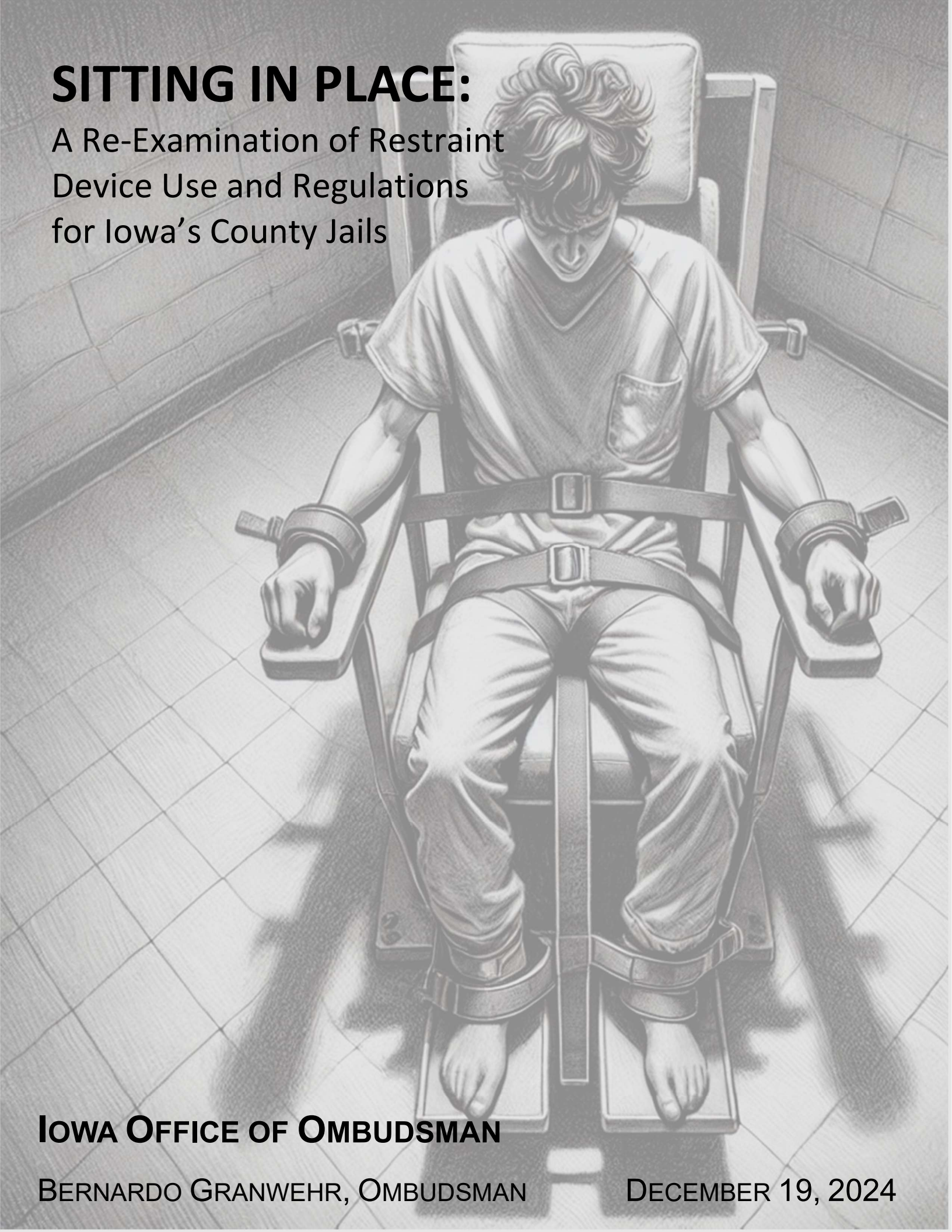

SITTING IN PLACE:

A Re-Examination of Restraint Device Use and Regulations for Iowa's County Jails

IOWA OFFICE OF OMBUDSMAN

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Executive Summary

This report investigates the use of restraint chairs in two county jails in Iowa, Boone County and Webster County, and examines the circumstances leading to their deployment. It follows the Ombudsman's 2009 report that included 13 general recommendations for all of Iowa's jails on restraint device use and managing inmates with mental health needs. The Ombudsman's prior report noted a lack of guidance in Iowa law on restraint device use, but did not recommend amendments to the law at that time.

This investigative report builds on the 2009 report in its review of incidents that arose between 2019 and 2023. The Ombudsman highlights issues related to compliance with Iowa administrative rules, jail policies, and manufacturer guidelines, and also addresses broader concerns about mental health evaluations and treatment for inmates.

The Ombudsman recommends changes to the Iowa Administrative Code to address those issues.

KEY FINDINGS

Lack of Mental Health Evaluations:

In several cases, inmates placed in restraint chairs were not promptly evaluated for mental health issues, despite exhibiting signs of distress or self-harm. These failures often led to prolonged and repeated use of restraint chairs.

Inadequate Documentation and Monitoring:

Both jails showed inconsistencies in documenting the need for restraint, the checks performed during restraint, and the conditions of the inmates. In many instances, required 15-minute checks and continuous monitoring were not adequately recorded or conducted.

Non-Compliance with Restraint Chair Policies:

Instances were found where restraint chair use exceeded recommended durations without medical supervision, and restraints were applied without following established guidelines.

Use of Restraint Chairs as Punishment:

The report identifies cases where restraint chairs were used not as a response to immediate threats but as punishment for disruptive behavior, which is contrary to Iowa law and best practices.

Failures in Reporting to State Jail Inspector:

Incidents involving restraint chairs were not consistently reported to the state jail inspector as required by Iowa law. This lack of reporting hinders oversight and accountability.

RECOMMENDATIONS

Implementing Comprehensive Mental Health Screenings:

Administrative rules should be amended to require jails to adopt a screening tool like the Brief Jail Mental Health Screen to promptly identify inmates needing mental health evaluations.

Consider Less Restrictive Alternatives:

Administrative rules should be amended to require jail staff to consider less restrictive alternatives before using the restraint chair, and when those alternatives are not used, staff should be required to document the reasons.

Visual Observations:

Administrative rules should be amended to require jail staff to check for any adverse medical conditions during the 15-minute personal visual observations. Jail staff should also be required to conduct periodic reviews (at least hourly) to determine whether an inmate can be released from the restraint chair and document if the inmate was released or the reason for keeping the inmate in the restraint device.

Involve Medical and Mental Health Professionals:

Administrative rules should be amended to require in-person medical reviews to occur every two hours. Jails should also contact a mental health professional whenever an inmate with a known or suspected mental health condition is placed in a restraint device, or whenever any inmate is restrained longer than a few hours.

Improve Documentation and Video Monitoring:

Administrative rules should be amended to require improved documentation practices and ensure all restraint incidents are video recorded and retained for at least two years. Continuous monitoring via CCTV with unobstructed views should be mandatory.

Regular Training for Staff:

Jails should ensure all staff are properly trained and certified in the use of restraint chairs and conduct annual refresher courses to maintain compliance with policies and guidelines.

Strict Adherence to Policies:

Jail staff should follow the restraint chair policies strictly, especially concerning periodic checks, the duration of use, and medical supervision.

Reporting and Oversight:

Jails should ensure all restraint chair incidents are reported to the state jail inspector within the required timeframe to maintain oversight and accountability.

Message from the Ombudsman

Long before I started my tenure, the Office of Ombudsman issued a 180-page public report on the use of restraint devices by Iowa's county jails.[1] That 2009 report was massive in scope, detailing the legal aspects of this controversial tool, and identifying one of the key factors underlying the widespread use and abuse of the devices: unmet mental health needs.

While our report detailed disturbing scenes of mental crises and prolonged restraint in five jails, we issued the report with all Iowa jails in mind. We mailed courtesy copies to the Iowa Law Enforcement Academy, the Iowa State Association of Counties, the Iowa State Sheriffs' and Deputies' Association, Iowa's jail inspector (part of the Iowa Department of Corrections), and the South Iowa Area Crime Commission. The report also received broad coverage by the media at the time.

We laid out in 13 recommendations our expectation that all inmates should be screened for mental health needs upon jail admission; when to follow up with mental health professionals; when to use restraint devices; preferred restraint device types if they must be used; how and when to monitor inmates; what action must be documented; and ideal time limits.

Our report had a positive impact. Several jails reached out to our office for advice on how to implement our recommendations and expressed a desire to do the right thing. Over a decade passed before we began fielding new complaints that resembled the type we had profiled in the 2009 report.

To some extent, a resurgence of complaints could be expected as personnel changes, retirements, and local elections create turnover over time. Memories fade, institutional knowledge is lost, and we sometimes fail to learn from past mistakes.

That was one of the reasons our office had attempted to codify our recommendations in the Iowa Administrative Code. Immediately following our report, we encouraged the Iowa Board of Corrections to consider our recommendations for inclusion in the Administrative Code. The Board declined to implement our recommendations. Years later, we met with the Iowa State Sheriffs' and Deputies' Association (ISSDA) to garner support for changes to the rules. Specifically, we proposed eight additions and changes to DOC's Administrative rules for jail facilities based on our 2009 recommendations.

While ISSDA supported some of our 2019 proposals, those that ISSDA did not support included:

- Requiring jails to document other less-restrictive alternatives that were considered prior to using a restraint device.
- Documenting periodic reviews of an inmate, including whether an inmate was released or the reason for not releasing the inmate.

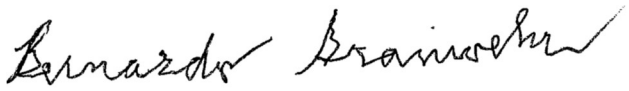
[1] Iowa Office of Ombudsman, *Investigation of Restraint Device Use in Iowa's County Jails* (2009) (https://ombudsman.iowa.gov/browse/files/39dacd16bc0a49ea882c895c4a88c61e/download).

- Documenting the reason an inmate was placed in restraints, who ordered placing the inmate in restraints, observations during the already-required 15-minute checks, and observations of medical reviews.
- Video recording all aspects of restraint device use, including placement, duration of use, and release.

With the emergence of COVID-19, my office shifted its focus to more pressing matters, and we were unable to continue the discussions with the ISSDA or the Department of Corrections. Soon after, we received our first significant restraint chair complaint mentioned in this report, followed by several others. These cases offered our office the opportunity to revisit our recommendations to determine which ones held up over time.

While incidents in this report are disturbing, fortunately no one died. Misuse of restraint chairs *can* result in death, and it has in other states.[2] It is our hope that the recommendations in this report will result in changes that will minimize such a possibility in Iowa's jails.

The subject of this report is restraint chair use in county jails, but at its heart is a bigger issue – mental health in Iowa. The practical effect of our laws is that many people with untreated mental illness end up being funneled into our correctional system. For that reason, jails and prisons need to be adequately prepared to deal with mental illness in their facilities. I hope that by issuing this report we will start a conversation that will ultimately help jails enhance or affirm their preparedness.



Bernardo Granwehr
Ombudsman

[2] *See* Rudi Keller, *Missouri corrections officers charged with murder of restrained inmate*, Colum. Daily Trib. (MO), July 3, 2024, at A2. *See also* Caitlin Knute, *Jackson County settles $1.2M wrongful death lawsuit involving man in restraint chair*, KSHB 41 Kansas City (MO), December 11, 2023.

Role of the Ombudsman

The Office of Ombudsman (Ombudsman) is an independent and impartial agency in the legislative branch of Iowa state government. The Ombudsman investigates complaints against most Iowa state and local government agencies. The Ombudsman has jurisdiction to investigate any administrative action of any person providing child welfare or juvenile justice services under contract with an agency that is subject to investigation by the Ombudsman. The governor, legislators, judges, and their staffs fall outside the Ombudsman's jurisdiction. The Ombudsman's powers and duties are defined in Iowa Code chapter 2C.

In response to a complaint or on the Ombudsman's own motion, the Ombudsman determines whether an agency's actions were unlawful, contrary to policy, unreasonable, unfair, oppressive, or otherwise objectionable. The Ombudsman may make recommendations to the agency and other appropriate officials to correct a problem or to improve government policies, practices, or procedures. If the Ombudsman determines that a public official has acted in a manner warranting criminal or disciplinary proceedings, the Ombudsman may refer the matter to the appropriate authorities.

If the Ombudsman decides to publish a report of the investigative findings, conclusions, and recommendations, and the report is critical of an agency, official or employee, they are given an opportunity to reply to the report, and the unedited reply is attached to the report.

Introduction

This report focuses on events arising out of the Boone and Webster County jails.

The first case came to our attention in 2020 from Jim[3]. He alleged that Boone County Jail officials held him in a restraint chair for four days straight, out of the six days he was at the jail in December 2019.

A second inmate, Paul, complained to our office in September 2022, reporting that Webster County Jail staff had repeatedly placed him in a restraint chair, including one occasion that lasted for 16 continuous hours. A few months later, a third inmate, Ryan, claimed Webster County Jail staff had placed him in a restraint chair for eight hours without any water, bathroom breaks, or periodic releases to stretch. In 2023, Jack, a fourth inmate, claimed Webster County Jail staff had placed him in a chair without justification. He, too, was allegedly denied food, water, or breaks during his four-hour restraint. We investigated each of these four complaints on its own merits.

The Ombudsman used the findings and recommendations from the 2009 report as the foundation for investigating the four new complaints. In doing so, the Ombudsman's investigation focused on three broad issues: first, whether the jails' use of the restraint chair complied with Iowa Administrative rules, the jails' policies, and the Emergency Restraint Chair's[4] manufacturer's recommended guidelines. Second, absent any non-compliance with Iowa law, policy, or manufacturer recommendations, whether the jails' use of the restraint chair device was considered objectionable based on the circumstances. Third, whether the jails properly assessed the complainants' mental health needs, and in response, provided a referral for mental health services.

Methodology

Upon receiving the recent complaints, our office submitted formal, written information requests to the Boone County Jail and the Webster County Jail. We requested restraint chair documentation, including incident reports, supervision logs, documentation concerning the decisions and actions taken related to the restraint chair uses, medical logs, documentation concerning any medical reviews or checks, and mental health intake and screening documents. We also requested video footage, the jails' restraint chair policies, and the restraint chair manufacturer's instruction manual.

The Webster County Jail was unable to fully comply with our requests. County officials could not locate a copy of the restraint chair manual "likely due to the age of the chair," they told us. [5] Certain incident reports, which should have documented all of the staff's actions and decisions

[3] To protect medical confidentiality, the names used in this report for inmates are pseudonyms.
[4] Both the Webster County Jail and Boone County Jail used the Emergency Restraint Chair during the time periods of which the complaints were received. The Emergency Restraint Chair was manufactured by Emergency Restraint Chair Inc., or E.R.C., Inc., a company formerly based on Denison, Iowa. The Ombudsman was informed that the Webster County Jail obtained a new restraint chair in 2023.
[5] Undated letter from Webster County Chief Deputy Derek Christie in response to initial information request.

related to the chair, were never created when Paul was placed in the chair. Webster County Jail Administrator Mark Gargano admitted that incident reports should have been created in each instance but could not explain why reports had not been made in this case.[6]

The Webster County Jail also failed to provide our office with any video that captured Ryan's placement or duration in the restraint chair. Despite our written request that footage be preserved, months before their system overrode the footage, the jail did not attempt to preserve the recording until after the system had already deleted it. Similarly, and without any explanation, the jail also did not provide all of the video footage related to Paul's numerous restraint chair incidents. The jail also did not provide all video footage of Jack's restraint chair incidents because, again, the jail failed to preserve the video before it was overwritten.

The Boone County Jail could not provide video footage of Jim's restraint. The Ombudsman made the request for Jim's video footage four months after the incidents, and the Boone County Jail reported that the recording had by then been deleted from the jail's server.

Following our formal information requests, our investigators conducted several interviews of current and former jail staff. The investigators also toured the Webster County Jail, which included an observation of the restraint chair, control center, and padded cell.

[6] Email to Ombudsman on August 15, 2023. *See also* Webster County Jail Policy 07.04, dated June 13, 2017, that requires staff to "log and report information regarding the use of the chair."

Boone County Jail

BACKGROUND FACTS: "JIM"

Jim complained to our office in February 2020 that the Boone County Jail failed to treat injuries that he had sustained in the moments before jail staff placed him in a restraint chair. His primary complaint was that he should have seen a doctor, but the jail had him reviewed by a nurse instead.

We quickly dismissed his complaint about which type of medical professional had treated him. However, we decided to inquire further when we learned he had been placed in a restraint chair on four occasions during his six-day stay.

We discovered that, as soon as law enforcement brought Jim to the jail on December 6, 2019, he started fighting staff. Staff left him in the jail's "flush room," where new inmates are housed when they cause a disturbance. Once there, Jim began striking his head against the door until he caused a laceration. Officers intervened and placed him in a restraint chair for his own safety. Still, Jim repeatedly freed a leg from a retaining strap and kicked the wall, causing the chair to tip over several times and inflicting additional minor injuries to his head.

A jail nurse had checked on Jim for his injuries and checked the straps to ensure proper circulation. On this first night, Jim remained in the restraint chair for a little over two hours.

Jim continued to engage in aggressive behavior the next day, December 7, leading to another placement in the restraint chair. According to an incident report:

> Around 1100 court was ending for [Jim]. He was having another fit. Which included uncontrollable yelling and was [sic] Steve took him down and I ran to help him.[7]

Jim was then placed in handcuffs and leg irons to prepare him for placement in the restraint chair. There are few records capturing what transpired after Jim's placement. It is unknown what checks were done, how often he was released from the restraint chair, and whether he was offered food and water. The jail's logbook states he was released at 6:00 p.m. to make a phone call, but it does not state whether staff placed Jim back in the restraint chair after the call. The next relevant entry in the logbook refers to an event at 12:40 a.m. on December 8, which reads:

> We finaly [sic] got inmate Jim calmed down enough to get him out of the chair and into bed.

If the log entries are accurate, that would mean Jim was in the restraint chair for nearly 14½ hours, aside from the time he was released to make a phone call.

[7] Incident report dated December 7, 2019. This incident report is unsigned, and it is unclear who wrote it.

During the evening of Jim's third day at the jail, he began hitting his head on the floor. Staff placed him in the restraint chair at 7:12 p.m., at which time he made comments about killing himself. Jim was able to flip the chair over, as he had during his first restraint, so a staff member was assigned to the room. Two hours later, staff offered to release Jim from the chair if he agreed to wear a safety smock. Jim refused.

Four hours after being placed in the chair, Jim was still highly agitated. He spit on the officer assigned to the room and started rubbing his wrists on the restraining straps to the point that he started to bleed.

Staff released Jim at 12:12 a.m. when he began falling asleep. By that time, he had been in the restraint chair for just over five hours.

Jim's fourth placement in the restraint chair occurred on his fifth day at the jail. He had become upset when the jail ran out of his medication, resulting in him yelling, punching and headbutting his door, and punching himself in the face. When staff directed him to stop, he attempted to cut himself with a dinner plate left in his cell. When that did not work, he tried to cut his wrists on a door latch, at which time staff placed him in the restraint chair to prevent further self-harm.

Jail logs indicate that staff began releasing some of Jim's limbs almost three hours after his placement. Jail records do not state when he was fully released from the chair.

ANALYSIS AND CONCLUSIONS

It is clear to us that Jim was suffering from a mental health crisis while at the Boone County Jail, leading to the repeated use of the restraint chair. Yet staff failed to obtain a mental health evaluation during or immediately after his arrival to assess his needs and whether the jail could meet his needs.

Our review of available jail records revealed that staff also failed to follow its own restraint chair policy during Jim's stay.

Further, the jail failed to document the need for the restraint chair and failed to document staff actions to ensure Jim's safety once he was restrained.

We will address each of these findings.

Mental Health Evaluation

The jail did not perform a mental health evaluation on Jim when he first arrived. That is understandable given the harm he caused himself immediately upon admission; but we are disappointed that staff seemingly did not attempt to conduct an evaluation at a later time. Under Iowa law, the jail is required to have a written plan to provide prisoners "access to services for the detection, diagnosis and treatment of mental illness."[8] At a minimum, a mental health

[8] IOWA ADMIN. CODE r. 201—50.15(6)(d).

assessment could have been conducted at the same time as the medical questionnaire during Jim's third day in the jail.

We advocated for the Brief Jail Mental Health Screen[9] in our 2009 report on restraint device use. This form can be used by staff even if they have no formal mental health training. The form helps to identify individuals who may need the attention of a mental health professional for further evaluation and treatment. The form, or a similar one, may have been useful to assess Jim's mental health needs. If the screening had suggested that Jim needed further evaluation, the jail may have been able to curb its use of the restraint chair or reduced the time of its use.

Even absent the screening tool, jail staff should have reached out to a mental health professional following the first use of the restraint chair. Jim demonstrated signs of self-harm by hitting his head to the point of injury immediately after arrival at the jail. The second incident does not detail Jim's specific behaviors, but staff determined they rose to the point of concern to deploy the restraint chair on his second day of incarceration. The third and fourth incidents of restraint, like the first, followed attempted self-harm.

In our 2009 restraint chair report, we underscored the importance of identifying mental health concerns and seeking professional advice:

> 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.

Our 2009 report highlighted the stark difference in one inmate's behavior when, at our urging, a jail sought a civil commitment for a highly aggressive inmate who had been placed in a restraint chair for long periods of time. Once the inmate got on a regular antipsychotic medication schedule, the jail administrator described the inmate's agitation level as "almost none" upon his return. As we detail in another case later in this report, it is not unusual to see a significant shift in inmate behavior once they have received proper mental health treatment.

Aside from risking injury to the inmate and staff, the jail risks violating the inmate's Eighth Amendment rights and increases its liability when it ignores the signs and symptoms of severe mental illness.[10]

[9] An eight-question form endorsed by the National GAINS Center, a federal agency that develops mental health services in the justice system.

[10] Federal courts have found that under the Eighth Amendment, a correctional facility cannot ignore the mental health care needs of inmates. Additionally, 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 (*See Hartsfield v. Colburn*, 491 F.3d 394, 396 (8th Cir. 2007).

Written and Video Documentation

We reviewed jail incident reports, jail logs, and nurse's logs as part of our review. We found the content and detail in these documents to be highly inconsistent. In some cases, the incident reports clearly described the need for restraint chair use. In another case, we were not able to determine why the chair was deployed. Jail logs contained the release rationale in some cases, but not in others. In a few cases, we found that the nurse's log contained no information on the nurse's actions.

The nurse's log from the first incident documented her interactions with Jim, while jail logs stated the times of his placement and removal from the restraint chair. None of the jail's records, however, recorded staff's 15-minute checks, even though the incident report stated that staff "will be conducting 15-minutes watches."

The second use of the restraint was documented in far less detail than the first. The incident report contains only vague descriptions of Jim's actions and is incomplete. It only described Jim as having a "fit" of "uncontrollable yelling." It did not explain whether and how Jim was a threat to himself, others, or the security of the jail, as is required by Iowa law.[11] As such, we cannot conclude whether this particular restraint was legally justified.

Further, the incident report for the second use of the restraint chair notes that 15-minute checks were performed, but those checks were not recorded or noted individually in any of the jail's documentation. The jail's records do not indicate whether verbal checks were performed to evaluate the need to keep Jim in the restraint chair. Jail records also failed to note when Jim was released from the chair. The only way we were able to determine that Jim was released from the chair at all was because a phone call was recorded in the jail's logbook. At that point, he had been strapped into the chair for about 6 hours and 45 minutes.

We found that the incident report did not match the nurse's log. For instance, the incident report from the second restraint referenced a nurse's evaluation of Jim with orders to administer ice and ibuprofen. The nurse's log, on the other hand, had no similar entry on this evaluation and subsequent treatment.

Entries in a nurse's log were also absent during Jim's third and fourth times in the restraint chair. The information we relied on in those cases came only from two incident reports and the jail log.

On two occasions, there was no information indicating when Jim was released from the restraint chair, and what factors were considered in those releases. During the fourth incident, after Jim was released to make a phone call to his mother, he was placed back in the restraint chair after he refused to wear a safety smock.

[11] IOWA ADMIN. CODE r. 201—50.13(2)(f).

This raises two questions:

> 1) What was Jim's demonstrated behavior that required he be placed in the restraint chair, other than refusing to wear a safety smock; and
>
> 2) What was his demonstrated behavior that compelled staff to eventually release him?

The jail's documentation does not provide answers to either of these questions.

The jail also was not able to provide us with video documentation of any of the incidents. Our office requested the videos, along with other documentation, approximately four months after the incidents. By that time, we were told that the recordings had been deleted from the jail's server.

Our 2009 public report addressed video recording and retention of the records when restraint devices are used. At that time, we stated:

> 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.

We cannot comment on the jail's specific video recording practices in this case since we were not able to review them. However, we were told that the recordings consisted of stationary security cameras. In 2009, we found problems with other jails when they relied solely on stationary cameras because they did not fully capture the events of restraint device placement and use. These problems were evident in our review of the Webster County Jail's stationary cameras, detailed below. We do not object to the jail's use of stationary cameras to record the events, but in general, the jail should ensure that the camera has an unobstructed view of the inmate and the restraint device.

Our 2009 report also addressed retention of video, recommending that the best practice is to keep restraint chair recordings for at least two years, the statute of limitations for tort actions in Iowa.

Restraint Chair Procedures

The Emergency Restraint Chair instruction manual that the jail incorporates as policy specifically states that handcuffs and leg irons must be removed from a restrained inmate as soon as possible to prevent injury. Yet jail staff kept Jim in leg irons throughout the second restraint. Several incident reports indicate that Jim was able to free his legs when he was not restrained by leg irons. It is unclear whether the jail's restraint chair can effectively restrain an inmate's legs without deviation from the manufacturer's instructions.

When Jim was placed in the restraint chair for the third time, jail staff failed to follow their own restraint chair policy when they kept him restrained for more than five hours without direct

supervision of a medical professional. Although jail staff were present with Jim during this time, no doctor or nurse was involved after the initial two-hour time limit, as required by the manufacturer's Emergency Restraint Chair instruction manual.

Jail records pertaining to the second incident did not provide sufficient detail for our office to determine whether Jim was kept in the restraint chair longer than two hours without direct supervision of a medical professional.

Incident Reporting Required by Law

The Iowa Administrative Code requires that jails report specific incidents to the state's jail inspector at the Iowa Department of Corrections:

> **50.22(14)** *Incident reports*. Records shall be made to document the following:
> a. Use of force;
> b. Suicide/suicide attempts;
> c. Threats to staff, staff assaults, escapes, fires, prisoner abnormal behavior, any verbal or
> nonverbal references to suicide and self-mutilation.
> d. The state jail inspection unit of the department of corrections shall be notified within 24 hours of any death, attempted suicide, fire, escape, injury to staff or prisoners from assaults, or use of force and prisoner self-injuries. A copy of the investigative reports and other records shall be given to the state jail inspector upon request.

The Ombudsman discussed this requirement with Chief Jail Inspector Delbert Longley, who reported that restraint chair use is considered to be a use of force.[12] Chief Jail Inspector Longley confirmed that jails are required under Iowa law to report all restraint chair incidents to his office.

Even though placement in a restraint chair qualifies as a use of force, and Jim injured himself and made references to suicide and self-mutilation, there is no indication from the jail inspector's website that the jail had filed any reports on these incidents as required by law.

We previously advised the jail in 2017 and 2022 about this obligation. In response to the recommendation made to the jail in 2017, the jail filed several reports the following year. However, no reports were filed between 2019 and 2022. Following the Ombudsman's recommendation in 2022, the jail filed five reports in 2023, and seven so far in 2024.[13]

[12] Telephone call between Assistant Ombudsman Angela Long and Chief Jail Inspector Delbert Longley on April 29, 2024.
[13] https://jailstats.iowacorrections.us/IncidentReport/logon/.

Webster County Jail

In just over one year, our office received three complaints from inmates at the Webster County Jail about their placements in a restraint chair. In each case, our office requested and reviewed available incident reports, supervision logs, and the few security videos that were provided to us. We also conducted site visits and interviewed jail officials.

BACKGROUND FACTS: "PAUL"

Paul was first booked into the Webster County Jail on August 2, 2022, and released eight days later. His freedom did not last long, as he was re-arrested four days later and booked at the Webster County Jail, where he stayed for the next six weeks before being transferred to the Black Hawk County Jail. During his seven total weeks at the Webster County Jail, Paul was placed in the restraint chair 13 times.

First Jail Stay

A week after Paul arrived at the jail, staff moved him to a padded cell because he "kept hitting the intercom button stating he was having a heart attack."[14] Staff reported that they had to use a shock glove[15] during the move because he had threatened and attempted to assault an officer.[16] Soon after, Paul began throwing water at staff, pounding on the door, and yelling.[17] This led to staff placing him in the restraint chair until he calmed down approximately four hours later.[18]

Staff felt compelled to place Paul back in the restraint chair again four hours after his release, where he remained for another two hours. We did not receive the incident reports from this occasion, either. Video footage showed Paul covering the room's security camera with his hand and banging on the door while attempting to talk to staff.

Five hours after his release, Paul was placed in the restraint chair for a third time for yelling at staff, pounding on the door, and asking for food and water.[19] We received the incident report this time, which read:

[14] Incident report dated August 8, 2022, at 8:05 a.m., by Madeline Richardson states that Paul was placed in the padded cell that day at 7:38 a.m. The padded cell is used when an inmate is threatening or non-compliant and is typically used before a restraint chair. In the event the chair is needed, it is brought into and used in the padded cell.
[15] According to a news article dated November 13, 2021, regarding the Webster County Jail's use of the shock glove, the use of force device is described as "a pair of electric shock gloves known as Generated Low Output Voltage Emitter, or GLOVE, which is a safer and more sustainable alternative to using a Taser in close quarters like a jail cell." (https://www.messengernews.net/news/local-news/2021/11/shocking/).
[16] Undated letter from Webster County Chief Deputy Derek Christie in response to initial information request.
[17] The video footage provided did not include audio from the padded cell.
[18] According to the video footage, Paul was wheeled out of the cell while still in the restraint chair at 12:36 p.m., and the video skips to 12:52 p.m., when Paul walks back into the padded cell without the restraint chair present. The jail did not provide an explanation for the skips in the video footage.
[19] According to video footage, Paul was placed in the restraint chair at 11:35 p.m. on August 8, 2022.

> With [Paul's] continued behavior CO Jergens and I decided to call up a deputy to get [Paul] into the ERC for the third time today."[20]

However, the video footage shows that Paul was calm by the time staff entered the padded cell. He also cooperated without incident when directed to sit in the chair. He was released two hours later.

Paul's fourth placement in the chair came after he started "kicking and pounding on padded door while screaming."[21] The Ombudsman observed this behavior on the security video. However, we also observed him lying down and resting before staff brought the chair into the cell ten minutes later. At that point, Paul got up, got dressed, and sat in the chair of his own volition. We observed this same cooperative behavior when Paul was released for a bathroom break an hour later, even placing his arms in the chair's straps while staff were out of the room. This restraint lasted two hours and 45 minutes.[22]

Second Jail Stay

Four days after his release from the Webster County Jail, Paul was booked back into the jail and placed in the restraint chair on his second day. Over the course of three weeks, staff placed him in the chair on nine separate occasions. The length of each restraint varied considerably, from as little as 35 minutes to as long as 13 hours and 40 minutes.[23] In total, he spent almost 45 hours in the chair during his second stint at the jail.

Staff used the chair on Paul due to property destruction, assaults on staff, threats, yelling, and insulting staff. In one instance that resulted in a seven-hour restraint, Paul had thrown urine at an officer who had entered the padded cell to remove a clothing item that Paul had placed over the security camera. Staff decided to place him for this incident instead of simply removing the item from the camera and cell. During his placement in the chair, Paul reportedly kneed an officer in the face. We could not verify this occurred, as the clothing item was still covering the room's camera.

Another notable restraint lasted over nine hours. It was initiated when Paul made physical threats toward staff if they "did not have a cleaning cart ready for him in 10 minutes."[24] Staff justified the restraint "in order to prevent the harm of others or himself due to his erratic behavior."[25]

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[20] Incident report dated August 8, 2022, at 11:47 p.m., by Kyle Shook.
[21] According to video footage, Paul was placed in the restraint chair at 9:21 a.m. on August 10, 2022.
[22] According to video footage, Paul was released from the restraint chair at 12:03 p.m. on August 10, 2022.
[23] According to video footage, Paul was making vulgar, inappropriate comments to staff while in the "North Detox" cell around 5:30 p.m. on August 21, 2022. Paul then attempted to cover the camera, which resulted in him being escorted out of the cell. The next available camera footage is from the padded cell, and begins at 6:21 p.m., with Paul already in the restraint chair. The video ends at 10:26 p.m. and does not begin again until 12:45 a.m. the next day (August 22), with Paul still in the chair. Paul remains in the restraint chair until 8:02 a.m. In addition to missing video footage, the Webster County Jail failed to provide supervision logs from the start of the chair use at 6:21 p.m., on August 21, until 12:30 a.m. on August 22.
[24] Incident report dated September 7, 2022, at 2:04 a.m. by Jonathan Rodriguez.
[25] *Id.*

Despite the length of time involved during this restraint, the placement and use of the chair was not video-recorded at any point. The supervision logs do not describe Paul's demeanor throughout the chair's use or document when he was released from the chair. What they document are the two occasions when his straps were checked, his three bathroom breaks, and that he was provided a meal at one point.

Mental Health Assessment

The Webster County Jail did not provide our office with Paul's mental health screen following his initial booking on August 2, 2022, but they did provide the screen from his second booking on August 14, 2022.

The document, titled "mental disability/suicide intake screening," includes Paul's answers to questions pertaining to his mental health. According to the intake screening, Paul answered "No" to risk factors relating to suicide, hearing noises/seeing things, depression, and anxiety. Further, he answered "No" to the medical history question about whether he was on any medication at that moment.

The jail did not make a referral for mental health services at any point until after Paul's 13th restraint chair placement, which was a full month after his first placement. It had done so after Paul had requested an evaluation for "diabetes, schizophrenia, ADHD, hypertension, and bipolar." He was seen by a provider three weeks after his request and started medications the next day.

Explaining the cause for the delay in a mental health referral, Correctional Officer Brody Goodman shared with our office that Webster County Chief Deputy Derek Christie had ordered jail staff not to allow Paul out of the building due to his threatening and assaultive behavior toward staff.

Following the mental health assessment and the start of his medication, the jail reported no additional use of the restraint chair on Paul during the rest of his stay.

BACKGROUND FACTS: "RYAN"

Ryan was placed in a restraint chair in mid-September 2022, presumably after assaulting the interim jail administrator. Ryan complained that he was not allowed any bathroom or stretching breaks during his eight-hour restraint.

Our review of available jail documents could not identify any breaks from the chair, even though a supervisory log described Ryan as "calm" after four hours in the chair. He remained in the chair for an additional three and a half hours.[26] Ryan admitted to our office that he was resistant and had yelled for over an hour when he was first placed in the chair, but had quieted down after that point.[27] He claimed the acting jail administrator told him the Sheriff had ordered he be kept

[26] Incident report dated September 12, 2022, by Brody Goodman.
[27] Interview with Ryan on May 11, 2023.

in the chair for eight hours.[28] We were told by jail staff that no such order had been made; only that Ryan should remain in the chair so long as he was making threats of violence.[29]

This was not the only time we had heard about staff being directed to hold an inmate in the restraint chair for a set time. The Ombudsman also discovered that staff were directed to place another inmate in a restraint chair for a specified amount of time, which will be discussed in the next section.

Throughout Ryan's time in the chair, we found no indication that he had been seen by medical or mental health staff.

BACKGROUND FACTS: "JACK"

Jack was placed in the restraint chair on seven occasions within a three-week period between August 24 and September 13, 2023.[30] He stated that he was placed in the restraint chair because he had covered his camera and kicked his cell door. However, he claimed he had ended his outburst and had calmed down by the time staff placed him in the chair.

We informed Jail Administrator Gargano a couple of weeks after Jack's restraint that we would soon be requesting a copy of the video. Gargano told us that all restraint chair incidents were recorded and he was proactively saving the footage.

We formally requested video footage and other documentation the next day. We eventually received the incident reports, supervision logs, and video for two of the seven occasions – September 10 and September 13. Video of the placement and restraint use was missing for the other five incidents.

The first restraint chair use occurred on August 24, after Jack threw his shoes and toilet paper and stomped on his desk. We did not receive video of that incident, but the jail's incident report states that Jack was placed in the chair "as he's been given multiple warnings the last few days and has continued to violate the rules."[31]

Jack was placed in the restraint chair a second time four days later after he threw his lunch tray, kicked the door, and flooded his cell. Although the jail incident report indicates Jack was placed in the restraint chair at 12:53 p.m., we did not receive video of this incident, nor did we receive any other documentation that provides the time Jack was removed from the chair.[32]

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[28] *Id.*
[29] Conversation during jail tour on September 26, 2023.
[30] According to supervision logs, incident reports, and other communication by the jail, Jack was placed in the restraint chair on the following dates in 2023: August 24, August 28, September 10 (two occasions), September 11, and September 13 (two occasions).
[31] Incident report dated August 24, 2023, by Shayla Baschke. The incident report indicates that Jack was placed in the restraint chair at 10:10 p.m. and was moved back to "A1" at 10:40 p.m. However, a document from the jail titled, "Jail Shift Log" indicates that Jack was removed from the restraint chair at 11:34 p.m.
[32] Incident report dated August 28, 2023, by Shayla Baschke.

A third use of the restraint chair appears to have occurred on September 10, but we did not receive video of that incident. [33] Later that night, Jack was placed in the chair again when he "continued to kick his door."[34] Staff removed Jack from the chair an hour later when he agreed to wear a safety smock.[35]

Minutes later, he removed the smock, clogged the toilet, and covered the security camera in his cell. Jack was placed back in the chair, naked, in the heavily trafficked booking area before being moved to a cell for the next five hours.[36] The only covering placed on him was a spit mask to prevent him from spitting on the wall. Jack did not receive any bathroom or stretching breaks while in the chair, though staff did offer him water on four occasions, which he declined.

After four hours in the restraint chair, Jack informed staff that he felt sick. The video shows him shifting in the chair – still naked – in what appeared to be physical discomfort. He did not respond when jail staff asked if he would continue to kick the door once released. Jack remained in the chair for another hour and a half.

Six hours after his release, Jack was placed in the restraint chair a fifth time.[37] Details about this incident are lacking because the jail did not provide our office with the incident report or video footage.

Jack's sixth restraint occurred two days later after he covered the security camera. Five officers escorted him out of the cell, where staff reported to our office that he was taken to a cell referred to as "North Detox" and placed in the restraint chair for 30 minutes.[38] However, we were not provided video of this restraint.

Jack's last restraint – his seventh during his stay at the jail – occurred later that evening when he again covered his camera and made threatening remarks to staff.[39] Video from the North Detox cell captures Jack requesting toilet paper and saying, that it will be a "long night" for staff if he is not let out of the cell for his hour out. Twenty minutes later, he asks for his hour out again, which is followed by staff entering his cell to place him in the restraint chair.[40]

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[33] Supervision logs indicate that Jack was placed in the restraint chair at 9:47 p.m. on September 10, and was listed as "out of ERC" at 11:42 p.m. on September 10. The Ombudsman noted that the incident report dated September 10, 2023, at 9:22 p.m., states that Jack was placed in the restraint chair at 9:42 p.m.

[34] Incident Report dated September 10, 2023, at 11:56 p.m., by John Simpson.

[35] Jail records do not say, and it is not clear to us, what purpose the safety smock was intended to serve in this case. A safety smock is typically used to prevent an inmate from using their regular jail-issued clothing for self-harm by strangulation. We have found no supporting evidence that Jack was suicidal.

[36] Jack was in the booking area for two minutes before he was moved to a cell.

[37] According to a jail document titled, "Restraint Chair Log Report," Jack was placed in the restraint chair at 11:18 a.m. on September 11, 2023. There is no documentation concerning the length of time Jack was in the chair on this occasion.

[38] Telephone call with Jail Administrator Gargano on January 29, 2024.

[39] Incident Report dated September 13, 2023, at 8:35 p.m., by Griffin Hein.

[40] Jack is placed in the chair at 9:07 p.m. on September 13, 2023.

Jack was initially agitated after his placement, but was calm 25 minutes later when the following exchange occurred:

> **Jack**: If I'm cool, can I get out of this chair?
>
> **Jail staff**: Let me go see if it has been long enough, and I'll get you out.

About 30 minutes later, jail staff re-enter the cell and the following interaction occurs:

> **Jail staff**: I've got an option for you; you may not like it. This is directly from Mark.[41] Mark said you can either go to A and you'll be able to have a half hour out there and you'll have a phone there, but you're going to have to stay in A.
>
> **Jack**: No.
>
> **Jail staff**: Then you're going to have to stay in the chair.
>
> **Jack**: Just take me out of the chair.
>
> **Jail staff**: I can't get you out of the chair. You're going to have to either go back to A or stay in the chair for the duration.
>
> **Jack**: For the duration of what?
>
> **Jail staff**: For the rest of the minimal amount we are supposed to have you.
>
> **Jack**: What's the minimal?
>
> **Jail staff**: Two hours.
>
> **Jack**: Two hours? How long has it been?
>
> **Jail staff**: I think it's been 40 minutes.
>
> **Jack**: Okay, an extra hour and 20 minutes. As soon as I get out, I'm going to take a 30-minute break.

Jack spent a total of three and a half hours in the restraint chair. Staff informed Jack at the time of his release that he was screaming the whole time he was in the chair, but we observed Jack to be calm and level-headed while he explained why he was upset and what he needed from staff.

He did become upset prior to being released from the chair, commenting that his straps had not been checked and he had not been offered water. We found this to be an accurate statement, and that he had not been released at any point during his restraint for a bathroom or stretching break. Jack was given a warning as staff left the cell that he would go back into the restraint chair if he kicked or punched the door again.

[41] The Ombudsman believes this to be Jail Administrator Mark Gargano.

ANALYSIS

Based on the available records, the Ombudsman found that the Webster County Jail failed to follow the Iowa Administrative rules, their own policies, and best practices articulated by the Emergency Restraint Chair manual.[42]

Additionally, the Ombudsman also analyzed the jail's actions in light of the use-of-force standards promoted by state and federal courts. The following sections analyze the jail's actions related to specific rules, policies, guidance, and case law, as well as best practices as determined by our office.

Overview of Record-Keeping Process

We must start with an overview of the jail's record-keeping process. According to Jail Administrator Mark Gargano, an incident report should be created each time an inmate is placed in the restraint chair.[43] The incident reports provided by the jail included the reporting officer's name, the date, the time, and a description of the incident.

Currently, jail staff monitor inmates' time in the restraint chair through a device called the Guardian RFID.[44] This handheld device allows staff to record the date, time, and location of a check, as well as what is observed. Jail Administrator Gargano reported that the Guardian RFID device will also alert staff when it is time to check on an inmate.[45]

However, the Guardian RFID device was not in use in 2022, the year two inmates reported concerns about the restraint chair. At that time, the jail used paper supervision logs to document each check. The logs were passed between officers during the shift and during shift change. The paper supervision logs reported the date, time, inmate activity, and "other comments." The "other comments" section included information concerning when an inmate was placed in or removed from the restraint chair, as well as an inmate's behavior during the check.

The jail also monitors inmates' time in the restraint chair through the security cameras in the cell. According to Jail Administrator Gargano, the camera footage is monitored at all times by an officer in the control center.

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[42] Although the Webster County Jail used the Emergency Restraint Chair with the three inmates mentioned in this report, the jail reported that the manual was unable to be located "likely due to the age of the chair." The Ombudsman noted that the Emergency Restraint Chair manual provides a clear warning on the front page:

> Use of the Emergency Restraint Chair without first reading and thoroughly understanding the instructions could cause injury or death.

As such, the jail's use of the device notwithstanding staff's inability to access and review the manual is concerning.

[43] Email to Ombudsman on August 15, 2023. *See also* Webster County Jail Policy 07.04, dated June 13, 2017, that requires staff to "log and report information regarding the use of the chair."

[44] According to an online resource, RFID stands for "Radio Frequency Identification Chip." https://www.corrections1.com/products/police-technology/software/jail-management/articles/guardian-rfid-brings-offender-management-into-the-21st-century-BbDoZv0ZD7oDiPl7/.

[45] Conversation during jail tour on September 26, 2023.

At the time of the 2022 complaints, the jail only had stationary cameras in select cells.[46]

Jail Administrator Gargano reported that in 2023, the jail installed a new camera system with higher-resolution cameras that have features such as zoom and 360-degree views. Gargano stated that, with the new camera system, additional storage is allowed, and the jail has been saving video footage related to restraint chair incidents.[47]

Mental Health Screening and Referral

A. Admission Process

Under Iowa law, jails are required to have a written plan to provide prisoners "access to services for the detection, diagnosis and treatment of mental illness."[48] It is imperative that inmates who screen positive for potential mental illness are assessed by 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/or observations of the inmate that show signs of mental illness.

We advocated in 2009 for jails to implement the Brief Jail Mental Health Screen. This form can be used by staff even if they have no formal mental health training. It helps to identify individuals who may need the attention of a mental health professional for further evaluation and treatment.

The form, which was not utilized by the Webster County Jail, may have been useful to assess the inmates' mental health needs. If the inmates had been referred and received further evaluation, the jails may not have only been able to curb or reduce the use of the restraint chair but may have avoided the documented assaults on jail staff.

The Webster County Jail utilizes a basic medical intake form for new admissions. According to the jail staffer who handles the coordination of mental health services for inmates, the jail's current intake form does not trigger an evaluation if the inmate answers a question in a certain way, as the Brief Jail Mental Health Screen does. The jail staffer indicated that it would be beneficial to utilize the Brief Jail Mental Health Screen, as the initial screening does not always result in the inmates sharing accurate information about their mental health.

There may be a number of reasons why the initial screening does not identify a mental health or medical condition. The inmate may be affected by drugs or alcohol at the time of the screening, the environment may not be conducive to opening up about personal health information, or an inmate may just distort the truth or fail to communicate effectively.[49]

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[46] *Id.*
[47] *Id.*
[48] IOWA ADMIN. CODE r. 201—50.15(6)(d).
[49] *See* Correctional Health Care Report, Intake Health Screening: Truth or Consequences? By Catherine M. Knox, Spring 2024.

Paul's intake screening did not identify a mental illness. However, the jail had multiple opportunities to realize Paul may have been suffering from a mental health crisis, including the three separate restraint chair incidents in a single day, his rapid re-entry to the jail after his initial release, and the additional restraint incidents that followed. That all came before Paul made an explicit request for an evaluation for schizophrenia, attention deficit hyperactivity disorder, and bipolar disorder. Still, there was a three-week delay following his explicit request before he saw a medical provider. While waiting for the evaluation, Paul was involved in numerous incidents and was placed in the restraint chair a total of eight times.

Jail Administrator Gargano explained that a three-week wait to see a mental health provider was typical when Paul was at the jail. However, he indicated that updates to the jail's processes have shortened the length of time an inmate waits for an evaluation.[50]

Correctional Officer Brody Goodman told us that another hindrance was the Chief Deputy's order to not allow Paul out of the building due to his threatening and assaultive behavior towards staff. This order prevented Paul from being scheduled for an offsite mental health evaluation or other treatment.

When jails ignore the signs and symptoms of severe mental illness, not only are there risks of injury to the inmate and staff, but the jails also risk violating the inmate's Eighth Amendment rights.[51] Additionally, failure to provide prescribed mental health medication may constitute liability for deliberate indifference.[52]

The Ombudsman's 2009 restraint chair report emphasized the importance of recognizing the signs and symptoms of mental illness and responding to them appropriately. This may involve obtaining a mental health professional's advice as to when an inmate needs to be transferred to another facility or when the jail should initiate civil commitment proceedings. The report highlighted an example of the changes with an inmate's behavior when, at the Ombudsman's urging, a jail sought a civil commitment for a highly aggressive inmate who had been placed in a restraint chair for long periods of time.[53]

Similarly, following Paul's evaluation and receipt of the mental health medication, there were no

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[50] Jail Administrator Gargano reported that the jail now can utilize a service called Integrated Telehealth Partners, or ITP, which provides mental health evaluations and services more efficiently through telehealth medical consultation. However, jail staff reported that ITP has only been used on a few occasions, as inmates typically already see a provider in the community or need to continue to see a provider in the community once released. Further, jail staff reported that only one person is trained to set up appointments through ITP, so this is a hindrance for utilizing this option when the staff person is away from the jail.

[51] Federal courts have found that under the Eighth Amendment, a correctional facility cannot ignore the mental health care needs of inmates. Additionally, 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 (*See Hartsfield v. Colburn*, 491 F.3d 394, 396 (8th Cir. 2007).

[52] *See Dadd v. Anoka County*, 827 F.3d 749, 757 (8th Cir. 2016), in which a court found that "when an official denies a person medication that has been prescribed, constitutional liability may follow." *See also Phillips v. Jasper Cnty. Jail*, 437 F.3d 791, 796 (8th Cir. 2006), in which the court found "[t]he knowing failure to administer prescribed medicine can itself constitute deliberate indifference."

[53] Investigation of Restraint Device Use in Iowa's County Jails, February 19, 2009, https://www.legis.iowa.gov/docs/publications/CI/9966.pdf, page 79.

further restraint chair uses during his time at the Webster County Jail, or following his transfer to the Black Hawk County Jail on September 26, 2022.[54]

B. Central Iowa Community Services

We interviewed two officials from Central Iowa Community Services (CICS), the administrative entity in charge of the mental health region that includes Webster County. Brittany Baker is the Justice Involved Service (JIS) Coordinator for CICS in Webster and Wright counties. While the JIS coordinator role has served the counties for the past decade, Baker was provided office space in the Webster County Law Enforcement Center just in the last year.

Baker described her role to the Ombudsman as important to the "justice-involved" inmates who are overwhelmed with a legal proceeding and are struggling with their mental health and substance abuse issues.[55] JIS coordinators such as Baker can provide support to those inmates to determine what services they may need and how to obtain those services.

Among other duties, Baker coordinates medical and mental health service referrals for inmates. Her involvement is not limited to requests submitted by jail staff; if she hears an inmate being disruptive, she inquires about the inmate and participates in the de-escalation process. In addition, CICS offers free de-escalation training for any law enforcement or jail staff interested in taking it.[56]

We only became aware of CICS and Baker's involvement with the jail late in our investigation. We found no reference to her in documents regarding any of the three cases mentioned in this report. We learned that Baker had seen both Paul and Jack when they were in the jail. She spoke to Paul a week after he was admitted to the jail but was otherwise unaware of his restraint incidents until we asked about her involvement. She was surprised to hear of his 13 restraints, as she had not been contacted before, during, or after any of the restraints.

Her preference would have been to be informed *before* the restraint chair was used to see if she could have de-escalated the situation. Even if she was not available, she told us she could have assessed what services Paul needed.

Baker only saw Jack at his request, prior to his seven restraints. She referred him to mental health services, but never heard back from jail staff on whether those were set up.

Baker and Jen Sheehan – CICS's Planning and Development Officer – are well-aware and supportive of the Brief Mental Health Screen for new jail admittees. Sheehan shared with us that it "would be a perfect world" if the Brief Jail Mental Health Screen was universally used and the

[54] According to Black Hawk County Jail Administrator Nate Neff, Paul was never placed in the restraint chair following his transfer on September 26, 2022.
[55] Email to Ombudsman on June 5, 2024.
[56] According to CICS Planning and Development Officer Jen Sheehan, CICS contracts with Solution Point Plus for trainings, including a crisis intervention training (CIT). According to Sheehan, CICS region reimburses training attendees from the CICS region for the wages, mileage, lodging, and meals.

scores triggered an automatic referral to services.[57] Baker shared similar sentiments, emphasizing the need to make the Brief Mental Health Screen mandatory based on her experiences with jail staff:

> I think this would be great if it could be part of the booking process for every inmate and be available for the JIS Coordinator to review. Completing this and having [it] available to the JIS Coordinator to review will help to ensure each inmate who reports struggling is seen[;] I witness jail staff being too busy and overwhelmed to be willing to complete another document, it would need to be mandatory.[58]

However, they told us that in their experience, jails are resistant to incorporating the Brief Mental Health Screen because staff have questioned its accuracy and believe it takes too much time to fill out. Sheehan and Baker shared that they believe the only way to get jails to use the Brief Jail Mental Health Screen is if it were mandated.

Decision to Place Inmates in Restraint Chair

Iowa law requires that use of restraint devices be restricted to those circumstances when an inmate is an imminent risk of harm to themselves or others or is jeopardizing jail security.[59] The Ombudsman interprets Iowa law to mean the risk of harm must be immediate and ongoing.

A. Inmates' Behavior Prior to Restraint Chair Use

On August 10, 2022, Webster County Jail officials entered Paul's cell 10 minutes after he was pounding on the door. During those 10 minutes, however, Paul appeared to have calmed down and was seemingly asleep when staff entered with the restraint chair. There was no indication that Paul was still causing problems at the time he was placed in the restraint chair.

We observed the same approach by staff with Jack. Nearly an hour had passed since he had kicked a door and threatened a "long night" for staff on September 13. Before his restraint, Jack appeared to rest for 20 minutes and then asked staff again when he could get his hour out. Although Jack was agitated about not being let out, he did not kick the door or make threats in the moments immediately before his placement in the chair.

The Webster County Jail policy provides additional clarification on the circumstances that warrant restraint chair use. Policy provides that staff may use the chair in emergencies in the following situations:

1. When an inmate has demonstrated threatening, uncooperative, violent, combative, aggressive, or uncontrollable behavior;
2. To prevent self injury; injury to others or property damage when other techniques have been ineffective in assisting the inmate regain control.

[57] Email to Ombudsman on May 17, 2024.
[58] Email to Ombudsman on June 5, 2024.
[59] IOWA ADMIN. CODE r. 201—50.13(2)(f).

3. Upon recommendation by a psychiatrist, physician or other health care professional; or
4. As a means of moving a combative, violent, or uncooperative inmate safely from one section of the facility to another.[60]

B. Property Damage

On two occasions, Paul was placed in the restraint chair following incidents involving property damage. First, Paul was placed in the restraint chair after he kicked and broke a glass door on September 1, causing over $2,000 in damage. Paul was also placed in the restraint chair on August 20, after he tore up pieces of padding. During the Ombudsman's tour of the jail, staff shared that Paul had caused $26,000 in damages following his destruction of the padded cell.

However, according to a criminal complaint filed on August 20, 2022, there was tape on the wall that was holding up padding that was previously destroyed by a different inmate. Video footage that we reviewed shows that the damage to the padded cell predated Paul's placement in the cell on August 20. Footage from August 10 shows a different inmate – not Paul – pulling the padding off the cell wall around 11:00 p.m.

It is noteworthy that this other inmate was not placed in the restraint chair as a result of damaging the wall, and he remained in the padded cell through the duration of the evening. Only on the following day was that inmate placed in a restraint chair, for what appears to be him covering the camera on two occasions.

The Ombudsman questions the jail's policy allowing the restraint chair use beyond what is articulated in Iowa law. Iowa Administrative Rule 201—50.13(2)(f) specifies that restraints can only be used when an inmate is "a threat to self or others or jeopardizes jail security." Contrary to Iowa law, the jail's policy seemingly expands the bases for restraint chair use to include when the inmate's behavior is "threatening, uncooperative, violent, combative, aggressive, or uncontrollable."

When questioned on the authority to use the restraint chair due to property damage, a former jail employee indicated that the property damage must be coupled with injuries to the inmate or others to justify using the restraint chair. The former jail employee reported to the Ombudsman that property damage, by itself, would not be appropriate justification for the restraint chair use.[61]

Jail Administrator Gargano justified the use of the restraint chair by citing Iowa Administrative rule 50.21(2), which reads:

> The use of physical force by staff shall be restricted to instances of justifiable self-protection, the protection of others or property, the prevention of escapes or the suppression of disorder, and then only to the degree necessary to overcome resistance. Corporal punishment is forbidden.[62]

[60] Webster County Jail Policy 07.04, dated June 13, 2017.
[61] Interview with former jail employee on August 3, 2023.
[62] IOWA ADMIN. CODE r. 201—50.21.

However, this rule pertains to discipline and grievances, not restraint devices.[63]

C. Punishment for Disruptive Behavior

We identified a number of occasions when Webster County Jail staff employed the restraint chair for simple verbal outbursts that were unaccompanied by a threat or actual harm to self or others.[64] Paul had been placed in the restraint chair after he "started yelling at staff and pounding on the doors because he wanted water and food." On another occasion, he was placed in the chair because he "was kicking and pounding on padded door while screaming."[65]

Jack was placed in the restraint chair for similar reasons when he "continued to kick his door."[66] On another occasion, Jack was placed in the chair after kicking the door and throwing his shoes and toilet paper.[67] Staff noted in the incident report that Jack had been given "multiple warnings" but he "continued to violate the rules" so it was determined he would be placed in the restraint chair.[68]

Iowa law provides for when a restraint device may be used, limited to when an inmate is "a threat to self or others or jeopardizes jail security."[69] It should not be used as a form of punishment.[70] The jail's policy conforms for the most part with Iowa law. Some of its provisions may be too vague and leave too much to interpretation that can run afoul of the law, including when an inmate is "uncooperative."

In the instances we just cited, the inmates were not a threat to themselves or others. The incident reports do not state how yelling or pounding on the door created a security risk. The padded cell, where the inmates had been housed, is designed to receive impacts and reduce the risk of self-harm. It makes little sense to place an inmate in a restraint chair for engaging in behavior that is mitigated by the padded cell. It is also worth noting that the restraint chair was not intended, and is incapable, to be used to prevent someone from engaging in uncooperative behavior, such as yelling or making threats.

Instead, the restraint chair in these instances appears to have used as a form of punishment for the inmates' behavior.[71] This particularly stands out on the occasions when the inmate's behavior

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[63] The Ombudsman believes that if it was intended that property damage be a justification for restraint chair use, the "protection of others or property" language from Iowa Administrative Code r. 201–50.21 would have also been included in the section of the rules pertaining to restraint devices (201–50.13(2)(f)).

[64] See incident report dated August 8, 2022, at 11:47 p.m., by Kyle Shook, which states that Paul was placed in the restraint chair due to his "continued behavior."

[65] See incident report dated August 10, 2022, at 9:22 a.m., by Madeline Richardson.

[66] See incident report dated September 10, 2023, at 11:56 p.m., by John Simpson.

[67] See incident report dated August 24, 2023, at 9:15 p.m., by Shayla Baschke.

[68] *Id.*

[69] IOWA ADMIN. CODE r. 201—50.13(3)(f).

[70] IOWA ADMIN. CODE r. 201—50.21. See also Emergency Restraint Chair instruction manual, issued on February 10, 2001.

[71] See letter from Bill Lann Lee, Acting Assistant Attorney General, Civil Rights Division, to Ryan S. Quirk, Black Hawk County Board of Supervisors, Chair (Jan. 4, 1999): "We find . . .that the Jail at times uses the chair for punitive purposes when inmate control is not an issue. For example, the chair has been used to punish inmates who

had subsided, and he had calmed down but was placed in the restraint chair anyway. As one corrections expert commented:

> Mechanical restraints are not about what has occurred, they are about what is occurring now. When they are about the past, it is punishment.[72]

When asked whether any of the restraint chair uses were strictly to punish Paul, Goodman reported that perhaps the instances in which he was in the chair for shorter periods of time could have been seen as punishment. However, Goodman believed the restraint chair uses were all justified based on Paul's behavior.[73]

The Ombudsman found that Goodman was involved in the vast majority of Paul's restraint chair incidents. Goodman remarked that Paul did not especially like him, and he was often the subject of Paul's verbal outbursts and assaults. Goodman was the victim of Ryan's assault on one occasion that led to use of the restraint chair.

According to the jail's policy, "only the Jail Administrator, Shift Supervisor, Senior Officer, or their designee can authorize the restraint chair use."[74] The Ombudsman notes that Goodman, as interim Jail Administrator at the time, had the authority to authorize the restraint chair for Paul and Ryan; however, he was also the subject of the verbal threats and physical assault, which could have potentially blurred the lines of using the device as a form of punishment.

D. Less Restrictive Alternatives – The Padded Cell

Iowa law provides that four- and five-point restraints shall be used only when other types of restraints have proven ineffective.[75] The Webster County Jail's policy echoes Iowa's law, allowing for the restraint chair "when other techniques have been ineffective in assisting the inmate regain control."[76] A strict reading of the law and jail policy would mean that jails must first attempt a litany of other types of restraint, and only resort to a restraint chair when those alternatives have proven ineffective. We do not believe this interpretation is reasonable or workable.

We do not expect jails to test alternative types of restraints to determine their effectiveness before resorting to the restraint chair as would be required under a strict reading of the law; however, jails should at least consider alternative restraints prior to the restraint chair's deployment. In Webster County's case, the jail employs a padded cell where it gives the inmate a

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are verbally disrespectful to officers and inmates who inappropriately call out to other inmates from their cells. Use of the chair in this manner constitutes excessive force."

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

[73] Based on the information contained in incident reports, Paul's behavior that the jail determined warranted the restraint chair use included verbal outbursts, kicking/pounding the padded cell door, covering the camera, making threats and, on one occasion, throwing urine at and assaulting an officer.

[74] Webster County Jail Policy 07.04, dated June 13, 2017.

[75] IOWA ADMIN. CODE r. 201—50.13(2)(f).

[76] Webster County Jail Policy 07.04, dated June 13, 2017.

chance to calm down.[77] As a general matter, we support this alternative. However, the padded cell can itself be subject to abuse and have adverse effects on an inmate.

Paul was placed in the padded cell on numerous occasions during his stay at the jail, including a stint for two and a half days. He was released on only one occasion for an hour and on another occasion for 30 minutes, and two other times for only a few minutes each. During our review of the security video, we observed Paul become increasingly agitated during his prolonged stay in the padded cell. He paced the cell often and took very brief rest breaks.

Jail Administrator Gargano told us during the tour of the jail that it is not uncommon for inmates to be placed in the padded cell for several days at a time. During our first tour, an inmate was housed in the padded cell and had been there for several days due to his continuous erratic and threatening behavior.

Our 2009 report addressed on the topic of placing mentally ill inmates in isolation:

> 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. 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." [78]

In a letter to the Ombudsman, Chief Deputy Christie reported that "[Paul] has been one of the most difficult inmates that we've encountered." [79] While the candor regarding the difficulties the jail experienced with Paul is appreciated, we considered whether Paul's time in isolation – coupled with the multiple restraint chair uses – perhaps exacerbated his mental illness, and in turn, led to further violent and destructive behavior.

Despite the padded cell being used as a less restrictive alternative to four- and five-point restraints, staff still placed Paul in the restraint chair on four occasions during his stay in the cell.

While the padded cell can offer a less restrictive alternative to the restraint chair, it is not without its limitations. The padded cell is not a substitute for mental health treatment and may in fact exacerbate mental health and aggression in an inmate, making a restraint chair use inevitable.[80]

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[77] Conversation during jail tour on September 26, 2023.
[78] Investigation of Restraint Device Use in Iowa's County Jails, February 19, 2009, https://www.legis.iowa.gov/docs/publications/CI/9966.pdf, page 64, citing *Buckley v. Rogerson*, 133 F.3d 1125 (8th Cir. 1998).
[79] Undated letter from Webster County Chief Deputy Derek Christie in response to initial information request.
[80] Another issue the Ombudsman found was that jail staff placed Paul in the restraint chair on a number of occasions after he covered his camera. We found that jail staff reacted to Paul covering the camera by immediately putting him

E. Restraint as a Supplement for Treatment and Staffing Issues

Jails should not use the restraint chair to address a mental health issue. A report issued by Disability Rights Iowa in 2016 noted that some jails resort to the restraint chair when they lack mental health training.[81] However, this can have counterproductive results since "restraint, use of force, and isolation may escalate a situation or cause further significant and lasting mental health deterioration for the individual."[82]

The U.S. Department of Justice (DOJ) investigated a New Jersey county jail's use of the restraint chair to address mental health emergencies, and made the following finding:

> We uncovered numerous cases in which CCJ officers handled mental health emergencies by improperly resorting to the use of restraints, particularly by restraining inmates for too long without proper assessments, and failing to refer inmates to medical and mental health professionals at the jail, who could provide appropriate treatment or transfer the inmates to a hospital for further psychiatric care.[83]

In an effort to compare the Webster County Jail's practices to another county jail's, the Ombudsman contacted the Johnson County Jail and requested information on its protocols and practices. When we questioned whether the Johnson County Jail restrains inmates in the chair for being loud or verbally abusive, Jail Administrator Captain John Good replied:

> We approach each encounter with a holistic perspective, considering the full context to determine the appropriate course of action. For instance, when confronted with someone who is being loud and screaming, we carefully assess the situation, considering the specific content of their statements. The response would differ depending on whether the person is threatening self-harm or violence towards others. It is crucial to treat each encounter as distinct, as a one-size-fits-all approach is not suitable.

Webster County Sheriff Luke Fleener told the Ombudsman that Paul was a "pain in our butt."[84] Correctional Officer Brody Goodman and Sgt. Madeline Richardson shared similar sentiments during our tour of the jail, describing Paul as a very difficult inmate to manage because of the threats and violence he displayed towards staff.

Chief Deputy Christie told us during the tour of the jail that the jail was severely understaffed during Paul's and Ryan's stays. According to Chief Deputy Christie, the jail was down to eight

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in the restraint chair, instead of removing the items from the cell that were being used to cover the camera. We believe a less restrictive alternative would have been to remove the items before resorting to the restraint chair.

[81] Disability Rights Iowa, *In Jail and Out of Options*, *An Examination of the Systematic Issues affecting the Housing and Treatment of Iowans with Mental Illness in County Jails*, December 2016.

[82] *Id.*

[83] U.S. Department of Justice's Investigation of the Cumberland County Jail (Bridgeton, New Jersey) (January 14, 2021), *available at* https://www.justice.gov/opa/press-release/file/1354646/download.

[84] Telephone conversation with Sheriff Luke Fleener on September 20, 2022.

staff following the departure of the former jail administrator in July 2022, even though the jail at full staff is with 22 employees and a normal shift has at least six-to-seven jailers scheduled. According to Jail Administrator Gargano, the jail was close to shutting down in 2022 due to the understaffing.[85]

The Ombudsman contemplated whether, because of the understaffing, the jail had the manpower to appropriately address and respond to Paul's constant issues. However, when questioned whether the understaffing had any role in the decision to place Paul in the restraint chair on such a frequent basis, Goodman indicated that it did not. On the contrary, Goodman explained that the understaffing caused more difficulty for placing any inmate in the restraint chair, due to the number of staff required to assist with the placement and removal from the chair. As such, Goodman reported that the jail may have been less likely to use the restraint chair.

Goodman also told us that jailers would make decisions on whether to place inmates in the restraint chair at times when the jail was short-staffed. We note that this would have been contrary to the jail's policy that requires "only the Jail Administrator, Shift Supervisor, Senior Officer, or their designee can authorize the restraint chair use." [86]

F. Medical or Health Concerns

The Webster County Jail's policy requires that staff consider an inmate's "medical or health care concerns" when placing an inmate in the chair.[87] The jail's policy follows Iowa law that requires restraint guidelines, to consider "an individual's physical and health condition."[88]

Paul was diagnosed with hypoglycemia on September 1, 2022. The medical provider's after-care plan gave instructions to have his blood sugar levels checked and provide additional food when necessary.[89] Following this diagnosis, Paul was in the chair on numerous occasions, including for over two hours on the same day as his appointment. He was placed in the restraint chair on two other occasions, one for nearly seven and a half hours.

The Ombudsman questioned whether the Webster County Jail considered Paul's September 1, 2022, medical diagnosis of hypoglycemia when determining whether to place him in the restraint chair. Brody Goodman reported that the jail does take certain medical conditions into consideration – it was noted that a seizure disorder was considered for another inmate – but, according to Goodman, jail staff did not take Paul's hypoglycemia into consideration prior to placing him in the chair, or while he was in the chair.[90]

The jail provided the Ombudsman with Paul's medication chart, which did not state that Paul's blood sugar levels were checked at any point while he was in the restraint chair following the

[85] Telephone conversation with Jail Administrator Gargano on August 21, 2023.
[86] Webster County Jail Policy 07.04, dated June 13, 2017.
[87] *Id.*
[88] IOWA ADMIN. CODE r. 201—50.13(2)(f)(3).
[89] Paul was seen by a provider at the Community Health Center on September 1, 2022, and the clinical visit summary included information pertaining to Paul's care plan and instructions for meals and checking blood glucose levels.
[90] Conversation during jail tour on September 26, 2023.

hypoglycemia diagnosis on September 1, 2022. By not checking his blood sugar levels, the jail placed him at risk of suffering a medical emergency.[91]

Restraint Chair Use

The Ombudsman found numerous issues with the circumstances surrounding the placement of the inmates in the restraint chair, including failing to: video record placement and use of the restraint chair; utilize required number of staff; document all actions associated with restraint chair use; and perform periodic checks and breaks.

A. Video Recording the Placement and the Duration of Use

As we mentioned above, we found inconsistent use by the Webster County Jail of video recording inmates during placement and retention in the restraint chair. Paul was often placed in the restraint chair in an unknown location and then wheeled into the padded cell. The jail also did not provide the video of Ryan's placement in the chair, or several of Jack's placements. As a result, we are unable to determine the appropriateness of the placements.

Our 2009 public report addressed the multitude reasons for recording the placement and duration of restraints:

> 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. [92]

The use of video also serves to comply with Iowa law, which requires continuous monitoring when an inmate is placed in a restraint chair:

> If prisoners are restrained in a four/five-point position, the following minimum procedures shall be followed:
>
> (1) Observation by staff shall be continuous. (A CCTV system may be used.)
>
> (2) Personal visual (non-CCTV) observation of the prisoner and the restraint device application shall be made at least every 15 minutes. …[93]

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[91] According to an online resource (https://www.mountsinai.org/health-library/diseases-conditions/low-blood-sugar#:~:text=Severe%20low%20blood%20sugar%20is,called%20hypoglycemic%20or%20insulin%20shock.), "Severe low blood sugar is a medical emergency. It can cause seizures and brain damage. Severe low blood sugar that causes you to become unconscious is called hypoglycemic or insulin shock."

[92] Investigation of Restraint Device Use in Iowa's County Jails, February 19, 2009, https://www.legis.iowa.gov/docs/publications/CI/9966.pdf, page 66.

[93] IOWA ADMIN. CODE r. 201—50.13(2)(f).

Our 2009 report also identified the importance of jails utilizing a closed-circuit television (CCTV) to monitor inmates in restraint chairs:

> 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. [94]

The Webster County Jail's policy allows for CCTV-monitoring and clarifies that the restraint chair should be positioned such that the inmate can be observed on video or by direct supervision. [95] During our tour of the jail, we observed the control center that houses the CCTV monitors. The jail explained that at least one staff person is always in the control center monitoring the CCTV footage, including any live footage of an inmate in the restraint chair.

We noted in our 2009 report that 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. The video must allow staff to be able to identify emergency conditions on the video immediately when they arise.

However, the Ombudsman found that Paul moved the restraint chair around the padded cell on numerous occasions, such that he was outside of the camera view or was otherwise not directly facing the camera. On one occasion, Paul was out of camera view for over 30 minutes until staff finally entered the cell to position the chair back to facing the camera. [96] When questioned whether the jail has taken any steps to address the situation with inmates being able to move the restraint chair around the cell, Jail Administrator Gargano reported that the jail recently obtained a new restraint chair device that does not allow inmates to move the device around the cell as easily. [97]

The Ombudsman believes an unobstructed camera view of the inmate is necessary to accurately review the events of the restraint application and use; however, during this time period, the jail staff viewing the cell through the CCTV were unable to appropriately ensure Paul was continuously monitored.

During our last tour of the jail in the Spring of 2024, we were able to observe newly installed cameras throughout the jail that could pan and zoom to track an inmate. This is a marked improvement over the old system that existed when we first started looking into the complaints.

The 2009 report also addressed the retention of video, recommending that the best practice is to keep restraint chair recordings for at least two years, the statute of limitations for tort actions in Iowa.

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[94] Investigation of Restraint Device Use in Iowa's County Jails, February 19, 2009, https://www.legis.iowa.gov/docs/publications/CI/9966.pdf, page 66.
[95] Webster County Jail Policy 07.04, dated June 13, 2017.
[96] If at least one staff person was in the control room continuously monitoring the CCTV at the time, it is not clear why Paul was allowed to be out of the camera's view for 30 minutes.
[97] Conversation during jail tour on September 26, 2023. According to Jail Administrator Gargano, the newer chair has a heavier footrest that appears to level out the center of gravity, making it more difficult to tip over.

B. Minimal Number of Trained Staff

Having at least two staff to secure an inmate in the restraint chair helps minimize the chances of an inmate causing harm to staff during placement. Of the instances in which video footage was available, the Ombudsman observed a sufficient number of staff during Paul and Jack's placements, with the exception of one occasion. According to the Webster County Jail's policy and the ERC manufacturer's instructions, a minimum of two officers should be present to assist with the placement of an inmate in the restraint chair.[98]

The jail's policy further states:

> Only staff trained in the use of the restraint chair are authorized to place an inmate in the chair. … Relating to the restraint chair the Shift Supervisor(s) or Senior Officers: … Verify that there are sufficient trained staff available to affect the restraint and subsequent watch process.[99]

Iowa law requires that jail staff receive annual training on certain topics, including use of force and methods of restraining violent inmates.[100] The law also requires that jailers receive training in "suicide prevention/mental illness."[101]

It was reported by two confidential sources that staff at the jail are not properly trained in how to use the restraint chair. Further, a complainant claimed that a staff person told him he was not properly trained to use the chair.

When asked whether staff are trained on the restraint chair, Jail Administrator Gargano reported that all new staff have been trained. Jail Administrator Gargano provided the Ombudsman with documents that designated which staff have completed restraint chair training. These documents included a check list of manufacturer recommendations and "operational considerations."[102] However, asked whether staff have also received restraint chair certification from the manufacturer, Jail Administrator Gargano reported they had not.[103]

C. Medical Attention Following Placement

Our office had recommended in 2009 a series of procedures involving medical reviews that should be conducted while an inmate is in a restraint device. These included direct, in-person

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[98] During an interview with the Ombudsman in 2008, 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.
[99] Webster County Jail Policy 07.04, dated June 13, 2017.
[100] IOWA ADMIN. CODE r. 501—9.1(2).
[101] *Id.*
[102] Sureguard Correctional Safety Restraint Chair Check List, signed by correctional staff and Jail Administrator Gargano.
[103] According to information found on the online resource restraintchair.com, certificates are given to individuals who successfully complete the restraint chair certification process through the manufacturer's training program. The Ombudsman does not necessarily believe each staff member needs to go through the manufacturer training program; however, it may be beneficial for one individual to become certified through the program and use the information gathered to assist with trainings at the jail with the other staff.

medical reviews of a restrained inmate by a physician, nurse, physician's assistant, nurse practitioner, or other appropriate licensed medical professional. Aside from the numerous medical conditions we cited in our 2009 report that can arise during the chair's use,[104] even the manufacturer's instructions contain a warning that any use of the restraint chair may be extended beyond two hours "only under medical supervision (Doctor/Nurse)."[105]

Ryan did not receive any medical intervention during the seven and a half hours he was in the restraint chair. The jail records provided to the Ombudsman also do not reflect that Jack received any medical intervention during the time periods he was in the chair.

The jail had documented Paul's blood pressure issues, along with his later hypoglycemia diagnosis. Regardless, the jail did not have him seen by a medical provider at any point before, during, or after his restraint chair placement.[106] This is true even in the case when he was restrained for over 13 hours. Additionally, jail records do not indicate that staff had checked Paul's blood pressure during any of the restraints with the exception of one occasion on August 21. The supervision logs also do not indicate that Paul was provided additional food pursuant to the provider's directives following the visit on September 1.[107]

To gain a better understanding of what medical review and attention other jails provide to inmates in a restraint chair, we asked Johnson County Jail Administrator Captain John Good to shed some light on how his jail handles medical and mental health reviews. Captain Good shared with the Ombudsman that, when inmates are placed in a restraint chair, staff will "prioritize their well-being and strive to provide appropriate medical attention when needed." Captain Good explained that the jail staffs a full-time nurse, and inmates receive medical and mental health services from the University of Iowa Hospitals and Clinics as well as from the Abbe Mental Health Clinic.

In addition to medical reviews to check for adverse physical effects from restraint, our office recommended in our 2009 report that jails incorporate a policy that requires a mental health professional be contacted whenever an inmate with a known or suspected mental health condition is placed in a restraint device. As mentioned earlier, the jail should have been aware of or at least suspected that Paul had a mental health condition based on his frequent violent and erratic behavior that led to three restraint incidents in a single day. But even beyond that, our report had also recommended that a mental health professional be consulted if any inmate is placed in a restraint device for longer than a few hours.

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[104] See California Disability Rights Restraint Chair Report, which found "Restraints have been associated with death by asphyxia and aspiration, even when properly applied. Immobilization might be a risk factor for death because of its relationship to fatal pulmonary embolisms."
[105] https://restraintchair.com/pdfs/2023/SureGuard(r)Instructions2.pdf (Last accessed August 22, 2024).
[106] The Ombudsman could find no documentation from a medical provider diagnosing Paul with Hypoglycemia prior to September 1, 2022; however, according to the Webster County Jail records, Paul's blood sugar levels were being checked frequently following his admission at the jail on August 14, 2022.
[107] Clinical Visit Summary from Community Health Center dated September 1, 2022.

Our recommended time limit was based in part on the restraint chair manufacturer's warning label. The current instruction manual reads:

> Violent behavior may mask dangerous medical conditions therefore detainees must be monitored for and provided with medical treatment if needed. **Detainees should not be left in the SureGuard® Correctional Safety Restraint Chair for more than two hours.** This time limit was established to allow for the detainee to calm down, and if needed it allows for the correctional staff to seek medical or *psychological help* for the detainee. (Bold emphasis in original; italics added.)[108]

Ideally, a mental health professional would be able to identify whether the behavior is caused by a suspected mental health condition and draft a plan of action for the jail to address or mitigate the underlying cause of the violent acts, and whether the jail is in the best position to manage the inmate in the meantime. Not only could a mental health professional address the acute issues giving rise to the immediate placement in the chair, but prevent additional placements such as was needed in Paul's case.

Captain Good informed the Ombudsman that Johnson County Jail employs a social worker in the jail division who provides support to inmates, monitors the inmate population, and assists individuals in developing coping skills. Captain Good reflected on the positive impact the social worker has had on inmates following their release from jail: "This valuable addition to our team has had a significant impact on reducing recidivism among our inmates."

Justice Involved Service Coordinator Brittany Baker, who is located at the Webster County Jail, could play a role in facilitating mental health services to inmates who are placed in the restraint chair and demonstrating signs of mental illness. When asked if she is involved in the restraint process, Baker replied no, but her preference would be for jail staff to notify her before inmates are placed in the chair so she can assist with de-escalating the situation. However, even if Baker is unavailable before a restraint becomes necessary, the jail could utilize her during the time the inmate is in the chair, to determine whether mental health services should be contacted.

D. Bathroom and Stretching Breaks/Food and Water Offerings

The Webster County Jail does not have a policy about providing an inmate with food and stretching breaks while in the restraint chair. The policy does direct staff to offer water and bathroom breaks every two hours.[109] The policy goes on to state:

> Restroom and water breaks are important, but are not to be attempted if the inmate continues to be threatening, uncooperative, combative, or aggressively attempting to get out of the chair.[110]

In line with this, the policy provides that removing an inmate from the restraint chair for bathroom breaks should be done with two or more officers.

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[108] https://restraintchair.com/pdfs/2023/SureGuard(r)Instructions2.pdf (Last accessed August 22, 2024).
[109] Webster County Jail Policy 07.04, dated June 13, 2017.
[110] *Id.*

For the most part, the video footage and supervision logs demonstrate that Paul was offered water at least every two hours, with the exception on one occasion on August 8 when nearly three hours passed before he was provided water. However, there were numerous instances in which Paul was not released for bathroom breaks every two hours, or at all. For instance, of the restraint chair uses on August 8 that lasted more than two hours, Paul was not released for a single bathroom break.

Additionally, during the restraint chair incident on August 20, there was a three-hour period in which Paul was not released for a bathroom break. There is no documentation to suggest that Paul was being threatening, uncooperative, combative, or aggressively attempting to get out of the chair. Correctional Officer Goodman told us that Paul was continuously combative and threatening with staff while in the chair.[111] If Paul was not released from the restraint chair for a bathroom break due to his behavior, the jail was required to document this decision pursuant to Iowa law.[112]

We also found that Paul was released from the chair for bathroom breaks by only one jail staffer, contrary to the jail's policy requiring at least two jail staff be present.

Records reflect that Paul was offered food during meal times while in the restraint chair; however, there was no information to suggest the jail provided additional food during the occasions he was restrained following his diagnosis of hypoglycemia on September 1.[113]

According to Ryan, he was not offered any bathroom breaks or any periods of time outside of the chair to stretch during the seven-and-a-half period of restraint. This corresponds with the jail's supervision logs, which do not mention any bathroom breaks or periodic releases from the chair. Ryan reported to the Ombudsman that he was offered water, although the supervision logs do not state this. Additionally, Ryan stated he was offered food on one occasion, but he threw the tray at jail staff and was subsequently not offered any additional meals while in the chair.

While Jack was offered water during the September 10, 2023, restraint chair use, he was not offered water for over three hours during the September 13, 2023, use. Jack also was not released for bathroom breaks at any point during either the five-hour restraint chair use, or the three-hour restraint chair use.

E. 15-Minute Checks

The Webster County Jail's policy states:

> Once an inmate has been restrained, keep the inmate under frequent, close and personal observation. … Monitoring of an inmate in a restraint chair via closed-

[111] Conversation during jail tour on September 26, 2023.
[112] IOWA ADMIN. CODE r. 201—50.13(2)(f)(4). Iowa law requires that all decisions and actions be documented when an inmate is placed in four- and five-point restraints.
[113] Clinical Visit Summary from Community Health Center dated September 1, 2022, in which the Webster County Jail was instructed to provide three meals and three snacks a day to Paul, as well as an extra tray if available.

> circuit television is advisable, but such monitoring is not a substitute for personal observation and interaction on a frequent basis.[114]

The jail's policy directs staff to check on the individual "approximately every hour" to inspect the inmate's safety and well-being.[115] Iowa law requires more frequent checks, mandating personal visual observation of an inmate in a restraint chair at least every 15 minutes.[116] Our 2009 report addressed what constitutes personal visual observation of an inmate in a restraint chair:

> To determine what is required under Iowa law during the 15-minute 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.**[117]

The Ombudsman also noted that the padded cell at the Webster County Jail has a curtain over the one window of the cell, and the video footage showed that the curtain was pulled closed most of the time that Paul was in the restraint chair.

The Ombudsman questioned whether the curtain hindered the jail's ability to provide personal visual observation, and Jail Administrator Gargano reported that the curtain is for the privacy of the inmate in the padded cell and when there is no one else in the area, the curtain could remain open. However, this rarely occurs, according to Gargano. The area outside the padded cell is heavily trafficked, as there is a booking desk, two detox cells, and the medical room all in the same small vicinity.

In an interview with our office, a confidential source reported that the 15-minute checks were not happening during the times Paul and Ryan were at the Webster County Jail. We were told that staff would occasionally not print off the supervision logs, so there would be whole periods of supervision that were unaccounted for. This appeared to be accurate, as the jail did not provide supervision logs for a several-hour period in which Paul was in the restraint between August 21 and August 22, 2022.

However, when asked whether the 15-minute checks were happening during the time Ryan and Paul were in the restraint chair, Goodman reported that they were. He noted that the checks

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[114] Webster County Jail Policy 07.04, dated June 13, 2017.
[115] *Id.*
[116] IOWA ADMIN. CODE r. 201—50.13(2)(f).
[117] Investigation of Restraint Device Use in Iowa's County Jails, February 19, 2009, https://www.legis.iowa.gov/docs/publications/CI/9966.pdf, page 124.

occurred to the detriment of other inmates, who were unable to do recreation time or other activities because the jail staff needed to be available to complete the 15-minute checks.

For the most part, Paul's numerous restraint chair incidents were documented with the jail's supervision logs. However, when we compared the available video footage to the supervision logs, we found that the 15-minute checks documented on the supervision logs did not correlate with what happened based on video footage. It was clear that staff were not entering the cell every 15 minutes to observe Paul or check on him through the window. One example we found was that staff did not enter the cell for nearly two hours between 6:16 a.m. and 8:00 a.m. on August 22, 2022, while Paul was in the restraint chair. During this time period, staff did not conduct in-person checks to ensure Paul's safety, or observe him through the window, as the curtain was drawn.

By the time Jack was in the restraint chair a year later, in August and September 2023, the jail had upgraded its process for documenting checks. Instead of paper supervision logs, the jail obtained handheld Guardian devices. This device allows staff to record the date, time, location, as well as what is observed during the check. Additionally, Jail Administrator Gargano reported that the Guardian RFID device will alert staff when it is time to check on an inmate.[118]

However, the jail's Guardian logs concerning Jack's restraint chair uses did not correlate with what happened on the video footage. Jail Administrator Gargano admitted to us that the 15-minute checks did not happen while Jack was in the chair. He explained that this was because Jack was placed in the North Detox cell due to another inmate being in the padded cell, and the Guardian device used by jail staff was programmed for 45-minute checks in that cell, rather than 15-minute checks.

We found that even when staff did conduct strap checks, not all the checks were thorough. For example, during the August 20, 2022, restraint chair incident, staff checked Paul's shoulder straps, but not his wrists or ankles, which in our opinion are more susceptible to injury due to overtightened straps.

We did not receive video footage pertaining to Ryan's restraint chair incident. However, the supervision logs indicate that staff conducted strap checks on only three occasions during the seven and a half hours he was in the chair. The first strap check did not occur until three and a half hours after the initial placement.

For Jack, we found that jail staff only conducted a few strap checks for the two restraint chair uses captured on video, and those did not include thorough checks of all the straps.

As such, we found that the jail failed to conduct 15-minute checks in violation of Iowa law, as 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.

[118] Conversation during jail tour on September 26, 2023.

F. Periodic Reviews

Iowa law states that restraint devices "shall not be applied for more time than is necessary to alleviate the condition requiring the use of the restraint device."[119] Separately, the Emergency Restraint Chair manual states that an inmate should not be left in the restraint chair for over two hours.[120] The manual specifies that the recommended two-hour time limit was established based on the time period that an inmate needs to calm down or sober up, and also provides the time for jail staff to seek medical or psychological help for the inmate.[121]

Iowa law does not provide guidance on how jails are to determine when a condition giving rise to the restraint device has been alleviated. Our 2009 report included the following recommendation concerning periodic reviews:

> 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. … The review should determine if the inmate is still a threat to themselves, others, or property.[122]

The Webster County Jail's policy requires that staff must check on the inmate approximately every hour to ensure his or her well-being. It also requires staff to inform an inmate what actions led to the restraint chair use, and allows removal once the actions stop.[123] Inmates who have demonstrated acceptable behavior for one or two hours should be assessed as "a candidate for released [sic] from the chair," the policy adds.[124]

Very little information was provided by the jail to indicate what, if anything, was done during the checks to evaluate these three inmates' well-being. Further, there is no information in the supervision logs that would suggest jail staff spoke to Paul and Ryan with the purpose of explaining the reasons for the restraint chair, and what actions could lead to the removal from the chair.

Additionally, the video footage of the padded cell does not contain audio, so we were unable to decipher what exactly was said during the instances in which staff checked on Paul. However, the majority of the instances in which staff entered the cell were for very short periods of time, so we question whether any significant conversation could have taken place regarding Paul's actions and behavior.

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[119] IOWA ADMIN. CODE r. 201—50.13(2)(f).
[120] https://restraintchair.com/pdfs/2023/SureGuard(r)Instructions2.pdf (Last accessed August 22, 2024).
[121] *Id.*
[122] Investigation of Restraint Device Use in Iowa's County Jails, February 19, 2009, https://www.legis.iowa.gov/docs/publications/CI/9966.pdf, pages 7 and 59.
[123] Webster County Jail Policy 07.04, dated June 13, 2017.
[124] *Id.*

According to Correctional Officer Goodman, Paul was continuously combative and threatening with staff, and would spit on staff while in the restraint chair. Goodman reported that this was why he remained in the chair for lengthy periods of time.

Contradicting Brody's testimony, we observed from video that the majority of Paul's time in the restraint chair showed he appeared to be calm and cooperative. There were several instances in which Paul sat back down in the chair of his own will after being removed to stretch or use the bathroom. The Ombudsman found no video footage in which Paul was aggressive or violent towards staff after the initial placement in the restraint chair. We did not observe any video of Paul spitting at staff, or any instances in which staff utilized a spit mask.

We were also not provided any documentation that explained the justification for continued use of the chair for any of the occasions Paul was restrained. The jail's supervision logs occasionally reference Paul yelling while in the chair. We recognize that verbal abuse during restraint can indicate a heightened emotion and risk of violence if released. However, we found only one occasion in which it is documented that staff spoke to Paul to explain why his actions resulted in the restraint chair use and what behavior would need to be displayed for him to be removed from the chair.[125]

Because the jail did not preserve the video involving Ryan, we were unable to determine to what extent staff were present in the cell during the restraint chair use to check on the inmate's well-being. According to Goodman, he informed staff that Ryan should remain in the chair so long as he was threatening or combative towards staff.

Ryan admitted to us that he threw a tray of food at staff after he was placed in the restraint chair. The jail's supervision logs do not mention this incident or state it was a basis for prolonged restraint. The only other description of Ryan's demeanor while in the restraint chair was at 8:45 p.m. – three and a half hours before he was released – when staff wrote on the supervision logs that he was "calm."[126]

Asked whether Ryan should have remained in the chair following this description of his "calm" demeanor, Goodman responded that no, he should have been removed at that point. As such, we found that there was insufficient justification to keep Ryan in the chair beyond this point.

During Jack's September 13, 2023, restraint chair use, we found that jail staff told Jack that he could be removed from the chair if he agreed to "go to A." It is not clear to us exactly what this would have entailed, or why Jack did not want to go to this area of the jail. However, when Jack reported that he would not go to "A," he was informed that he would need to stay in the chair for a minimum of two hours.

There is no indication that jail staff considered Jack's behavior while in the chair – which was, for the most part, calm – and instead, it appeared to be predetermined that he would remain in the restraint for at least two hours. Considering the lack of information to show Jack's behavior required his continued stay in the chair, we concluded that there was insufficient justification to

[125] Incident report dated September 1, 2022, at 3:36 p.m. by Kyle Shook.
[126] Incident report dated September 12, 2022, by Brody Goodman.

keep him in the chair for three-and-a-half hours on September 13, 2023.

G. Documentation

Iowa law requires that all decisions and actions be documented when an inmate is placed in four- and five-point restraints.[127] Our office interprets this to include:

- 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 Webster County Jail's policy requires that the following be documented following the decision to place an inmate in the restraint chair:

- the authorization for the restraint chair use,
- the time and reason for the placement, and
- the checks done on the inmate, and the time of release.

The jail's policy further states that staff should "initiate a restraint chair checklist for appropriate documentation."[128]

We received no checklist concerning the documentation relevant to Paul, Ryan, or Jack's restraint chair uses. The jail's incident reports and supervision logs included information relating to the time and reason for the placement, the checks, and the time of release. However, the documentation did not specifically mention who authorized the restraint chair use, or that proper authorization was obtained.

The legal requirement to document "all decisions and actions" also includes the periodic reviews of an inmate in a restraint chair and whether the continued use of the device is warranted, in our opinion. When a jail is not able to provide documentation demonstrating that the inmate needed to remain in the device, it raises the question whether the restraint device was used for an excessive amount of time.[129] If this is the case, the jail may violate Iowa law and possibly the inmate's constitutional rights against using the restraint as punishment.

In Paul, Ryan, and Jack's restraint chair uses, the Webster County Jail did not provide documentation that the inmates were periodically reviewed to determine if the continued need for restraints was warranted. Additionally, there was no documentation provided to explain the justification for continuing the restraint chair use following the periodic reviews that did occur.

We conclude that, to justify the continued use of the restraint, jails must provide documentation showing that an inmate is still a threat to self, others, or jeopardizes jail security. The most

[127] IOWA ADMIN. CODE r. 201—50.13(2)(f)(4).
[128] Webster County Jail Policy 07.04, dated June 13, 2017.
[129] *Ogden v. Johnson*, No. C00-0034, WL 32172301 (N.D. Iowa Sept. 5, 2002).

effective way to make this determination is to conduct periodic reviews of the inmate and note the inmate's actions and disposition.

H. Clothing or Covering

Iowa law states that, "[w]hile restrained, prisoners shall be either clothed or covered in a manner that maximizes prisoner privacy."[130] The jail's policy is silent on this requirement, though the Emergency Restraint Chair manual states that inmates should be "clothed in their shirt, pants, or dress."[131]

During the September 11, 2023, restraint chair use, Jack was naked without any sort of covering for the four hours he was in the chair. We find this to be a violation of Iowa law.

Duration and Frequency of Restraint Chair Uses

A. Duration of Restraint Chair Use

We found several issues with the length of time the inmates were seated in the restraint chair. As such, we 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 to alleviate the condition causing the restraint."[132]

Our 2009 report noted that, while there are no parameters in Iowa law regarding the maximum number of hours in the chair, a federal court in Iowa had upheld a jury verdict that found an arrestee's five-hour placement on a restraint board was unreasonable.[133] The same court had also found that an eight-hour restraint had violated an inmate's Eighth Amendment right to be free from cruel and unusual punishment, including excessive use of force.[134] Factors a court may consider when determining if excessive force has been used include whether the inmate posed an imminent threat of bodily harm to himself or others, or whether there was an "emergency situation" that required the use of the restraint device.[135]

During our tour, we observed a large warning sign on the restraint chair where the inmate's head is placed that read:

> WARNING Do not leave detainees in this chair for more than TWO hours.

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[130] IOWA ADMIN. CODE r. 201—50.13(2)(f).
[131] Emergency Restraint Chair instruction manual, issued on February 10, 2001.
[132] IOWA ADMIN. CODE r. 201—50.13(2)(f).
[133] *Ogden v. Johnson*, No. C00-0034, WL 32172301 (N.D. Iowa Sept. 5, 2002).
[134] *Rogers v. Dunn,* No. C00-0188-PAZ, 2001 U.S. Dist. LEXIS 22710 (N.D. Iowa Nov. 27, 2001). "The basic legal principle is that once the necessity for the application of force ceases, any continued use of harmful force can be a violation of the Eighth and Fourteenth Amendments, and any abuse directed at the prisoner after he terminates his resistance to authority is an Eighth Amendment violation."
[135] See *Young v. Martin*, 801 F.3d 172 (3d Cir. 2015), quoting *Hope v. Pelzer,* 536 U.S. 730, 122 S.Ct. 2508, 153 L.Ed.2d 666 (2002).

The Emergency Restraint Chair manual similarly sets limitations on the amount of time an inmate should be restrained:

> Detainees should not be left in the Emergency Restraint Chair for more than two hours. … The two hour time limit may be extended, but only under **direct** medical supervision (Doctor / Nurse). This extended time period must not exceed eight hours … Therefore we do not recommend anyone be left in the Emergency Restraint Chair for more than ten hours total.[136]

During an interview with our office in 2008, the Emergency Restraint Chair's creator, Tom Hogan, reported that the policies drafted by the company were based on his experience in medical treatment and law enforcement. Accordingly, little or no medical research designates specific time period for medical checks, which Hogan set at two hours, or maximum amount of time an inmate can be left in the restraint chair, which he set at ten hours.[137]

As the limitations identified in the manual do not appear to be based on any medical or scientific research, our office 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.

However, we considered whether the lengths of time Paul, Ryan, and Jack were in the restraint chair were excessive considering the other issues identified regarding the jail's use of the chair. According to the manufacturer's manual, the two-hour limit is recommended as it is considered an appropriate time to locate a mental health professional to assess the inmate and situation.[138] For each of the inmates, the jail failed to consult a mental health professional as the restraint chair manufacturer recommends.[139]

The jail also failed to document the justification for the continued use of the restraint chair, when there is evidence to suggest that the inmates had calmed down well before being removed from the restraints. Paul and Jack were both observed on video to be calm during their restraint chair incidents, and Ryan was documented as being calm three-and-a-half hours before he was released.

We requested information from the jail regarding the average total length of time inmates are in the restraint chair. It was reported that for the calendar years of 2019, 2020, 2021, and 2022, and to-date 2023, the average length of time that inmates were in the restraint chair from initial placement to final release from the chair was an hour and a half.

However, Paul, Ryan, and Jack were restrained much longer than this reported average on multiple occasions.

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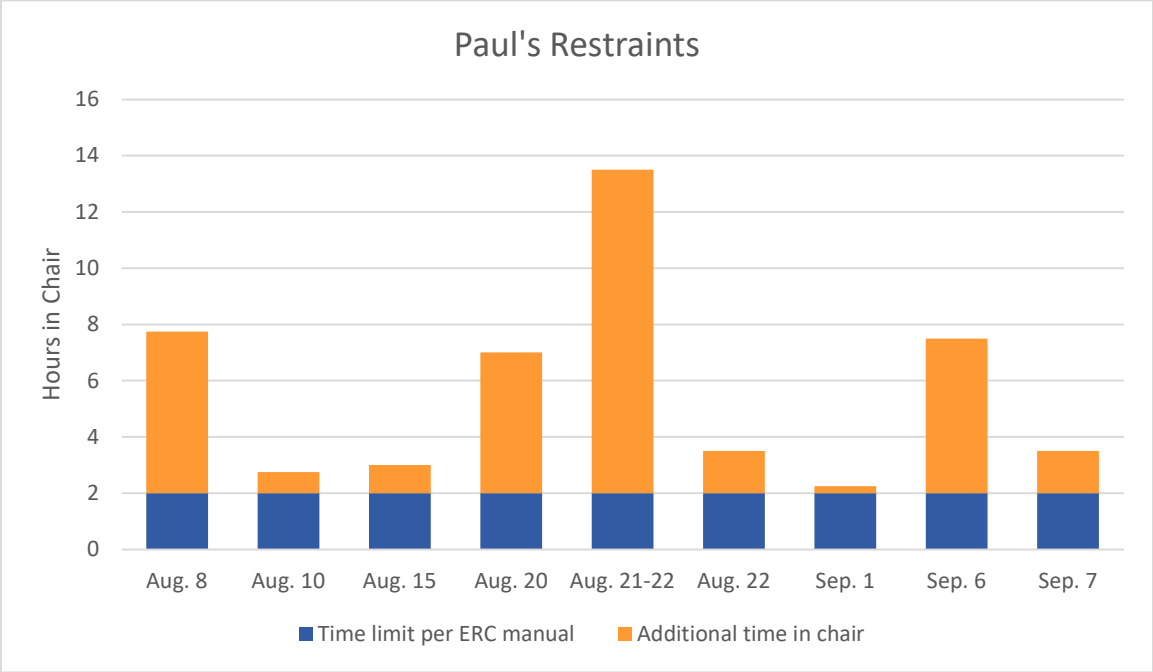
[136] Emergency Restraint Chair instruction manual, issued on February 10, 2001.
[137] Telephone Interview with Tom Hogan, President, Emergency Restraint Chair, Inc. (June 11, 2008).
[138] *Id.* "This time limit was established to allow for the detainee to calm down, and if needed it allows for the correctional staff to seek medical or psychological help for the detainee."
[139] https://restraintchair.com/pdfs/2023/SureGuard(r)Instructions2.pdf (Last accessed August 22, 2024).

In 2022, Ryan was in the chair for seven and a half hours. More alarmingly, Paul was placed in the chair during the following time periods, all exceeding the recommended two-hour limit:



Without consulting a mental health professional or documenting the behavior of the inmates that justified the continued use of the restraint chair, the Ombudsman believes that the prolonged lengths of time Jack, Ryan, and Paul, were in the restraint chair were excessive.

B. Frequency of Restraint Chair Use

We questioned whether the frequency of the restraint chair incidents involving Paul and Jack were excessive. During a 30-day period, Paul was placed in the restraint chair on 13 occasions. Particularly, we noted that Paul was placed in the restraint chair on three occasions on one day, and he was placed back in the chair for three and a half hours shortly after being released from a 13.5-hour restraint chair use.

Correctional Officer Goodman reported to our office that Paul's behavior warranted the frequent use of the restraint chair, and the jail's severe understaffing did not have any role in determining how often to use the device.

Nevertheless, we believe the Webster County Jail should have considered the number of times Paul was being placed in the restraint chair as a basis to seek mental health services, as early as after the first three occasions on August 8.

Similarly, Jack was placed in the chair several times within a short period – seven occasions within three weeks. Jack was also placed in the chair on multiple occasions in one day, and on one occasion, three times within a 14-hour period.

The Emergency Restraint Chair manual addresses the need to consider an inmate's medical condition: "violent behavior may mask dangerous medical conditions." The Ombudsman believes this applies to mental health as well, and identified the following in the 2009 report:

> 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."[140]

The DOJ's investigation into an Alabama county jail found that continuous restraint chair use was an indicator that the jail was not appropriately handling the inmate's mental health needs:

> The prolonged and successive use of restraints is an improper practice and indicative of a failure to manage disruptive or mentally ill inmates. For example, a particular inmate at MCMJ was placed in five-point restraints in May 2003 for "breaking sprinkler head" at 11:30 p.m. and remained in restraints until 8:30 a.m. the following morning. The inmate was again placed in five-point restraints for "breaking sprinkler head" at 9:15 a.m. and was not released until 6:00 p.m. This inmate was placed in five-point restraints a third time for "breaking sprinkler head" at 6:39 p.m. and the date and time of his release from restraints was not noted. This cyclical use of five-point restraints indicates that MCMJ failed to either identify and treat an inmate who possibly had serious mental health needs or, if he was not mentally ill, to manage appropriately this inmate's behavioral issues.[141]

Our office polled several other similarly sized county jails (as well as larger jails) to compare the frequency of the restraint chair use with the reported restraint chair incidents at the Webster County Jail.

Jail Administrator Gargano provided 22 incident reports and stated that these represented the number of occasions that the restraint chair was used in 2022. However, we found that several of the incidents involving Paul were not included in the incident reports shared. There were no incident reports for the time periods Paul was in the restraint chair on August 15, August 16, August 18, and August 22. Including these additional restraint chair incidents, the jail provided documentation for 26 restraint chair uses in 2022.

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[140] Investigation of Restraint Devise Use in Iowa's County Jail, February 19, 2009, https://www.legis.iowa.gov/docs/publications/CI/9966.pdf, page 64, citing MARIN DRAPKIN ET AL., MANAGEMENT AND SUPERVISION OF JAIL INMATES WITH MENTAL DISORDERS 2-38 (2003).

[141] Letter from Grace Chung Becker, Acting Assistant Att'y General, Civil Rights Div., to Stephen Nodine, President, Mobile County Commission and Sam Cochran, Sheriff (Jan. 4, 1999), *available at* https://www.justice.gov/sites/default/files/crt/legacy/2010/12/15/MCMJ_findlet_01-15-09.pdf.

By comparison, Clinton County Jail Administrator Paul Hammond informed us that the restraint chair was only used on one occasion since he started with the jail in 2018. Hammond said that the Clinton County Jail utilizes a padded cell for difficult inmates, rather than a restraint chair.

For comparison purposes, the Ombudsman obtained information from other county jails regarding the number of restraint chair uses in 2022. The Ombudsman polled jails of similar size to the Webster County Jail, as well as larger county jails.

Of the similar-sized jails, only one jail reported a similar number of restraint chair uses. Of the other jails polled, the number of restraint chair uses in 2022 were as follows:

County Jail	Number of Restraint Chair Uses in 2022	Jail Capacity
Black Hawk County Jail	76	280
Webster County Jail	**26**	**56**
Johnson County Jail	24	92
Dubuque County Jail	12	212
Polk County Jail	11	1,500
Pottawattamie County Jail	5	288
Des Moines County Jail	4	74
Jefferson County Jail	1	32
Boone County Jail	1	56
Hamilton County Jail	1	44
Cerro Gordo County Jail	0	171
Lee County Jail	0	134
Clinton County Jail	0	115
Sioux County Jail	0	67
Muscatine County Jail	0	255

The Johnson County Jail – which holds 35 more inmates than the Webster County Jail – had 24 restraint incidents in 2022. However, according to Johnson County Jail Administrator John Good, the longest consecutive amount of time the restraint chair was used on one inmate was two and a half hours.

A handful of jails explained to the Ombudsman that the restraint chair is used very infrequently, or not at all. Besides the Clinton County Jail, the Sioux County Jail reported that the restraint chair, or any sort of restraint board or bed, is not used at all.

Similarly, the Muscatine County Jail, which houses more inmates than the Webster County Jail, reported that there have been no restraint chair uses in the last four years, as the jail also utilizes the padded cell for difficult inmates, rather than the restraint chair.

We found that in some instances, larger jails had fewer restraint chair uses than the Webster County Jail. In 2022, the Polk County Jail restrained inmates on only 11 occasions out of the 15,631 inmates that came through the jail, compared to Webster County's 1,349 inmates. Polk

County reported that the longest an inmate was placed in the restraint chair was two hours, explaining:

> We make every attempt to get inmates out of the safety chair at the one hour mark but occasionally some make it to the two hour mark.

The Black Hawk County Jail had more restraint chair uses than the Webster County Jail in 2022, but the Black Hawk County Jail processed 6,130 inmates in 2022, 4,781 more inmates than the Webster County Jail processed the same year. Similarly, the Johnson County Jail processed more inmates in 2022 than the Webster County Jail and had two fewer restraint chair uses.[142]

Report to State Jail Inspector

Iowa law requires jails to report use-of-force incidents, including the use of the restraint chair, to the state's jail inspector.[143] However, we found that the Webster County Jail has not consistently made such reports.

According to the Iowa State Jail Inspector's incident reporting website, the Webster County Jail filed only one use of force report in 2021, one in 2022, five in 2023, and two so far in 2024.[144] None of the instances of restraint chair use for Paul, Ryan, or Jack were reported to the jail inspector.

We raised this issue with Jail Administrator Gargano, who replied that they recently learned how to submit the use-of-force reports to the state's jail inspector, and this previously was not done on a regular basis.[145]

Chief Jail Inspector Delbert Longley explained the importance of jails submitting the use-of-force reports to his office, as it serves as an opportunity for him to review the reports and provide feedback to the jails on how to handle and correct certain situations. We questioned whether the reports are reviewed as they are submitted. Longley indicated that they are not. He reviews the use-of-force reports only periodically to look for issues and ensure all the appropriate information has been submitted.[146]

Longley acknowledged that a number of restraint chair incidents on one inmate over a short period of time would have stuck out to him. If the Webster County Jail had submitted reports and he had reviewed the information, Longley said he would have reached out to the jail to get more information on what was going on, and he could have brought it up during his next jail inspection.

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[142] Johnson County Jail processed 4,949 inmates in 2022, 3,600 more than Webster County Jail the same year.
[143] IOWA ADMIN. CODE r. 201—50.22(14).
[144] https://jailstats.iowacorrections.us/IncidentReport/logon/.
[145] Conversation during jail tour on September 26, 2023.
[146] Telephone call with Chief Jail Inspector Delbert Longley on April 29, 2024.

CONCLUSIONS

Based on the available records, the Ombudsman finds that the Webster County Jail repeatedly failed to follow Iowa law, its own policies, and best practices articulated by the Emergency Restraint Chair manual in its use of the restraint chair. The Ombudsman makes the following conclusions concerning the restraint chair uses on Paul, Ryan, and Jack:

Mental Health Screening and Referral

The Ombudsman concludes that the jail did not have appropriate steps in place to screen for, identify, or address inmate mental health issues. This included employing a screening tool for inmates upon admission, recognizing signs and symptoms of possible mental health issues during the inmates' stay, and referring inmates to mental health services when appropriate. In our opinion, this failure precipitated additional and unnecessary restraint chair uses. At the same time, the jail not only risked the safety of the inmates and staff, but also risked violating inmates' Eighth Amendment rights.[147]

Decision to Place Inmates in Restraint Chair

The Ombudsman concludes that there were several instances where the jail's decision to place inmates in a restraint chair was unwarranted and contrary to Iowa law. Iowa law requires that use of restraint devices be restricted to those circumstances when an inmate is an imminent risk of harm to themselves or others or is jeopardizing jail security.[148] However, we found multiple occasions when the restraint chair was used on the inmates in response to their prior behaviors or verbal outbursts that were unaccompanied by an imminent threat of harm to themselves or others or had otherwise jeopardized jail security. Use of the restraint chair for these types of incidents can easily be interpreted as punishing the inmates, which is prohibited by Iowa law.[149]

The Ombudsman also concludes that the jail did not appropriately consider inmates' medical conditions when deciding whether to place inmates in the restraint chair.

Restraint Chair Use

The Ombudsman found that the jail did not appropriately record or retain video of restraint chair uses. The Ombudsman recommended in 2009 that jails should retain video for at least two years, which is the statute of limitations for tort actions in Iowa. However, the jail did not retain the video, hindering our ability to determine the appropriateness of the restraint chair uses.

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[147] Federal courts have found that under the Eighth Amendment, a correctional facility cannot ignore the mental health care needs of inmates. Additionally, 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 (*See Hartsfield v. Colburn*, 491 F.3d 394, 396 (8th Cir. 2007).

[148] IOWA ADMIN. CODE r. 201—50.13(2)(f).

[149] IOWA ADMIN. CODE r. 201—50.21. *See also* Emergency Restraint Chair instruction manual, issued on February 10, 2001.

We also found that the jail did not seek medical attention or mental health reviews for the inmates following their placement in the restraint chair. We raised the need to seek medical review of restrained inmates in our 2009 report, but it is also emphasized in the manufacturer's own instructions.[150] This failure to consult with professional medical staff placed at least one inmate with a diagnosed medical condition at a heightened risk of harm.

We found numerous instances where the inmates were not offered bathroom breaks or water during the restraint chair use, contrary to the jail's policy. These breaks were not provided even when the inmates were not exhibiting threatening or aggressive behavior.

The jail did not continuously monitor an inmate during restraint, contrary to Iowa law.[151] This occurred multiple times when an inmate was able to move the restraint chair out of view of the video and staff had no other means to visually observe the inmate. The Ombudsman notes that the stationary cameras that enabled limited views have been replaced by a new camera system with higher-resolution cameras that have features such as zoom and 360-degree views.

The Ombudsman found that the jail failed to follow Iowa law requiring personal visual observation at least every 15 minutes of an inmate in a restraint chair.[152] We observed videos where these checks were not being consistently done on multiple occasions. We also found the checks that were done did not always 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 were not affecting the inmate's circulation.

Iowa law requires that restraint devices "shall not be applied for more time than is necessary to alleviate the condition requiring the use of the restraint device."[153] The Ombudsman found that jail staff did not appropriately assess the inmates for removal based on the inmates' behavior. As a result, the inmates were held beyond the time that was necessary to alleviate the condition requiring the restraint chair uses. Based on the evidence we reviewed, we could not substantiate staff claims in several instances that an inmate continued to be combative and threatening while in the chair.

The Ombudsman found that the jail failed to appropriately document all decisions and actions of the restraint chair uses, as required by Iowa law.[154] This includes the jail's inability to provide documentation that inmates were periodically reviewed to determine if the continued use of the chair was warranted. Additionally, there was no documentation provided to explain the justification for continuing the restraint chair use following the periodic reviews that did occur.

Lastly, we found the jail allowed an inmate to remain unclothed during the entirety of the four hours he was in the chair, contrary to Iowa law.[155]

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[150] https://restraintchair.com/pdfs/2023/SureGuard(r)Instructions2.pdf (Last accessed August 22, 2024).
[151] IOWA ADMIN. CODE r. 201—50.13(2)(f).
[152] *Id.*
[153] *Id.*
[154] *Id.*
[155] *Id.*

Duration and Frequency of Restraint Chair Uses

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.

However, without consulting a mental health professional or documenting the behavior of an inmate to justify the continued use of the restraint chair, the Ombudsman found the jail's prolonged restraint on several occasions was excessive. We also concluded that the frequency of restraints on two inmates was objectionable and should have compelled staff to contact mental health services. In resorting to the restraint chair to address inmate behavior, the jail used the device as de facto mental health treatment.

Report to State Jail Inspector

Iowa law requires jails to report use-of-force incidents, including restraint chair uses, to the state's jail inspector; however, the Ombudsman found that the Webster County Jail did not submit reports for any of the restraint chair uses any of the inmates mentioned in this report.[156] By failing to follow Iowa law, the jail missed an opportunity for oversight and, possibly, corrective action by the chief jail inspector.

[156] IOWA ADMIN. CODE r. 201—50.22(14).

Recommendations to Boone and Webster County Jails

We have had the opportunity to review the 13 recommendations detailed in our 2009 report[157] and apply them to the recent complaints mentioned in this report. We can say that we do not find a reason to alter or amend any of our previous recommendations as they apply to individual jails. However, the limited feedback we received from jail officials during the course of our investigation revealed that frontline jailers had little to no familiarity with our 2009 report. We therefore recommend that the Boone County and Webster County jails review and follow those recommendations.[158]

In addition to our 2009 recommendations, we make three other recommendations to the Boone County and Webster County jails:

1. Ensure all staff are properly trained and certified in the use of restraint chairs and conduct annual refresher courses to maintain compliance with policies and guidelines.

2. Ensure staff follow the restraint chair policies strictly, especially concerning periodic checks, the duration of use, and medical supervision.

3. Ensure all restraint chair incidents are reported to the state's jail inspector at the Iowa Department of Corrections, as required by Iowa law.

[157] Iowa Office of Ombudsman, *Investigation of Restraint Device Use in Iowa's County Jails* (2009) (https://ombudsman.iowa.gov/browse/files/39dacd16bc0a49ea882c895c4a88c61e/download). *See also* Appendix A.
[158] *Id* at page 68.

Ombudsman's Prior Work with Stakeholders

Earlier in this report, we alluded to our work with the Iowa State Sheriffs' and Deputies' Association (ISSDA) on changes our office wanted to see to administrative rules governing Iowa's county jails. We first approached the Iowa Department of Corrections (DOC) in 2017, which is charged with adopting the rules for the Administrative Code and ensuring compliance through its jail inspector. DOC is required to consult with the ISSDA, among other stakeholders, prior to adoption of or amendments to its rules. Instead, DOC pointed us to the ISSDA to consult with the organization on our recommended rules changes.

We sent ISSDA a memo in 2017 detailing eight proposed rule changes and met in-person with its Jail Committee's representatives to present our proposal in September 2018. We received ISSDA's feedback in a letter dated April 10, 2019.

The following details our proposals, followed by ISSDA's *responses*:

1. Iowa Administrative rule 201—50.15(6)(d) requires the jail to have a written plan to provide prisoners access to services for the detection, diagnosis and treatment of mental illness, and include a mental health screening process at admission. It is not clear if this requirement applies to all inmates or just those identified earlier in the section as those charged with a simple misdemeanor.

   The rules should clearly state that all inmates should be screened for mental illness at admission and the jail have a written plan for detection, diagnosis, and treatment of mental illness. Further, the rules should require a jail to contact a mental health professional within 14 days in the event the inmate screens positive for, or shows signs of, a mental illness.

   > *Administrative rule 201-50.15(6)(d): Provided that there is understanding that 14 days for some counties may be the most rapid response they are able to muster, we agree with both the premise and intent of ensuring proper planning, coordination, and treatment for those diagnosed with mental health issues. Understand that we as an association and a majority (if not all) sheriff's offices do not like being the placement choice of last resort for those with serious mental illness. Our state's approach to mental health care and our criminal justice system is predicating the criminalization of our state's mentally ill simply because there is no other placement option for our most critically mentally ill.*

2. Rule 50.13(2)(f) states "Four/five-point restraints shall be used only when other types of restraints have proven ineffective." It is not clear what "proven ineffective" means, but we do not necessarily agree that other types of restraints MUST be used first before four/five-point restraints are used. It will depend on the circumstances.

   The Ombudsman previously recommended that 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.

Some version of our recommendation can/should be incorporated into the rules to replace the current rule language, cited above.

> *Rule 50.13(2)(f): While we agree that jail staff must consider using less restrictive alternatives to restraint devices, we resist the need to somehow articulate all of the considerations, thought processes, and contemplations of "pros vs. cons" of each other methodology available to that staff and why/why not employed. We suggest that requiring documentation of the event which precipitated the restraining of an inmate, the measures taken prior to that restraint, and where applicable and possible, encouraging electronic video/audio recording of any such event be pursued. Asking an officer or staff member to recite any and all lesser means of force available and their contemplation of the perceived success or failures of such means is cumbersome, impossible to obtain and unduly jeopardizes each staff member whoever is placed in this unfortunate position.*

3. Rule 50.13(2)(f)(2) requires personal visual observations of the prisoner and restraint device application at least every 15 minutes. The rules should include an additional clarifying statement that the purpose of the observation is to check for any adverse medication condition the inmate may be experiencing.

> *Rule 50.13(2)(f)(2): We are not opposed to a clarifying statement that includes medical condition as one of the reasons for personal visual observations of a prisoner and restraint device application. It is clearly not the sole purpose of that rule. There may be changes to the restraints, the impedance of the effectiveness or operation of the device, and a myriad of other reasons why these 15-minute checks are a best practice.*

4. Rule 50.13(2)(f) states “Restraint devices shall not be applied for more time than is necessary to alleviate the condition requiring the use of the restraint device.” It is not clear how this is determined or how staff must make this determination.

   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. The rules should require periodic reviews to be conducted at least every hour.

> *Rule 50.13(2)(f): We are comfortable with the present language and feel that it is sufficient to allow for staff and administrators to determine, based on their training and experience, the appropriate time and level of response. It is assumed (and normal practice) that incident reports contain much if not all of the details you are indicating should be mandated. We would recommend no change to this present language.*

5. Current rules do not require medical reviews of inmates restrained in a four or five-point restraint device.

   The rules should provide that, 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 every two hours. The checks should be used to determine the physical condition of the inmate, check vital signs, and review to determine if any other medical emergencies exist.

   > *Medical Reviews of inmates restrained: Depending on the type of restraint device, it should be required that the jail and jail staff follow the manufacturer's recommendation.*

6. Current rules do not require jails to contact a mental health professional when a mentally ill inmate is placed in a restraint device.

   The rules should require jails 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.

   > *Contacting mental health professionals: It is hoped that with the complex needs legislation passed last session, access to and options for mental health professionals to most counties will improve. This being the case, the jails inspector should be able to inquire and review documentation of contracted mental health professionals and their involvement and accommodations for diagnosed mentally ill inmates housed in the county jail.*

7. Rule 201—50.13(2)(f)(4) requires all decisions and actions be documented when prisoners are restrained in a four/five-point position. This requirement is too vague.

   The rules should include language that requires the documentation to include 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 (hourly) reviews.

   > *Rule 201-50.13(2)(f)(4): We are comfortable with the present language and implications of such documentation as it presently reads.*

8. Current rules do not require placement to be videotaped. The rules should require that 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.

> *Videotaping: While we acknowledge videotaping refractory inmates is a best practice, we also recognize that this association represents all county jails of size, scope, and budget. We would acknowledge the desire for a best practice statement, but rules should not be implemented where there is not the structural need, infrastructure (IT and otherwise) to support such technology. With such a best practices type statement, jails would be accepting the liability for not pursuing such technology.*

We were not able to fully consider ISSDA's response and follow through with DOC before the COVID-19 outbreak, which caused us to reprioritize our resources to address immediate health and safety issues affecting Iowans. Soon after, we began fielding additional complaints of mental health and restraint chair use detailed in this report.

We are now taking advantage of this opportunity to present recommended changes to the Iowa Administrative Code for DOC's consideration, with ISSDA's feedback in mind.

Recommendations to Iowa Department of Corrections

We have considered ISSDA's feedback to our proposed changes to Iowa Administrative Code and have arrived at the following eight recommendations for the Department of Corrections to consider:

1. Iowa Administrative rule 201—50.15(6)(d) requires the jail to have a written plan to provide prisoners access to services for the detection, diagnosis and treatment of mental illness, and include a mental health screening process at admission. It is not clear if this requirement applies to all inmates or just those identified earlier in the section as those charged with a simple misdemeanor.

   The Ombudsman recommends that the rules be amended to clearly state that all inmates be screened for mental illness at admission; that jails have a written plan for detection, diagnosis, and treatment of mental illness; and that jails must contact a mental health professional within 14 days if an inmate screens positive for, or shows signs of, a mental illness.

2. Rule 50.13(2)(f) states: "Four/five-point restraints shall be used only when other types of restraints have proven ineffective." It is not clear what "proven ineffective" means, but a plain reading of the current law would require jails to go through each alternative and prove its ineffectiveness before a restraint chair is used.

   The Ombudsman recommends that the rule be amended to require jail staff to merely *consider* using less restrictive alternatives, and when those alternatives are not used, require staff to document the reason for not employing them.

3. Rule 50.13(2)(f)(2) requires personal visual observations of the prisoner and restraint device application at least every 15 minutes.

   The Ombudsman recommends that the rules include an additional clarifying statement that the main purpose of the observation is to check for any adverse medical condition the inmate may be experiencing.

4. Rule 50.13(2)(f) states: "Restraint devices shall not be applied for more time than is necessary to alleviate the condition requiring the use of the restraint device." It is not clear what steps staff take to review placement and determine whether the condition has been alleviated.

   The Ombudsman recommends, to trigger staff reviews, the rules require jails to conduct periodic reviews (at least hourly) of the inmate for the purpose of determining whether the inmate can be released from the restraint device, and that jail staff document if the inmate was released or the reason for keeping the inmate in the restraint device.

5. Current rules do not require medical reviews of inmates restrained in a four or five-point restraint device.

   The Ombudsman recommends that the rules provide that, absent specific manufacturer recommendations, a jail must 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 every two hours to determine the physical condition of the inmate, check vital signs, and review to determine if any medical emergencies exist.

6. Current rules do not require jails to contact a mental health professional when a mentally ill inmate is placed in a restraint device.

   The Ombudsman recommends that the rules require jails to contact a mental health professional whenever an inmate with a known or suspected mental health condition is placed in a restraint device, or whenever any inmate is required to be held for longer than a few hours.

7. Rule 201—50.13(2)(f)(4) requires all decisions and actions be documented when prisoners are restrained in a four/five-point position. This requirement is too vague.

   The Ombudsman recommends that the rules include language that requires the documentation to include 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 (hourly) reviews.

8. Current rules do not require placement to be video recorded.

   The Ombudsman recommends that the rules require all facets of restraint device use to be video recorded, including placement, duration of use, and release; and that jails retain video copies of restraint device use for a period of at least two years.

Appendix A

General Recommendations for All Jails:[159]

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:

    - It should be vetted and approved by a mental health organization for its accuracy in identifying mental health conditions;
    - It should be brief and easy to administer;
    - Limited training should be needed for a screening officer to use it;
    - It should notify 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.

[159] From the report entitled, *Investigation of Restraint Device Use in Iowa's County Jails* (2009) (https://ombudsman.iowa.gov/browse/files/39dacd16bc0a49ea882c895c4a88c61e/download).

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.

Boone County Response

BOONE COUNTY SHERIFF'S OFFICE

Andrew D. Godzicki, Sheriff

1019 West Mamie Eisenhower Ave.
Boone, Iowa 50036
PH. 515-433-0524 FAX 515-433-0942

September 17, 2024
Iowa Office of Ombudsman
1112 East Grand Avenue
Des Moines, Iowa 50319
Attn: Bernardo Granwehr

Subject: Public Report Re Restraint Chair Use by Iowa Counties

To Whom It May Concern,

Thank you for providing the 21-page report regarding your investigation into the use of the Restraint Chair by Iowa Counties. While I appreciate the effort put into this report, I feel compelled to express my concerns about the significant four-year delay in its completion.

Your office received a complaint in 2020 and had 48 months to conclude the investigation. In your cover letter, you mentioned, "If you decide to reply to my report, please submit a written reply within 30 calendar days of your receipt of this letter." Given the extensive time taken for your investigation, I believe it would be reasonable for us to respond in the same 48-month timeframe.

A lengthy investigation like this can seem excessive, especially when it may undermine the urgency of the issues at hand. A more timely resolution would have been able to spur immediate actions to address the concerns raised, which I would have greatly appreciated.

On page four, you dramatically state, "While incidents in this report are disturbing, no one died, fortunately. Misuse of restraint chairs can result in death, and it has in other states."

If the Ombudsman's Office truly had serious concerns about potential fatalities resulting from these incidents, I would have expected a much quicker investigation aimed at preventing such incidents from occurring.

Your First Finding: Lack of Mental Health Evaluations

At the Boone County Jail, we conduct a medical intake screening upon each inmate's arrival. If an inmate is uncooperative or combative, jailers are trained to complete the medical intake screening as best as they can based on their observations. The screening includes several questions addressing the inmate's mental health, which I consider to serve as an initial evaluation.

Here are some questions included:

- Are there any visible signs of trauma or illness requiring immediate medical care?
- Does the inmate show signs of depression?
- Is the inmate acting or talking in a strange manner?
- Are you suicidal?
- Have you ever tried to hurt yourself?

These questions—the 54-total question intake form, of which 24 specifically address mental health—allow for a comprehensive initial assessment. A nurse reviews these evaluations to determine if further mental health intervention is necessary. We collaborate with Integrated Telehealth Partners, where Dr. Antony Kovilparambil typically conducts evaluations as needed.

I contacted Integrated Telehealth Partners on August 30, 2024, to inquire about the number of inmates seen from our facility since our collaboration began. However, due to scheduling issues, their representatives will not have access to records until September 9, 2024. I am concerned that the delays might impact our ability to refute your findings regarding mental health evaluations.

The Boone County Jail books approximately 1,000-1,200 inmates annually, which totals about 4,000 bookings over the four-year period in question. Thus far, to my knowledge, there haven't been other investigations of the intake assessments by your office, raising questions about the impartiality of your report. It feels as if your office has selected this particular case from a pool of 4,000 to further an agenda.

Understanding that mental health assessments require inmates to be cooperative and sober, I am curious about what measures you recommend we take if an inmate is not in a condition to be evaluated. Your statement on page nine suggests disappointment that staff did not conduct an evaluation at a later time; however, how can you be certain that staff did not attempt to do so, particularly if it wasn't documented?

Documentation, while crucial, can often fall short when jailers are managing many responsibilities. Given that our staff deals with a range of complex situations, it's understandable that not every action might be formally recorded—a reality that seems to have been overlooked.

Moreover, the importance of the operational responsibilities of jailers needs to be emphasized, particularly in high-stress situations involving combative or intoxicated individuals.

Your Second Finding: Written and Video Documentation

I'd like to revisit a few points regarding the documentation issue.

It's important to highlight that the Ombudsman's report seems to present a biased view. It appears to overlook any positives in the documentation conducted by jail staff, which skews the perspective.

When only one side of the story is shared, it's easy to shape a narrative that doesn't reflect the full picture.

Having served seventeen years with the Boone County Sheriff's Office, I've yet to see an Ombudsman conduct an in-person investigation here. For such a serious matter, an in-person review would ensure the seriousness of the matters laid out by the Ombudsman's Office.

Additionally, did the Ombudsman's Office check with Jim's healthcare provider after he left our facility to validate his mental health claims? It would be helpful if the Ombudsman's report included this aspect, as it seems to be missing.

With 99 counties in Iowa, and uncertainty about whether all have jails, it's worth asking whether a broader review of restraint chair use across all counties was conducted. The omission of specific county names in the report raises questions about the thoroughness of the investigation.

On page 10 of the Ombudsman's report, there is a general statement about shifts in inmate behavior with proper mental health treatment. However, this lacks specific data or statistics, which makes it difficult to assess the report's validity.

The Ombudsman's report does not mention Jim's history of problematic behavior, which is relevant to understanding the current situation. A review of his past conduct would have provided context for the staff's approach.

Given the many responsibilities of jail staff, including managing 20-45 inmates with varying levels of mental health issues, documentation can sometimes fall short. Staff are doing their best, but documenting everything is a significant challenge. Adding more staff dedicated solely to documentation might be necessary to meet this expectation.

The Ombudsman's report on page 12 refers to recommendations from 2009 about retaining restraint chair recordings for at least two years. However, I haven't seen this set of recommendations shared widely. It would be beneficial if the Ombudsman's Office provided regular updates on these practices to relevant training and oversight bodies.

Considering the importance of these issues, as noted in the report, it seems reasonable to establish a routine of sharing recommendations to help address and prevent future concerns.

Third Issue: Non-Compliance with Restraint Chair Policies

The Ombudsman's report highlights a concern regarding the use of the Emergency Restraint Chair. Specifically, it mentions that the jail's policy requires removing handcuffs and leg irons as soon as possible to prevent injury. However, it appears that Jim was kept in leg irons during the second restraint, which raises questions about whether the restraint chair alone could effectively secure an inmate's legs.

Here are a few points to consider:

- The Ombudsman's report notes that "several incident reports indicate that Jim was able to free his legs when not restrained by leg irons." This seems to contradict the earlier criticism of documentation issues. It's a bit confusing to see both claims of insufficient documentation and multiple reports cited in the same discussion.

- The report also questions whether the jail's restraint chair can effectively restrain an inmate's legs without deviating from the manufacturer's instructions. If this is a concern, it would be helpful to know if the Ombudsman's Office investigated whether deviating from these instructions was appropriate in this situation.

- Additionally, it's important to ask if the Ombudsman's Office checked with Jim's healthcare provider to see if keeping leg irons on while using the restraint chair caused any health issues.

It's worth noting that while manufacturers' recommendations are valuable, there may be circumstances that necessitate deviations from these guidelines. Policies and recommendations can't always account for every possible situation.

The Ombudsman's report also addresses a different concern:

"When Jim was placed in the restraint chair for the third time, jail staff kept him restrained for over five hours without direct supervision from a medical professional. While staff were present with Jim, no doctor or nurse was involved after the initial two-hour period, as recommended by the manufacturer's manual."

To address this, it's useful to consider the role of jail staff and their medical responsibilities. They are trained in CPR, first aid, and are responsible for reporting any health concerns to medical professionals. The report acknowledges that jail staff were present during this time, which suggests they were actively monitoring Jim's condition.

In my view, the jail staff's training equips them to handle situations and escalate concerns to medical professionals as needed. Their role involves making observations and taking appropriate actions, including reporting to healthcare providers when necessary.

Fourth Issue: Use of Restraint Chair as Punishment

In the Executive Summary of the Ombudsman's report, there is a mention of concerns regarding the use of restraint chairs. It states:

"The report identifies cases where restraint chairs were used not as a response to immediate threats but as punishment for disruptive behavior, which is contrary to Iowa law and best practices."

However, the report does not provide specific details about how the Boone County Sheriff's Office's use of the restraint chair in these situations might have been considered punitive. The mention in the Executive Summary seems to set a tone without further elaboration in the main body of the report.

It's important to ensure that any concerns about practices are fully explained and supported with details. This helps avoid misunderstandings and ensures that any potential issues are addressed with clarity.

Fifth Issue: Reporting to the State Jail Inspector

The Ombudsman's report notes:

"Incidents involving restraint chairs were not consistently reported to the state jail inspector as required by Iowa law. This lack of reporting hinders oversight and accountability."

According to Iowa law, the following incidents should be documented and reported:

- Use of force

- Suicide attempts or self-harm

- Threats to staff, staff assaults, escapes, fires, and any abnormal behavior

- Any incidents involving injury or self-injury, which should be reported to the state jail inspection unit within 24 hours

We acknowledge that there were lapses in reporting to the State Jail Inspector in this instance. However, we did maintain appropriate records and provided them to the Ombudsman's Office upon request.

We would appreciate the Ombudsman's Office clarifying whether the failure to report in this situation affected oversight and accountability.

Conclusion

We believe our response addresses the concerns raised.

7

The Boone County Sheriff's Office is considering the introduction of a padded cell in the booking area as an alternative to the restraint chair. While we understand there may be concerns about padded cells, we are exploring this option to improve our approach.

We welcome any recommendations from the Ombudsman's Office on humane ways to handle individuals exhibiting behaviors similar to Jim's.

Signed

CH #8-2

Cole Hoffman | Chief Deputy

8

Webster County Response

WEBSTER COUNTY SHERIFF'S OFFICE

702 1st Avenue South
Fort Dodge, IA. 50501

Office: (515) 573-1410
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TO SERVE AND PROTECT

November 8, 2024

Bernardo Granwehr
Ombudsman
1112 East Grand Avenue
Des Moines, Iowa 50319

Subject: Public Restraint Chair Use by Iowa Counties

Dear Ombudsman Granwehr:

Thank you for allowing Webster County to review the content of your report and provide a response. The 2009 public report issued by your office on the use of restraint devices in Iowa provides a good foundation for jails to follow to ensure that the rights of individuals are respected. Since much of our staff is new, with only a few Officers being here more than 5 years, many were not aware of the report, including the Sheriff and Chief Deputy. Jail Administrator Gargano was made aware of the report by Angie Long, Assistant Ombudsman, during her visits to investigate restraint chair use. It has proved to be a useful resource as we have worked towards making improvements to the process.

I will focus on the Key Findings section of the report and comment on the Recommendations suggested by your office.

Key Findings:

- Lack of mental health evaluations: All inmates are screened upon arrival, as has been done for the past several years. The Webster County Jail does not have on-site medical or mental health services, so we rely on Community Health to provide those services. When a mental health issue is identified, we are given an appointment time which unfortunately can be a week or more out. Any immediate need for mental health issues must be addressed by taking the inmate to Trinity Regional Medical Center or by using ITP (Integrated Telehealth Partners) via a tablet, to see a provider. ITP became an option for us in about the last year and a half.

- Inadequate documentation and monitoring: In the past, a paper system was used to document incidents, restraint use and security rounds, prior to July of 2023. We

have upgraded to the Guardian RFID systems to now document all areas electronically which accurately and securely records the information.

- Non-Compliance with restraint chair policies: The Webster County Jail now uses Lexipol, nationally recognized provider of policy and procedure manuals. Those policies are based on Federal, State, and best practices and are updated as the laws change.

- Use of restraint chairs as punishment: The policies at the time of incidents allowed staff to use restraint chairs to bring disruptive or self-harming behavior under control. We absolutely do not believe in using the restraint chairs as a form of punishment and always as a last resort.

- Failures in reporting to the State Jail Inspector: Due to complete transition of the Administrative Jail Staff and staff shortages, some incidents were not properly communicated. This issue has been corrected and incidents involving restraint use are reported.

Recommendations:

- All staff members have received training on the use of the restraint chair, as specified by the manufacturer, and documentation of such was sent to the Ombudsman's Office. Yearly competency training is being conducted and properly documented.

- With the addition of Lexipol, we are confident that we are receiving the most current policies which reflect the updated laws. We addressed camera issues by investing in an upgraded digital surveillance system. This allows us to record the entire cell and dayroom area to ensure staff safety and allows us to hold both staff and inmates accountable. The old cameras hindered our ability to provide the requested video to the Ombudsman's Office. All inmate interactions are noted on the Guardian system and records are retained indefinitely by Guardian. Two-to-three-month retention is now the norm for video.

- Restraint chair use is flagged so proper and timely notification is made to the State Jail Inspector. Use of the chair is not common, and all efforts are made to use the least restrictive options to avoid chair deployment.

We will always collaborate with the Ombudsman's Office to resolve any concerns expressed by our jail population. Our goal has always been and will continue to be transparent when asked for documentation. Your staff have taken a commonsense

approach when investigating complaints and they are often resolved and closed within a week.

If you have further questions, please feel free to contact me.

Sincerely,



Luke Fleener
Sheriff, Webster County

Ombudsman Comment

The Ombudsman is required by law to consult with the agencies criticized in an investigative report and attach their written replies to the report. The Ombudsman received responses from the Boone County and Webster County sheriffs' offices, and we will address each of the responses separately:

Boone County Jail

Deputy Sheriff Cole Hoffman's eight-page reply does not specifically address our findings and recommendations in his defense of the Jail's actions that were highlighted in our report. At the same time, Hoffman characterizes our report as motivated by some unspecified bias and agenda.

Far from being a hidden agenda, our mission is clearly spelled out in Iowa law. The Office of Ombudsman is charged with receiving complaints and investigating administrative actions that not only may be contrary to law or regulation, but also unreasonable, unfair, oppressive, or based on improper motivation or irrelevant consideration. We are further charged with strengthening procedures and practices that will lessen the risk of objectionable actions occurring.

Governor Robert Ray declared the purpose and intent of the Ombudsman's office during his 1969 inaugural address:

> An ombudsman would serve as a channel for redressing individual grievances which are beyond the reach of present court procedure and leave many people voiceless. Additionally, the ombudsman would analyze grievances and seek better administration of public agencies. He would improve the performance of legislative functions through identification of recurring problems which may require corrective legislation.

This report seeks to fulfill that purpose by both addressing individual grievances and recommending changes in Iowa law to correct recurring problems.

The most concerning aspect of Hoffman's reply is that it fails to identify which recommendations were accepted or rejected. Our report recommended that the Boone County Jail review and follow the 13 recommendations we made in our 2009 restraint device report. We additionally recommended the Jail train staff on the restraint chair, follow restraint chair policies, and file use-of-force reports with the State Jail Inspector. We received no acknowledgement of, or commitment to follow, any of these recommendations. As a result, we are concerned that the issues identified in this report will remain unresolved at the Boone County Jail.

The most direct response Hoffman provided to a recommendation concerned reporting use-of-force incidents to the Jail Inspector. Unfortunately, Hoffman seemed to conflate submitting records to our office with filing required reports with the Jail Inspector and questioned the purpose the legal reporting requirement serves. As with our other recommendations, Boone County's future commitment to complying with this legal requirement remains to be seen.

Importantly, Hoffman appeared to be unaware of our 2009 report and recommendations. The report is and has been available on our website since 2009, and we conducted a media blitz at the time of its release. As detailed in our report, we continued discussions on our recommendations with both the Iowa Department of Corrections (DOC) and the Iowa State Sheriffs' and Deputies' Association long after its release.

I suspect Hoffman is not the only jail official who is unaware of our 2009 report – despite our best efforts to publicize it. This underscores the need for DOC to implement our recommendations and make needed changes to the Iowa Administrative Code – the so-called "bible of jail operations" – so that clear directives endure for years to come and are easily accessible to all jail staff across the state.

In the meantime, I hope the Boone County Jail further considers the findings identified in this report and sincerely considers following our recommendations.

Webster County Jail

I want to thank Webster County Sheriff Luke Fleener for his thoughtful, good faith response to our findings and recommendations. I appreciate Sheriff Fleener sharing that his jail has taken steps to address our recommendations concerning training; camera and documentation inefficiencies; and use of force reporting to the State Jail Inspector. Our mission statement is "Making Good Government Better," and Sheriff Fleener's commitment to continually improve his office demonstrates that our two offices are aligned in that regard.