not delayed while a mask is tracked down.⁹⁵

⁹⁵ According to the OR-OSHA investigation records, it appears that masks are now readily accessible and available to SRCI staff.