

Public Report, Ombudsman Investigation

Anchorage Correctional Complex, Department of Corrections

A2017-2163

January 6, 2022

The Alaska State Ombudsman provides this public summary of the investigation of complaint A2017-2163, pursuant to AS 24.55.200. The report has been edited and redacted to remove information considered confidential by law and to protect the privacy of the citizens involved.

Summary of the Complaint

On November 22, 2017, an inmate¹ housed at Anchorage Correctional Complex (ACC) contacted the Ombudsman to report that he had been inappropriately sprayed with oleoresin capsicum (OC) by a group of correctional officers. The incident allegedly occurred at 9:00 a.m. that morning, after the Complainant and two other inmates² were transported in a van from ACC West to ACC East. The Complainant reported that, during the transport, all three inmates were restrained with waist restraints.

The Complainant alleged that the officers sprayed him and the other inmates with OC while they were seated in the van, and then the officers closed the van door and kept the three inmates in the closed van for about 10-15 minutes. The Complainant alleged that, while he was shut in the van, he heard officers laughing and discussing how they were going to write up the incident in corresponding disciplinary reports for all three inmates.

The Complainant said that he was removed from the van and escorted by three officers to the segregation wing of ACC East, where he was placed in one of the two segregation showers. He said that he did not shower because one of the officers pointed OC spray at him. He alleged that he was not offered any materials to decontaminate (to wash the OC off his skin), nor was he offered an opportunity to shower and change clothes.

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

² The other two inmates involved in this incident are referred to as Inmates A and B.

The Complainant later alleged that he had filed a grievance with the Department of Corrections (DOC) to address the alleged staff misconduct, but the responses he received from DOC were evasive or non-responsive. The grievance investigation deferred to the findings of a separate administrative investigation conducted by the DOC Professional Conduct Unit (PCU), and the PCU would not provide any details on the results of its investigation.

At the time he contacted the Ombudsman, the Complainant reported he was still wearing the same clothing. He reported that a correctional officer [CO] gave him a towel and bar of soap to try and wash the OC off. Later, the ombudsman investigator learned that the Complainant was unable to take a shower or obtain a change of clothing for two days following the incident.

Allegations and Recommendations

The Ombudsman investigated five (5) allegations:

1. **Contrary to Law:**³ DOC staff used excessive force by pepper spraying three inmates in a transport van and leaving the inmates in the van for several minutes without proper ventilation.
2. **Unreasonable:**⁴ DOC staff did not allow the three inmates to properly decontaminate following exposure to oleoresin capsicum spray.
3. **Unreasonable:** DOC staff did not follow DOC policy on use of active force.
4. **Unreasonable:** DOC's employee misconduct investigation and disciplinary process was ineffective in holding its staff accountable.
5. **Unfair:**⁵ DOC's Professional Conduct Unit's practice of keeping the results of its investigation confidential failed to achieve the Unit's commitment to transparency.

³ In an ombudsman investigation, "contrary to law" means that the agency: did not comply with statutory or regulatory requirements; misinterpreted or misapplied a statute, regulation or comparable requirement; failed to follow common law doctrines; or failed to comply with court or administrative orders. Ombudsman Policy 4040(1).

⁴ In an ombudsman investigation, "unreasonable" means that the agency: adopted and followed a procedure in managing a program that is inconsistent with, or fails to achieve, the purposes of the program; adopted and followed a procedure that defeats the complainant's valid application for a right or program benefit; or placed the complainant at a disadvantage relative to all others through actions inconsistent with agency policy. Ombudsman Policy 4040(2).

⁵ In an ombudsman investigation, "unfair" means that an administrative act violates some principle of justice. Ombudsman Policy 4040(3).

Assistant Ombudsman Jennifer Christensen conducted an extensive analysis of agency records, documents, and video evidence. She interviewed multiple members of DOC staff and other state agency staff, and considered confidential reports issued by the DOC PCU and DOC Human Resources.

At the conclusion of the investigation, the Ombudsman found all five allegations **justified**⁶ and made 11 recommendations to DOC.

Note: Confidential Matters Not Included

AS 24.55.160(b) provides that the Ombudsman “may not disclose a confidential record obtained from an agency.” DOC policies related to facility security, including use of force, are confidential. Records, evidence, and findings from the PCU and Human Resources investigations are confidential under the Personnel Act (AS 39.25.080). While the Ombudsman reviewed and considered this evidence in making her findings, this information cannot be disclosed or discussed in this public summary.

Agency Response to Preliminary Report

The Ombudsman hosted two consultations, pursuant to AS 24.55.180, with DOC leadership. The Ombudsman met with former Commissioner Dean Williams and his leadership team for the first consultation on May 30, 2018. She met with Commissioner Nancy Dahlstrom and her leadership team on June 20, 2019, for the second consultation.

The Ombudsman forwarded her preliminary findings and proposed recommendations to Commissioner Dahlstrom and DOC leadership on August 23, 2021. DOC Director of Institutions Jeremy Hough responded to the Ombudsman’s preliminary findings and proposed recommendations on October 5, 2021.

⁶ A complaint allegation is *justified* if the investigation establishes that the administrative act complained of occurred and the Ombudsman determines that criticism of the administrative act is valid. Ombudsman Policy 4060.03 Findings.

The Ombudsman carefully considered the information and evidence provided during the May 30, 2018 and June 20, 2019 consultations, as well as Director Hough's October 5, 2021 response to the preliminary report, in making her final report findings and recommendations.

Evidence Review and Summary

November 21, 2017 Assault at ACC West

On November 21, 2017, the Complainant, Inmate A, and Inmate B received disciplinary write-ups for assaulting a fourth inmate while they were housed at ACC West.⁷

November 22, 2017 Van Transport

On November 22, 2017, all three inmates were moved from ACC West to ACC East by transport van. The Prisoner Transport Officer (PTO) reported that, while he was handcuffing the inmates, he heard Inmate A tell the other two inmates that they knew what to do so that they could be returned to ACC West. The PTO reported that the Complainant and Inmate B agreed with Inmate A. The PTO further reported that Inmate A asked him if he would have a roommate, said he would not be housed with anyone, and would punch anyone housed with him in the face. After the PTO arrived at ACC East, he reported the inmates' alleged comments to the lieutenant in charge.

November 22, 2017 Security Video

The ombudsman investigator reviewed security video footage, provided by DOC, from November 22, 2017. No audio was included with the security footage video. The video evidence established the following facts.

At 8:34 a.m., the PTO loaded the three inmates into the van at the ACC West sally port. The van arrived at ACC East five minutes later. The PTO exited the van and motioned through the sally port window using hand signals. A lieutenant came out and spoke to the PTO.

Shortly after, a total of nine officers assembled in the sally port area, including the lieutenant and a sergeant. The sergeant left the sally port and returned with a can of OC spray. At 8:46 a.m., an

⁷ All three inmates were later found guilty of the assault at subsequent disciplinary hearings. They did not appeal the findings.

officer opened the side van door. At 8:47 a.m., the sergeant pointed the OC can into the van and sprayed. At 8:47 a.m., an unidentified officer shut the van door. All the officers walked away from the van after the van door was closed.

The video evidence showed that, after the sergeant sprayed the OC spray:

- Inmate B was left in the closed van exposed to OC spray for approximately 7 minutes (from 8:47 a.m. to 8:54 a.m.);
- The Complainant was left in the closed van exposed to OC spray for approximately 12 minutes (from 8:47 a.m. to 8:59 a.m.); and
- Inmate A was left in the closed van exposed to OC spray for approximately 18 minutes (from 8:47 a.m. to 9:05 a.m.).

The video evidence showed that DOC staff took more than an hour to provide Inmate A with a shower after the sergeant sprayed him with OC. The Complainant and Inmate B were taken to the segregation showers after being sprayed with OC. However, the escorting officers did not provide them with supplies for decontamination (soap, clean clothing, towels).

[November 22, 2017 Incident Reports and Write-Ups](#)

Incident Reports

All three inmates were written up for committing disciplinary violations on November 22, 2017. Inmate A received a disciplinary write-up for a C-19 violation: refusing to obey a direct order of a staff member. The Complainant and Inmate B each received a disciplinary write-up for a C-15 violation: engaging in a group or individual demonstration. However, all three of these write-ups were later reduced to informational reports. Based on DOC policy, even when a disciplinary report is reduced to an informational report, it remains in an inmate's institutional file and can be considered by DOC staff "for purposes of program assessment."

The lieutenant who wrote the primary incident report – the basis for the disciplinary actions – stated that he directed Inmate A to stop interrupting him and described Inmate A as "loud," "aggressive," and "shouting." He also wrote that Inmate A made "a move towards the van door."

According to the lieutenant's report, the sergeant, with the lieutenant's approval, sprayed Inmate A with a single burst of OC spray, hitting him in the face. The lieutenant confirmed that the van door was closed to contain the inmates and prevent their behavior from "escalating." He wrote that, after five minutes, he approached the van door and all three inmates complied with his orders. He wrote that the Complainant and Inmate B were taken to segregation for decontamination and housing. The lieutenant's report stated that Inmate A was permitted to decontaminate in the booking area.

Officers' Supporting Statements

The officers present during the incident wrote supporting statements. The lieutenant signed off on all the DOC employees' written accounts, except for one officer's – the only statement that did not align with the lieutenant's incident report.

The sergeant who sprayed the OC reported that "the prisoners were being disruptive, defiant and t[h]reatening hostile acts . . . [Inmate A] made a slight movement towards the van door. [Inmate A] was told not to move towards the door."

The PTO reported that the lieutenant started to talk to all three inmates, at which point "[Inmate A] started arguing and then became non[compliant] with [the lieutenant's] directions. He continued to become more aggressive in hi[s] arguing and refused to listen to [the lieutenant's] direction." The PTO reported that "a few minutes" after the sergeant sprayed the OC, the "inmates one by one were removed from the van to Segregation to decontaminate and housed in segregation."

Although the other officers' written reports varied to some degree, the majority consistently described Inmate A as "loud" and "argumentative," interrupting or talking over the lieutenant, and Inmate A ignoring the lieutenant's direct order to stop interrupting him. However, one officer noted that the lieutenant was also loud and argumentative with Inmate A. That officer described the lieutenant as getting "progressively louder" and shouting, and the lieutenant's interaction with Inmate A as a "lecture." In statements written a week after the incident, two officers described Inmate A as moving toward the van door.

One officer reported in their supporting statement that the sergeant directed them to place Inmate A in a holding cell in the booking area. The officer reported providing Inmate A with a towel, soap, and clean clothes and placing them back in the booking cell until a segregation cell was available later that afternoon. Another officer wrote that Inmate A was allowed “to decontaminate in the shower in booking” sometime later. A third officer wrote that Inmate A was decontaminated sometime after being placed in booking. The sergeant likewise reported that Inmate A was moved to a booking cell and later to a shower “so he could decontaminate.”

The sergeant stated in his report that “the other 2 prisoners were taken to the segregation unit and decontaminated there.” However, none of the other officers’ supporting statements reference an opportunity to decontaminate being offered to the Complainant or Inmate B.

[November 22 Requests to Medical](#)

On November 22, 2017, the Complainant submitted a written request to the medical department for a shower after being sprayed with OC. He did not request a medical exam. According to DOC Health and Rehabilitation Services Director Laura Brooks, a DOC nurse contacted an officer in segregation and the officer stated that the Complainant would be provided a shower. Medical staff did not examine the Complainant. Neither Inmates A or B submitted any requests to the medical department after being sprayed with OC spray. Neither was examined by medical staff.

[Inmates’ Grievances and DOC’s Response](#)

All three inmates filed grievances with DOC concerning the November 22, 2017 incident. An ACC lieutenant was assigned to investigate all three inmates’ grievances. In all three responses, the lieutenant deferred to the PCU’s investigation, which had been initiated by DOC on November 28, 2017.

The Complainant appealed the grievance response he received on January 18, 2018, questioning the lack of any grievance investigation or findings by the lieutenant. He noted that the PCU’s investigation report was confidential and stated his belief that ACC was attempting to circumvent the grievance process. Inmates A and B raised similar objections in their grievance appeals.

On February 15, 2018, the superintendent of a different facility denied the Complainant's appeal. It is unclear why they responded to the appeal, as DOC Policy 808.03 VII.A.2.i. requires the appeal of a facility superintendent's grievance decision (level 2 appeal) to be answered by the Director of Institutions.

The appeal response noted that the ACC lieutenant had responded to the grievance, the ACC Superintendent had ensured the video footage was preserved, and the matter was being investigated by the PCU. It also noted that any personnel action taken in response to the incident was confidential and could not be shared with the Complainant.

On March 2, 2018, the Complainant filed a level 3 appeal to the DOC Standards Administrator. The Standards Administrator responded on March 20, 2018, upholding the agency's grievance investigation and appeal responses, noting that the PCU had investigated the incident and that human resources matters were confidential.

Analysis — Allegation 1: Contrary to Law: DOC staff used excessive force by pepper spraying three inmates in a transport van and leaving the inmates in the van for several minutes without proper ventilation.

The Ombudsman defines contrary to law as action (or withholding of action) that fails to comply with statutory or regulatory requirements, or that misinterprets or misapplies statute, regulation, or comparable requirement. Contrary to law also includes individual misconduct in which a state employee engages in conduct for an illegal or improper purpose, or performed in an illegal manner (*see* AS 11.56.850, AS 11.56.860, or the Executive or Legislative Ethics Acts).

A correctional officer's use of force is justified under Alaska law if it is (1) authorized by DOC regulations, and (2) reasonably necessary and appropriate to maintain order.⁸ DOC staff are authorized to use chemical agents within a DOC facility only in the following situations:

- when necessary in self-defense;
- to protect a person from imminent physical harm;

⁸ *See Bachmeier v. State*, 276 P.2d 494, 496 (Alaska Ct. App. 2012) and AS 11.81.410(a).

- to enforce a lawful order of a staff member in the face of physical resistance by a prisoner;
- to prevent escape or serious damage to property; or
- to alleviate a security threat.⁹

The use of force must always be limited to the extent reasonably necessary to accomplish its purpose.¹⁰

The evidence showed that that Inmate A verbally resisted a lieutenant's orders to be quiet. There is no evidence to support the assertion that the inmate's behavior was likely to cause extensive property damage or physical harm to himself or others, or that he was physically resisting orders by being argumentative. Therefore, the use of active force (OC spray) against Inmate A was not authorized by DOC regulation or policy.

Based on a preponderance of the evidence reviewed, the Ombudsman concluded that DOC staff used excessive force when they sprayed Inmate A with OC spray in the transport van on November 22, 2017. The use of OC spray was not reasonably necessary or appropriate to maintain order and was therefore contrary to law.

The preponderance of the evidence showed that, while the sergeant intended to only spray Inmate A with OC, the other two inmates (Inmate B and the Complainant) were indirectly hit with the OC spray and were then further exposed to the OC spray when the van doors were closed. There was no evidence that any of the three inmates engaged in any conduct justifying the use of OC or other force while in the van.

The preponderance of the evidence showed that, once the sergeant sprayed Inmate A with OC, the lieutenant shut the van door and confined all three inmates for several minutes without proper ventilation. By both officers' own accounts, the van doors were closed to contain the OC spray and to contain the inmates. Despite various justifications offered after the fact, the evidence indicated that the officers left the inmates closed in the van as a form of punishment for their previous behavior (assaulting another inmate). This is expressly prohibited by DOC regulation.

⁹ See 22 AAC 05.060.

¹⁰ 22 AAC 05.060(a).

The Ombudsman found Allegation 1 *justified* by a preponderance of the evidence.

Agency Response

DOC did not dispute the Ombudsman's findings for Allegation 1.

Analysis — Allegation 2: Unreasonable: DOC staff did not allow the three inmates to properly decontaminate following exposure to oleoresin capsicum spray.

The Ombudsman defines unreasonable to include when an agency's or employee's acts were inconsistent with agency policy, placing the complainant at a disadvantage relative to all others. 22 AAC 05.060(d) provides that "If a prisoner is exposed to a chemical agent, medical personnel shall examine the prisoner as soon as reasonably possible after the exposure." The medical exam is mandatory, not optional. Despite the requirements of 22 AAC 05.060(d), none of the inmates received a medical examination. Despite DOC policy requirements, ACC staff did not offer a medical exam to the three inmates.

DOC policy requires that inmates be provided with both the opportunity and the means to decontaminate. Based on an officer's testimony to the ombudsman investigator, neither of the two other inmates who were indirectly sprayed with OC were taken to the segregation shower for the express purpose of decontamination. Instead, each was temporarily placed in the shower area while the officers removed the other inmates from the van.

The Complainant and Inmate B reported that they were not provided with a towel, clean clothing, or soap after they were placed in the segregation shower. A review of the security footage confirmed this. While both inmates may have been placed in the segregation shower, they were not provided with the means to remove the OC residue (water and soap, towels, and clean clothes).

Review of security footage confirmed that Inmate A was able to shower and decontaminate approximately one hour after he was sprayed with OC. An officer testified that he provided Inmate A with soap, a towel, and clean clothing. Video evidence confirmed this.

The Ombudsman found Allegation 2 *justified* by a preponderance of the evidence. While the two inmates who were indirectly hit by the OC were temporarily placed in the segregation shower, ACC staff unreasonably denied them the means to decontaminate themselves. The preponderance of the evidence shows that Inmate A was provided the means and opportunity to decontaminate, but not “as soon as practicable.” ACC staff waited more than an hour after he was sprayed with OC to allow his decontamination.

Agency Response

DOC did not dispute the Ombudsman’s findings for Allegation 2.

Analysis — Allegation 3: Unreasonable: DOC staff did not follow DOC policy on use of active force.

DOC policy related to the use of force is confidential and cannot be disclosed or discussed in this report. The preponderance of the evidence showed that the officers involved in the November 22, 2017, incident did not follow the policy in either the use of force or the documentation afterward.

Every correctional officer who witnesses inappropriate or excessive force has a duty to report these violations to a supervisor and DOC Human Resources.¹¹ The Code of Ethics for correctional officers is provided in 13 AAC 85.230(d):

(d) The correctional, probation, and parole officer Code of Ethics is:

As a correctional, probation, or parole officer, my fundamental duty is to respect the dignity and individuality of all people, to provide professional and compassionate service, and to be unfailingly honest. I will not discriminate against any person on the basis of race, religion, color, national origin, sex, age, physical or mental disability, marital status, changes in marital status, or pregnancy or parenthood, and will respect and protect the civil and legal rights of all inmates, probationers, and parolees. I will respect the right of the public to be safeguarded from criminal activity, and will be diligent in recording and making available for review all case information that could contribute to sound decisions affecting the public safety, or an inmate, probationer, or parolee. I will maintain the integrity of private information, and will neither seek personal data beyond that needed to perform my duties, nor reveal case information to anyone not having a proper professional use for the information. In making public statements, I will clearly

¹¹ See 13 AAC 85.230(d), Correctional, Probation and Parole Officer Code of Ethics.

distinguish between those that are my personal views and those that are made on behalf of the agency. I will not use my official position to secure privileges or advantages for myself, and will not accept any gift or favor that implies an obligation inconsistent with the objective exercise of my professional duties. I will not act in my official capacity in any matter in which I have a personal interest that could in the least degree impair my objectivity. I will not engage in undue familiarity with inmates, probationers, or parolees. I will report any corrupt or unethical behavior of a fellow correctional, probation, or parole officer that could affect either an inmate, probationer, or parolee, or the integrity of the agency, but will not make statements critical of colleagues or other criminal justice agencies unless the underlying facts are verifiable. I will respect the importance of, and cooperate with, all elements of the criminal justice system, and will develop relationships with colleagues to promote mutual respect for the profession and improvement of the quality of service provided.

There is no indication that any of the officers who were present on November 22, 2017, notified a DOC supervisor or Human Resources that excessive force had been used.

Based on the requirement that a correctional officer “will respect and protect the civil and legal rights of all inmates, probationers, and parolees,” the Ombudsman inferred a duty to intervene when the officer witnesses excessive use of force. None of the officers present during this incident intervened to protect the inmates’ civil and legal rights.

Based on a preponderance of the evidence, the Ombudsman found Allegation 3 that DOC staff failed to follow agency policy/policies *justified*.

Agency Response and Ombudsman’s Comments

DOC partially objected to the finding for Allegation 3, specifically to the Ombudsman’s reading of Alaska Police Standards Council (APSC) regulation 13 AAC 85.230(d) as imposing an affirmative duty to intervene upon correctional officers when they observe another officer engaging in excessive force. In his October 5, 2021 response to the preliminary report, Director of Institutions Jeremy Hough wrote as follows:

In the analysis of Allegation #3, your office makes the finding that DOC personnel have an obligation to intervene if they see another officer using an inappropriate level of force. However, I do not believe that the authority cited, the oath taken by correctional officers in 13 AAC 85.230(d), supports that finding. The oath specifies that an officer shall report corrupt or unethical behavior of another officer. To me,

the oath in 13 AAC 85.230(d) requires officers to report observed excessive force by others and requires immediate investigations of all uses of force. That is different from intervention, which requires the officer to take action at the time of the incident, which requires a reasonable opportunity.

Upon further review of the regulation in question, the Ombudsman agrees with Director Hough that 13 AAC 85.230(d) does not provide an explicit duty to intervene when they observe a fellow officer engaging in excessive force. However, as Director Hough also noted, the cited regulation does appear to impose an affirmative duty on correctional officers to report observed excessive force by their fellow officers. That did not occur. The ombudsman investigator found no evidence during this investigation that the correctional officers who witnessed the events of November 22, 2017 ever reported the use of excessive force by the sergeant to their superiors or Human Resources.

APSC noticed a new regulation package on January 4, 2021, proposing to amend regulations to specifically require that correctional officers receive training on their duty to intervene when they witness excessive force by a fellow correctional officer.¹² However, APSC subsequently voted to table the proposed regulations and start anew in the future.¹³

Although current APSC regulations may not specify that an officer has a duty to intervene when they observe unreasonable force used by another officer, it is noteworthy that DOC's training academy specifically covers this topic in its Basic Correctional Officer Training curriculum:¹⁴

The Basic Correctional Officer training consists of a 6-and-a-half-week Academy totaling approximately 270 hours of training. The training is provided by senior Correctional Officers who are APSC certified Law Enforcement Trainers.

The Alaska DOC Training Academy for basic Correctional Officers covers the following subjects . . .

¹² Proposed Regulatory Amendments, Alaska Police Standards Council (January 4, 2021), available at <https://dps.alaska.gov/apsc/regulations> (reviewed October 5, 2021).

¹³ See Email from Sarah Hieb, APSC Administrative Investigator, to Jennifer Christensen, Assistant Ombudsman (Dec. 20, 2021).

¹⁴Alaska Department of Corrections, Correctional Officer Training Synopsis, http://www.ajc.state.ak.us/acjc/docs/resources/Resources_for_RRR_WG/correctional_officer_training_synopsis.pdf (viewed October 5, 2021).

- Use of Force: This is an eight-hour class which covers constitutional use of force, Alaska Statutes, case law, and Department policy *as well as duty to intervene and specifics for reporting use of force.* [Emphasis added]

While the Ombudsman agrees that the APSC regulation does not impose an explicit duty to intervene, there is other relevant legal authority that imposes this duty.¹⁵ Were there no such duty, it is unlikely that the DOC training academy would specifically address it as a topic for new officers when conducting use of force training.

Correctional officers have been found civilly liable for failure to intervene under 42 USC §1983.¹⁶ Federal courts have found correctional officers liable for failure to intervene in excessive use of force they directly witness,¹⁷ and have found supervisors liable for failure to address officers' previous acts of excessive force.¹⁸

Whether or not DOC policy requires officers to intervene when they witness excessive use of force, agency policy is very clear about the duty to report such incidents. Since none of the officers made such a report after the November 22, 2017 incident, the Ombudsman maintains the finding that Allegation 3 is *justified*.

¹⁵ For example, a correctional officer could be charged with the crime of official misconduct for failing to intervene. See AS 11.56.850(a):

A public servant commits the crime of official misconduct if, with intent to obtain a benefit or to injure or deprive another person of a benefit, the public servant

(1) performs an act relating to the public servant's office but constituting an unauthorized exercise of the public servant's official functions, knowing that that act is unauthorized; or

(2) knowingly refrains from performing a duty which is imposed upon the public servant by law or is clearly inherent in the nature of the public servant's office. [Emphasis added].

See also 18 U.S.C. § 242. Section 242 provides in relevant part: "Whoever, under color of any law, . . . willfully subjects any person . . . to the deprivation of any rights, privileges, or immunities secured or protected by the Constitution or laws of the United States" shall be guilty of a crime. The US Department of Justice interprets this to mean:

An officer who purposefully allows a fellow officer to violate a victim's Constitutional rights may be prosecuted for failure to intervene to stop the Constitutional violation. To prosecute such an officer, the government must show that the defendant officer was aware of the Constitutional violation, had an opportunity to intervene, and chose not to do so. This charge is often appropriate for supervisory officers who observe uses of excessive force without stopping them, or who actively encourage uses of excessive force but do not directly participate in them.

United States Department of Justice website at: <https://www.justice.gov/crt/law-enforcement-misconduct#intervene> (viewed December 1, 2021).

¹⁶ The US Supreme Court held in 1961 that §1983 "should be read against the background of tort liability that makes a man responsible for the natural consequences of his actions." *Monroe v. Pape*, 365 US 167 (1961) at 187.

¹⁷ See *Byrd v. Brishke*, 466 F.2d 6, 11 (7th Cir. 1972); see also *Perry v. Monroe*, F.Supp.2d (S.D. Ill. 2009).

¹⁸ See *Locicero v. O'Connell*, 419 F. Supp. 2d 521 (S.D.N.Y. 2006); see also *Mathews v. Crosby*, 480 F.3d 1265 (11th Cir. 2007).

Analysis — Allegation 4: Unreasonable: DOC's employee misconduct investigation and disciplinary process was ineffective in holding its staff accountable.

The Ombudsman considers an agency's actions to be unreasonable when an agency followed a procedure in managing a program that was inconsistent with, or failed to achieve, the purposes of its program or the agency's act was inconsistent with agency policy.

DOC Policy 202.15 Standards of Conduct provides that DOC employees who violate the APSC Code of Ethics for Correctional, Probation, and Parole Officers are subject to corrective or disciplinary action. DOC employees are required to sign a written acknowledgement that they have read the Code of Ethical Professional Conduct, and have sought and obtained clarification on anything they may not understand. The written acknowledgement states that the employee recognizes they have a fundamental duty to respect the dignity of all people and to be unfailingly honest. Likewise, the written acknowledgement requires the employee to respect and protect the civil and legal rights of all inmates.

DOC employee misconduct investigations involving allegations of serious misconduct, including allegations of excessive force by correctional officers, should be thorough and impartial, and conducted in a reasonable, timely, and consistent manner. When DOC Human Resources concludes that a staff member has been untruthful, there should be significant and separate consequences, not merely an enhanced sanction. After extensive review of the video and documentary evidence, as well as witness and employee interviews, the Ombudsman concluded that some of the officers' testimony was either exaggerated or inaccurate.

DOC should be able to appropriately investigate and, if appropriate, discipline any correctional officer who is the subject of a substantiated misconduct allegation regarding use of excessive force, or a correctional officer who fails to report misconduct by another fellow officer. In deciding the appropriate discipline, DOC should consider the nature and scope of the officer's misconduct, and the officer's history of past misconduct investigations and discipline. Where the substantiated misconduct involves use of excessive force, any discipline issued should also include appropriate remedial measures.

After resolving a misconduct complaint investigation, DOC should, consistent with applicable personnel rules and statutes, inform the complainant in writing of the results of the investigation and what actions were taken by DOC, similar to what the Department of Public Safety does. See further discussion under Allegation 5.

Correctional officers are required to report misconduct by other officers that they either witness or of which they have knowledge.¹⁹ Officers who fail to report the misconduct of other officers should be subject to discipline under DOC Policy 202.15. That did not occur here.

The Ombudsman found Allegation 4 that DOC's misconduct investigation and disciplinary process was ineffective in holding its staff accountable *justified* based on the preponderance of the evidence.

Agency Response

DOC did not dispute the Ombudsman's findings for Allegation 4.

Analysis — Allegation 5: Unfair: DOC's Professional Conduct Unit's practice of keeping the results of its investigation confidential failed to achieve the Unit's commitment to transparency.

Commissioner Dahlstrom dissolved the PCU in December 2018, making Allegation 5 moot. However, the Ombudsman provides the analysis of the allegation to inform any future actions by the agency regarding an internal investigatory unit.

The Ombudsman defines unfair as an administrative act that violated some principle of justice. Procedurally, an administrative act can be considered unfair if adequate and reasonable notice of the matter was not provided to the complainant.

While the PCU was operating, its stated mission was "to demonstrate commitment to transparency and self-examination to continually improve community safety, employee safety, public service and fulfilling the obligations of the State of Alaska in regards to secure confinement, reformative

¹⁹ 13 AAC 85.230(d) Correctional, Probation and Parole Officer Code of Ethics.

programs, community supervision and rehabilitation.”²⁰ The PCU conducted a thorough investigation of the November 22, 2017 OC incident at ACC. However, no information from the PCU’s investigation could be shared with any of the three inmates who were directly affected by the officers’ actions. This is because, according to (now repealed) DOC policy 1120.01, investigation reports written by PCU staff were considered confidential.

The inmates involved in this matter expressed frustration that, even though the PCU investigated the matter, the PCU would not provide them with any information on the agency’s findings. State employees’ personnel records, which include disciplinary records, are confidential pursuant to the Personnel Act (AS 39.25.080 *et seq.*). However, the PCU investigation was separate and distinct from any Human Resources or disciplinary action. Instead, it was an internal administrative review of the officers’ conduct, similar to the Office of Professional Standards at the Department of Public Safety.

It would have been inappropriate for the PCU to provide a full account of its investigation and findings to the complaining inmates. However, nothing precluded the PCU from providing notice that it had concluded its investigation and whether the complaints were substantiated or not.

DOC has an obligation to ensure that its inmate grievance process is reasonable and effective in addressing and resolving an inmate’s grievance whenever possible. The DOC grievance process should provide inmates with an easily accessible complaint process in which they have confidence that their complaints will be given prompt and fair attention. Properly conducted grievance investigations ensure that corrective action will be taken by DOC when appropriate and protect against unwarranted criticism when policies or procedures were properly followed by DOC staff. However, DOC did not do that with the inmates’ grievances and appeals.

The officer who investigated their grievances responded that the matter was being investigated by the PCU and deferred to the PCU without making any specific grievance findings. This was not unreasonable, as long as DOC had then followed with some notice to the inmates regarding the results of the PCU’s investigation. That would have fulfilled the intent of the grievance process.

²⁰ DOC Policy 1110.01, Professional Conduct Unit Operations, (Effective December 14, 2017).

However, there was no substantive response to the inmates' grievances, even after the PCU was done.

Based on the preponderance of the evidence, the Ombudsman found that the allegation that DOC's practice of keeping the results of the PCU's investigation findings confidential, without providing even summary information to the inmates, was unfair *justified*.

Agency Response

DOC did not dispute the Ombudsman's findings for Allegation 5.

Recommendations

Former DOC Commissioner Williams reported that DOC was revising the agency's policy for use of OC spray and decontamination in 2018. The Ombudsman encourages agencies to resolve complaints whenever possible. However, the use of force policy has not been updated since the 2017 incident giving rise to this complaint and investigation. Therefore, the Ombudsman issued the following recommendations.

Recommendation 1: Establish an agency-wide use of force policy which includes specific provisions governing use of OC spray and other chemical agents.

ACC's use of force policy is not the same as DOC's use of force policy. Inmates should not be subject to different practices in the use of force based solely on the facility in which they are held. The Ombudsman recommends that DOC have a single, uniform use of force policy that applies to all state correctional facilities.

DOC should ensure that its policy on the use of OC spray and other chemical agents expressly addresses the following issues:

- the appropriateness of the chemical agent used by DOC staff given specific physical environments and inmate health conditions;
- the requirement to issue verbal warnings prior to application, absent imminent risk of physical harm to an officer or inmate;

- specific decontamination procedures and timelines;
- incident documentation; and
- sanctions that could ensue for failure to follow agency policy on the use of chemical agents by DOC staff.

Appropriateness of chemical agents: While OC spray does not create long-lasting or permanent health consequences when used appropriately, there are factors that can result in negative health consequences by the use of OC. The physical environment in which OC spray is deployed can increase the risk of harm to the target. The physical position of the target and whether they are already restrained in a manner that restricts respiration can make the use of OC spray dangerous to the target.²¹

The Ombudsman recommends that DOC’s Use of Force Policy include a requirement that the physical environment be considered prior to authorization of the planned use of OC spray, with direction to limit use when the inmate or officer is in a confined or poorly ventilated space (such as a transport van).

Underlying health conditions can also increase the risk of harm due to the use of OC spray.²² In addition to skin and eye irritation/pain, OC spray can cause “burning of the throat, wheezing, dry cough, shortness of breath, gagging, gasping, inability to breathe or speak (due to laryngospasm or laryngeal paralysis), and, rarely, cyanosis, apnea, and respiratory arrest.”²³ Research in 2008 documented that capsaicinoids (the active ingredient in OC and other pepper sprays) cause “acute pulmonary inflammation and respiratory cell injury in experimental animals and in human lung epithelial cells.”²⁴

²¹ See *The Effectiveness and Safety of Pepper Spray*, U.S. Department of Justice, Office of Justice Programs, National Institute of Justice (April 2003).

²² *Id.*

²³ “Health Hazards of Pepper Spray,” Smith, C. Gregory Smith, MD, MPH and Stopford, Woodhall Stopford MD, MSPH, North Carolina Medical Journal Sep-Oct 1999;60(5):268-74 *citing* “Oleoresin capsicum (pepper) spray and ‘in custody deaths,’” Steffee, CH, et al. American Journal of Forensic Medicine and Pathology 1995;16:185-92. *But see* “Pepper Spray’s Effects on Suspect’s Ability to Breathe,” Chan, T. et al., U.S. Department of Justice, Office of Justice Programs, National Institute of Justice Research in Brief (Dec. 2001), which reported the effect of OC spray shown by research “performed on human subjects in a clinical laboratory” which “did not attempt to replicate all the conditions that maybe encountered in the field.” *Id.* at 5.

²⁴ “Capsaicinoids cause inflammation and epithelial cell death through activation of vanilloid receptors,” Reilly CA, Taylor JL, Lanza DL, Carr BA, Crouch DJ, Yost GS. Toxicol Sci. 2003;73(1):170-181. doi:10.1093/toxsci/kfg044.

The Ombudsman recommends that DOC's Use of Force Policy require an express consideration of an inmate's underlying health conditions, if known to DOC, in relation to the level of threat of harm that the inmate poses to officers or other inmates.

Verbal warnings: Alaska's corrections population is ethnically diverse. According to the most recent Offender Profile published by the Department of Corrections (for CY2020), 39.7% of inmates were Alaska Native.²⁵ Another 19.19% of inmates were persons of color (Black, Asian, Hispanic/Latino, or other non-Caucasian ethnicity).²⁶ Other law enforcement agencies recognize that language and other barriers are important considerations when issuing commands or warnings, especially prior to the use of force. For example, the Philadelphia Police Department policy includes the following guidance to officers:

Subjects may be physically or mentally incapable of responding to police commands due to a variety of circumstances including but not limited to alcohol or drugs, mental impairment, medical conditions, or language and cultural barriers. Officers should be mindful of this when making use of force decisions.²⁷

The Federal Bureau of Prisons policy provides similar guidance:

Prior to any OC aerosol spray being used, staff must attempt verbal intervention to defuse the situation when feasible. Good communication skills can frequently eliminate the need for an elevated response.²⁸

The Ombudsman recommends that DOC policy require, absent an imminent threat of harm to another person, a clear and understandable (to the specific inmate) warning prior to use of active force.

Decontamination: *See* Recommendation 2.

Documentation: *See* Recommendation 3.

²⁵ *See* 2020 Offender Profile, Alaska DOC, at 11.

²⁶ *See id.*

²⁷ Philadelphia Police Department Directive 10.2 (September 18, 2015) at §2.C.

²⁸ Operations Memorandum 001-2015, U.S. Department of Justice, Federal Bureau of Prisons (February 26, 2015) at 4.

Possible Sanctions for Failure to Follow Policy: The Ombudsman recommends that DOC include an explanation of potential consequences for not following the agency's use of force policies, including documentation and decontamination.

Agency Response to Recommendation 1

In his October 5, 2021 response to the preliminary report, Director Hough raised the following concern in response to Recommendation 1:

Another concern I have is the recommendation that DOC adjusts the response to a prisoner's medical condition. It raises HIPAA privacy concerns and is not realistic due to the number of inmates we see yearly (35,000). In addition, the information is not likely to be available to an officer at the time of the incident. However, I agree that there can be medical conditions that are immediately evident that should factor into whether the use of force is reasonable. The steps were taken after the deployment of OC, taking into account where the incident occurred and the prisoner's condition is essential. Once the need for force has subsided, and [sic] decontamination is appropriate.

Director Hough noted that the agency is currently working on revising its use of force policy, inviting the Ombudsman to review the draft policy and provide any comments on it for DOC's consideration.

An agency-wide use of force policy that is applicable to all institutions will ensure consistency in chemical agent use by correctional officers. The Ombudsman appreciates Director Hough's offer to review DOC's current draft use of force policy and is available to offer research and comments for DOC's consideration prior to the agency finalizing its policy.

Recommendation 2: DOC policy and procedure should specify in detail the decontamination procedures to be used after the use of a chemical agent on an inmate, including the offer of medical attention to minimize discomfort or injury, and ensure that decontamination is offered in a timely and meaningful manner.

Whether DOC implements the recommendation for an agency-wide use of force policy or not, the Ombudsman recommends that DOC adopt a specific and detailed policy for decontamination of inmates and staff after exposure to OC spray. The Ombudsman recommends that the agency update

its use of force policy to provide that a specific officer (such as the incident commander) has final responsibility for decontamination of inmates in a timely and appropriate manner.

The Ombudsman recommends that DOC provide specific guidance in its use of force policy as to the elements of decontamination (water, soap, towel, clean clothing) and the time in which it should be conducted. The Federal Bureau of Prison's policy provides an example:

Decontamination procedures include fresh air and water rinsing. Within 15 minutes after OC has been applied, or as soon as possible, the inmate shall be allowed to wash with soap and water all areas affected by the agent, or assisted by staff as necessary. Normally, this is completed before the medical assessment.²⁹

22 AAC 05.060(d) requires that, "if a prisoner is exposed to a chemical agent, medical personnel shall examine the prisoner as soon as reasonably possible after the exposure." The Ombudsman recommends that DOC implement policy that aligns with regulation. DOC policy should expressly require that correctional staff contact medical personnel following an inmate's OC exposure and that medical staff examine the inmate (regardless of whether the inmate requests it or not). Furthermore, DOC policy should require that the medical examination is documented in the inmate's health record.

Agency Response to Recommendation 2

DOC did not specifically accept or reject this recommendation. Therefore, the Ombudsman considers DOC's non-response as an implicit acceptance of the recommendation.

Recommendation 3: DOC policy should require that each use of a chemical agent should be documented in a Special Incident Report and reviewed by management to ensure that its use was proper and in accordance with DOC policy.

DOC's use of force policies are ambiguous or conflicting in their documentation requirements. A Special Incident Form is used to "ensure accurate and timely reporting of non-routine events."

²⁹ Operations Memorandum 001-2015, U.S. Department of Justice, Federal Bureau of Prisons (February 26, 2015) at 5.

Establishing an agency-wide policy that is consistent for all DOC officers will ensure that DOC management reviews each use and verifies that its use by staff was proper.

Agency Response to Recommendation 3

DOC did not specifically accept or reject this recommendation. Therefore, the Ombudsman considers DOC's non-response as an implicit acceptance of the recommendation.

Recommendation 4: The Director of Institutions should conduct a quarterly review of all chemical agent use by DOC staff at each institution to ensure compliance with agency policies and procedures.

The Ombudsman recommends that the Director of Institutions, together with facility superintendents, conduct a quarterly review of the use of active force (including but not limited to OC and chemical spray) to determine whether its use at each institution follows DOC policy and is reasonable and necessary. To the extent possible, the Director of Institutions and superintendents should examine the precipitating events that led to the use of chemical agents by institution staff, to evaluate whether additional training or practices are necessary to avoid unnecessary or excessive use of force. The Director of Institutions should also analyze use of force data to detect potential patterns of conduct that could indicate or evolve into use of excessive force, so that DOC management can proactively coach staff to avoid violating DOC policy.

Agency Response to Recommendation 4

DOC did not specifically accept or reject this recommendation. Therefore, the Ombudsman considers DOC's non-response as an implicit acceptance of the recommendation.

Recommendation 5: Once a new or revised policy on the use of chemical agents has been implemented, DOC should conduct statewide staff training on appropriate OC deployment and decontamination procedures.

When DOC revises its use of force policies, all institutional staff with the authority to use force should be trained on the policy revisions to ensure consistent implementation. Understanding the

cost and constraints of training so many staff at once (especially during a public health emergency), DOC could consider online, cohort, and mentorship models for providing the training.

Agency Response to Recommendation 5

DOC did not specifically accept or reject this recommendation. Therefore, the Ombudsman considers DOC's non-response as an implicit acceptance of the recommendation.

Recommendation 6: DOC medical should create a new policy outlining the steps to be taken by DOC medical staff following an inmate's exposure to OC spray.

During the investigation, Director Brooks acknowledged that DOC medical staff do not have a written policy or procedure outlining the steps they should take following an inmate's exposure to chemical agents. The Ombudsman recommends that DOC update Policy 807.02 C. Special Health Care Services to include provisions for medical examination after use of force, within a specific time after the inmate is subject to use of force. The Ombudsman recommends that DOC update Policy 807.06 to specifically require documentation of medical examinations conducted after use of force (and any treatment provided), and documentation of mental health clinical interventions provided prior to and therapeutic services provided after an inmate is subject to use of force.

Agency Response to Recommendation 6

DOC did not specifically accept or reject this recommendation. Therefore, the Ombudsman considers DOC's non-response as an implicit acceptance of the recommendation.

Recommendation 7: DOC should remove the informational reports from all three inmates' institutional files.

All three inmates' disciplinary reports were reduced to informational reports by the ACC Assistant Superintendent. Based on DOC policy 809.04, even when a disciplinary report is reduced to an informational report, it remains in an inmate's institutional file and can be considered by DOC staff for other decisions, such as "for purposes of program assessment."

As discussed above, the Ombudsman finds, based on a preponderance of the evidence, that the inmates' actions on November 22, 2017 did not justify the use of force by DOC staff. Therefore,

it is unreasonable for DOC to use the reduced informational reports for the purposes of future program assessment for the three inmates. Accordingly, the Ombudsman recommends that the November 22, 2017, informational reports be removed from the inmates' institutional files.

Agency Response to Recommendation 7

DOC did not specifically accept or reject this recommendation. Therefore, the Ombudsman considers DOC's non-response as an implicit acceptance of the recommendation.

Recommendation 8: DOC Human Resources should ensure timely preparation of performance evaluations by supervisors, so that DOC management can use the evaluations as a tool to identify and address any egregious employee behavior.

Performance evaluations are a useful tool for DOC management in identifying officers whose performance indicates potential or actual misconduct. The performance evaluation process provides an opportunity for early intervention, counseling, and training to correct problematic behavior and promote accountability. Annual performance evaluations provide DOC with a way of keeping track of information identifying potential patterns of at-risk conduct by its officers. DOC management could then track performance management data and review it with managers and staff as part of wider agency continuous quality improvement efforts.

The collective bargaining agreement in effect for correctional officers provides that “evaluations are due fifteen (15) days prior to the mid-probationary period, completion of probation and the merit anniversary date.”³⁰ The Ombudsman recommends that DOC Human Resources provide simple 30-day reminders of staff evaluations coming due to supervisors. Performance evaluations of DOC supervisors should include whether the supervisor conducted performance evaluations – and any necessary coaching or performance improvement efforts – of their direct reports on time.

³⁰ Collective Bargaining Agreement between the State of Alaska and the Alaska Correctional Officers Association (July 1, 2018-June 30, 2021) at 30. The exact same provision was included in the previous collective bargaining agreement, which was effective on the date of the incident giving rise to the complaint. *See* Collective Bargaining Agreement between the State of Alaska and the Alaska Correctional Officers Association (July 1, 2015-June 30, 2018) at 30.

Agency Response to Recommendation 8

DOC did not specifically accept or reject this recommendation. Therefore, the Ombudsman considers DOC's non-response as an implicit acceptance of the recommendation.

Recommendation 9: DOC should reiterate in writing its expectations for staff with respect to the use of OC spray and specify any penalties for infractions.

Based on interviews with the Division of Personnel and Labor Relations and former DOC leadership, a barrier to holding staff accountable for poor performance and/or egregious conduct has been the reliance on past discipline and arbitration outcomes. Based on information provided by the Department of Administration (DOA) during the investigation, one way to mitigate the application of decisions which did not hold staff accountable for misconduct is by providing explicit written notice of policy changes, expectations, and consequences for violations of policy. This allows DOC to create a basis for imposing sanctions on employees found to have used excessive force or acted outside of security policies that are different or more significant than those imposed in the past. While this kind of notice is not a guarantee that the sanctions found warranted by DOC will be imposed by DOA, it may decrease the impact that precedent discipline has on sanctions for future misconduct.

Agency Response to Recommendation 9

DOC did not specifically accept or reject this recommendation. Therefore, the Ombudsman considers DOC's non-response as an implicit acceptance of the recommendation.

Recommendation 10: DOC should adopt a department-wide policy for recording corrections staff interactions with the inmate population, inclusive of a retention policy for recordings, for the protection of inmates and staff.

This recommendation was previously made by the Ombudsman in the investigation of DOC staff misconduct at a different facility (A2013-1560). DOC has not implemented the recommendation. In the prior investigation, DOC concurred that the use of body cameras, particularly the audio recording feature, would be helpful to the department to document prisoner and staff interactions. However, the department also responded that the current use of facility cameras had been adequate

to document prisoner and staff activity. DOC acknowledged that if clear audio could be obtained, it would help staff to investigate inmate allegations.³¹ However, given DOC's budgetary limitations, DOC concluded that the cost of purchasing body cameras and management of the systems would be cost prohibitive. Additionally, DOC noted that the department expected significant opposition from staff and their union representatives if DOC mandated the use of body cameras at all institutions. They declined to implement the recommendation.³²

The Ombudsman maintains this recommendation. The evidence in this investigation again showed the importance of recording staff interactions with inmates. The value of body cameras or other recording devices to the management of its facilities is that leadership does not have to rely solely on conflicting eyewitness accounts and facility cameras that lack audio recording capability. DOC management could review audio and video footage recorded by body cameras. Body cameras hold both inmates and officers accountable for their behavior and can protect both sides from false accusations.

Agency Response to Recommendation 10

DOC did not specifically accept or reject this recommendation. Therefore, the Ombudsman considers DOC's non-response as an implicit acceptance of the recommendation.

Recommendation 11: DOC should install video cameras with audio recording in vehicles used for inmate transportation and adopt a department-wide policy for recording corrections staff interactions with the inmate population during transport.

There was conflicting evidence from the inmates and the officers about who said what and when, as well as what occurred in the sally port area. In order to protect both staff and inmates, DOC should ensure that all vehicles used to transport inmates are outfitted with video and audio

³¹ The Ombudsman notes that inconsistent audio recording by the ACC security system remains an issue.

³² At least two DOC facilities, Lemon Creek Correctional Center and Spring Creek Correctional Center (SCCC), have provided body cameras to their officers in the past. The body cameras issued at SCCC in 2015 were provided in response to repeated unsubstantiated claims of abuse filed by one inmate. The body cameras were subsequently removed because correctional officers and their union representatives objected that the recordings would be used unfairly against the officers.

recording equipment. Other law enforcement agencies follow this practice, which allows them to capture an accurate record of interactions with people they have detained.

Equipping DOC vans with this technology would help DOC management when tasked with reviewing allegations of staff misconduct by inmates during transport and would help to resolve factual disputes between what inmates and staff relay to DOC management. Recordings of transport events should be retained according to the same policy as video security footage in the institution.

Agency Response to Recommendation 11

DOC did not specifically accept or reject this recommendation. Therefore, the Ombudsman considers DOC's non-response as an implicit acceptance of the recommendation.

Conclusion

The Ombudsman recognizes that DOC is responsible for a population of individuals who can be violent, non-compliant, obstructive, and otherwise difficult to manage. DOC has policies and standards in place to preserve the safety of DOC staff and inmates, and to maintain the integrity of DOC facilities. When DOC staff violate use of force policies or fail to report unreasonable use of force by their fellow officers, DOC management needs to ensure that all staff are held accountable for their actions or inactions.

The Ombudsman closed this investigation as **justified** and **partially rectified** based on DOC's concurrence with most of the Ombudsman's investigation findings, acceptance of Recommendation 1, and implicit acceptance of Recommendations 2 through 11.