Adele:

A Detainee at the Missoula County Detention Facility

An Investigative Report

by:

DISABILITY RIGHTS MONTANA

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PREFACE

As the designated protection and advocacy system for people with disabilities in Montana, one of Disability Rights Montana's (DRM) functions is to advocate for people with disabilities who are held in facilities, which includes detention centers, and to investigate allegations of abuse and neglect. In July 2006, DRM staff learned that Adele (called Adele in this Report to protect her identity) a woman with mental illness and developmental delays arrived at Montana State Hospital with seven deep and distinctive bruises on her arms and body. DRM started an investigation to determine how Adele received the bruises. We learned that Adele was brought to St. Patrick Hospital for help with her medication. A dispute took place with the hospital security. Missoula City Police were called and they transported Adele to the Missoula County Detention Center.

This Report details the events that took place between the time Adele was received at the Missoula County Detention Center until she was released less than 18 hours later with a misdemeanor charge and on a $10.00 bond. During the time she was held in custody, Adele was shackled, placed in a restraint chair for two and a half hours, later placed in a locked cell, shot seven times with a pepperball gun, again placed in a restraint chair where she sat for 44 minutes without the opportunity to be decontaminated. DRM confirmed that the detention center staff were familiar with Adele and aware she was a person with a mental illness and developmental delays. We learned and confirmed that Adele was crying and confused while in their custody but did not refuse or resist the detention officers' directions. We conclude that the detention center staff violated their policies, mistreated and abused Adele, lacked appropriate oversight, and is in need of training to respond appropriately to people with mental illness and developmental delays.

The purpose of this Report is to document and highlight the events experienced by Adele, a person with a disability in the detention center, and to make recommendations for improvements. We have made every attempt to be accurate in this Report.

Sheriff Mike McMeekin, who is responsible for the Missoula County Detention Center, was provided a draft copy of this Report on October 8, 2008, with the opportunity to respond. He responded on October 13, 2008, asking for clarification, which we provided. Sheriff McMeekin asked for two extensions of time to respond. Both times we agreed. On November 9th we received a letter from the Sheriff stating that "we are preparing a comprehensive response and will independently disseminate it to anyone asking us about the Report. You will be provided with a copy as soon as it is completed and approved by counsel." We have not received Sheriff McMeekin's response. Attached to this Report is all the correspondence between DRM and Sheriff McMeekin. All the documents have been redacted to preserve Adele's privacy.

On May 22, 2008, through private counsel, Heather M. Latino, of Paoli, Latino & Kutzman, P.C., Adele filed lawsuit against Sheriff McMeekin and the officers who mistreated and abused her.

Disability Rights Montana wants to acknowledge Michael Burch, the detention officer whose moral conscience guided him to do the right thing and report the abuse to the authorities. We are outraged that the authorities chose to fire Officer Burch and exonerated the officers who assaulted and abused Adele.

This Report is published in Michael Burch's honor. Michael died of a heart attack several months after he was fired. May his doing the right thing bring the much needed training and appropriate oversight to the Missoula County Detention Center.

Finally, a special thank you to Alexandra Volkerts, attorney and the investigator in this case, and the DRM staff who are responsible for the content of this Report.

Sincerely,

DISABILITY RIGHTS MONTANA

Bernadette Franks-Ongoy
Executive Director

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INTRODUCTION

On July 7, 2006, Montana Advocacy Program (MAP), now known as Disability Rights Montana (DRM), received a call that a woman with mental illness and developmental delays had arrived at the Montana State Hospital (MSH) with seven deep and distinctive bruises on her arms and body. DRM began an investigation which found that on July 1, 2006, the woman (called Adele in this report to protect her identity) was brought to St. Patrick Hospital emergency room (ER) for help with her medications. Although known to the hospital as a woman with mental illness and developmental delays, she was refused services at the ER. She ended up in a dispute with hospital security staff who called the Missoula Police Department to remove her. The police took her to the Missoula County Detention Facility (Jail). Although she was no longer obviously agitated when she arrived, she was met by overwhelming force, patted down without incident, and immediately put into a restraint chair for more than two and a half hours. The Jail performed no psychiatric or mental health evaluation for her and no medical staff was called to evaluate her before, while, or after she was in restraint. At least one medical staff was on duty at the time.

After two and a half hours, Adele was released from restraint after she fell asleep in the chair. She was then put in a cell. She awoke around 2:30 a.m., frightened, confused, and calling or screaming for her father. No medical staff or mental health professionals (MHPs) were called to evaluate her, talk to her, or provide calming medication. Although confused and crying, but responding to commands, she was shot more than six times with a pepperball gun while standing on the floor against a wall in a locked cell. Both she and her cell were covered with Oleocapicain powder (OC), the primary ingredient in pepperball guns and pepperspray. She compliantly exited the cell only to be strapped again into a restraint chair without the opportunity to decontaminate herself. A nurse briefly checked her for injuries, but did not insist she be decontaminated nor asked critical medical questions. She was released from restraint after forty-four minutes. At some unknown time, she was taken to the showers in another part of the Jail to decontaminate.

Adele was released from Jail July 2, 2006, after paying a nominal fine for disorderly conduct. Fearful, confused, and highly emotional, as well as in considerable pain, Adele went to the Community Hospital emergency room the next day seeking help. She was evaluated and released with pain medication. Several days later she returned to the St. Patrick Hospital emergency room, where she was recognized as decompensating from mental illness, evaluated by a MHP, and taken to MSH on emergency detention, pending commitment. That is when Disability Rights Montana received a call reporting Adele's injuries.

Montana has several systems that should have helped Adele. Those systems identify people with mental illness, provide humane treatment at the hospital and, divert people

with mental illness from incarceration. All systems failed Adele. This incident raises difficult issues regarding the community's response to vulnerable people in a mental health crisis, the use of jails as a default holding system when community crisis services fail to respond appropriately, and the inadequate training, standards, information access, and safeguards in the Jail to appropriately, safely and humanely respond to people with mental illness and developmental disabilities. It also points out the deficiencies in the statutorily mandated procedures for evaluation and diversion of people with mental illness who are charged with minor crimes.

This report is bifurcated: This report will address what happened at the Jail, the second report will address what happened at St. Patrick Hospital Emergency Room.

SUMMARY OF CONCLUSIONS

The decisions to release Adele from the St. Patrick Hospital ER without evaluation or treatment by a doctor and to send her to Jail where she was detained without screening her for mental illness led to a cascade of events which violated Adele's rights under Montana's Constitution, statutes, and multiple jail policies and procedures.

1. The Jail failed to screen Adele for mental illness when she was brought to the Jail in violation of Montana Code Annotated § 53-21-138.[1]

2. The Jail violated both the substantive requirements and reporting responsibilities of the Montana Elder and Persons with Developmental Disabilities Abuse Prevention Act, Montana Code Annotated § 53-2-801 et seq.

3. The Jail violated many of its own policies, including 7.24, which limits and defines the circumstances under which force, restraint, and non-lethal weapons, including the pepperball gun, may be used, and mandates safeguards and follow-up procedures; 12.02, which prohibits personal abuse, punishment, and discrimination based on disability; and 11.54 which provides a protocol for the treatment of inmates at risk for suicide.

4. The Jail violated Montana Code Annotated § 45-5-204, which defines "assault on an inmate" as a crime; and § 7-32-2248, a Montana statute

[1]The statute, captioned **"Diversion of certain persons suffering from mental disorders from detention center"** mandates that all inmates be screened for mental illness to identify those persons accused of minor misdemeanor offenses, including disorderly conduct, who appear to be suffering from mental disorders and who may require commitment. The Jail intake and booking procedures include no effective screening tools to determine whether a person may be suffering from a mental illness.

prohibiting the mistreatment of inmates at detention centers.[2]

5. The Jail's training program appears inadequate in respect of teaching officers to screen, identify, recognize, and treat detainees with mental illness and/or developmental disabilities, including appropriate use of force and restraint, and their reporting requirements in instances of alleged abuse and neglect.

THE INVESTIGATION

This investigation was complex, and was hindered and slowed by certain complicating factors.[3] However, in the process of investigation, the Jail did make some positive steps which may serve to mitigate some of the problems highlighted herein.[4]

[2]The list of prohibited actions also provides for criminal penalties.

[3]**Complicating Factors:** this investigation was complicated by a number of factors.

- The Sheriff's office consistently delayed or refused to provide information for over eighteen months to the extent that at the time of this report essential evidence including video tapes of Adele's arrival at the Jail, audio tapes confirming when she was actually taken to the shower, and other essential documentary evidence, including the FBI investigative report, has never been provided.
- The Sheriff's office appears to have provided erroneous information when it provided a list of inmates in the cell pod at the time of the pepperball shooting.
- The Sheriff's office obstructed DRM access to detention officers who participated in the pepperball shooting.
- The Sheriff's office initially obstructed access to inmate witnesses of the shooting and removed the investigator from the facility.
- The medical clinic contracted to provide medical services to the Jail has failed to provide access to the nurse who examined Adele immediately after the pepperball shooting.
- The Sheriff allegedly ordered his staff and medical staff not to speak with the investigator except with his permission.
- The Sheriff initially supported and was actively involved with developing a screening and diversion program for people with mental illness in conjunction with 4th Judicial District Court and other stakeholders as required by statute. Currently the Sheriff's representatives have withdrawn their participation in and support of the Diversion Committee.

[4]**Mitigating Factors**. The investigation and its results have been mitigated by:

- The Sheriff sent three detention officers and up to 5-6 beat officers to Crisis Intervention Training (CIT) to train officers how to work with people with mental illness. CIT training was held in Helena in April 2007.
- The Sheriff has become occasionally involved with and is a member of the Board of Directors for the Western Service Area Authority which is made up of

LEGAL FRAMEWORK

1. Constitutional Issues

Both the U.S. and Montana Constitutions require that an inmate receive adequate medical and mental health treatment while in custody. To deny adequate medical care while a person is in custody and unable to obtain their own medical care constitutes cruel and unusual punishment.[5]

Respect for the dignity of each individual is a fundamental right protected by Article II, Section 4 of the Montana Constitution which provides that "the dignity of the human being is inviolable."[6] Montanans with mental illness are entitled to the same civil rights as are other citizens of Montana. In addition, people with mental illness have a statutory right to treatment suited to their needs that is administered skillfully and humanely with full respect for the person's dignity and personal integrity.[7] This right to be treated humanely, with dignity and respect has been consistently recognized by the Montana Supreme Court.[8]

2. Statutory Enactments

a. Screening and Diversion of Persons with Mental Illness from Detention

It is the policy of this State that people with mental illness be identified and diverted away from jails and back into the mental health treatment system, when appropriate. Montana Code Annotated § 53-21-120 and 124 prohibit holding a person facing commitment proceedings in jail while they await their hearings.[9] Since 2003, jails have been mandated to screen *all* inmates to identify people with mental disorders accused of minor misdemeanors to determine if they may require commitment.[10] "Minor misdemeanor offense" means non-serious misdemeanors such as criminal trespass to property, loitering, disorderly conduct, and disturbing the peace. It covers a broad range of minor crimes which entail

consumers and other stakeholders working to develop an integrated mental health services system in Western Montana.

[5]U.S. Constitution, Article 8; *see Estelle v. Gamble*, 429 U.S. 97 (1976) (denial of adequate medical treatment constitutes cruel and unusual punishment); *Hoptowit v. Ray*, 682 F.2d 1237 (9th Cir. 1982) (the right to adequate medical care includes the right to adequate mental healthcare); *Morelli v. Lake County*, 255 Mont. 23 (1992) (county has a duty to give medical aid and treat prisoners humanely).

[6]Montana Constitution, Article II, Section 4; *Armstrong v. State*, 1999 MT 261, ¶ 72, 296 Mont. 361, ¶ 72, 989 P.2d 364, ¶ 72.

[7]Mont. Code Ann. § 53-21-101(1).

[8]*See In the Matter of the Mental Health of KGF*, 2001 MT 140, ¶ 45, 306 Mont. 1, ¶ 45, 29 P.3d 485, ¶ 45 (citing *Armstrong* in the context of right to dignity while under civil legal proceedings).

[9]Forty percent of jails acknowledge that in spite of the law, they use minor or no charges to hold people with mental illness until they can release them or obtain community mental health treatment. MAP Jail Survey July 2000, published by Montana Advocacy Program, page 24.

[10]Mont. Code Ann. § 53-21-138.

no significant injury to other people or property. If a person does require commitment, she or he may not be held in jail pending evaluation and hearing.[11]

b. Montana Elder and Persons With Disabilities Abuse Prevention Act

As a group, people with developmental disabilities are more vulnerable to abuse, neglect, and exploitation and require additional protections. Consequently, statutes impose an obligation on professionals and public employees, including law enforcement officers, to watch for and report incidences of abuse, neglect, or exploitation of people with developmental disabilities to the Department of Health and Human Services, Child Protective Services or Adult Protective Services, as appropriate.[12]

c. Jail Policies and Procedures

To distinguish between assault on an inmate or inmate endangerment and necessary use of force, the Montana Sheriff and Police Officers' Association (MSPOA) has developed and recommended policies to clarify this grey area. However, it is entirely voluntary whether a county adopts in part or in whole the MSPOA policies.[13] Other than sanitation, safety, and fire and building codes, there are no statewide standard policies and procedures applicable to jails or detention facilities.[14] Currently, each detention center administrator is allowed discretion to develop and adopt his or her own policies and procedures regarding the operation of local jails or detention facilities, at least with regard to city/county inmates subject only to constitutional, statutory, and common-law.[15] Missoula city-county detainees and Jail staff are subject to the policies and procedures adopted by the Jail facility administrators, under the supervision and oversight of the County Board of Commissioners.[16] The Jail has chosen to adopt some MSPOA and American Correctional Association (ACA) policies but created many of its own. Many jail policies have remained in draft form for years, and some were adopted in final form after this incident or during the investigation.

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[11]Mont. Code Ann. § 53-21-120, 124.

[12]Mont. Code Ann. § 52-3-801, et seq.

[13]*See* Mont. Code Ann. § 7-32-2201, 2204, 2234. County commissioners have jurisdiction and power . . . to cause a detention center to be . . . operated.

[14]Mont. Code Ann. § 7-32-2222. Detention center shall comply with state and local fire codes for correctional occupancy and with sanitation, safety and health codes.

[15]Mont. Code Ann. § 7-32-2234. When a detention facility accepts State or Federal prisoners, it agrees to abide by the policies and procedures set forth by the State or Federal contract for the care and custody of such prisoners. State policies are only mandatory for state prisoners while Federal policies are only mandatory for Federal prisoners.

[16]Pursuant to interview with Missoula County Sheriff, September 19, 2006.

d. Missoula County Detention Facility (MCDF) Policies and Procedures

A number of current policies and procedures adopted by the Sheriff or his predecessors provide some guidance on the use of force, pepperspray or powder (OC) and restraint chairs. These policies expressly recognize the civil rights of inmates to humane treatment and to be free from discrimination based on disability. An employee is required to abide by the Jail's policies and procedures or face sanctions up to and including dismissal. MCDF Policy 3.10.

1. Use of Force

Policy 7.24 provides guidance regarding if and when it is appropriate to use force against inmates. The policy identifies a use of force continuum to clarify increasingly forceful steps to be worked through in a roughly sequential manner when an officer faces a challenging situation. The policy further provides that force will only be used to the degree necessary to prevent serious bodily injury or death to staff or inmates. The policy later clarifies that an escalating use of force may only occur when a person presents an imminent danger of serious bodily harm or death to staff or third parties.

The use of force continuum starts with low-level passive intervention, such as talking to the person, video taping the person and bringing more officers to the scene in a show of force. If these do not work, the officer may move to active measures, including control holds, self-defense techniques, and restraint which would include hands on or handcuff restraints as well as the use of a restraint chair. The use of pepperspray and batons is restricted to the more severe incidents, requiring either an immediate response or a planned response under supervision of the shift supervisor or trained tactical team. Finally, in extreme situations, deadly force may be used if there are no other means of resolving the imminently dangerous situation.

To assist officers in the decision to use increasing levels of force, the policy mandates four factors which must be considered to determine whether the inmate's actions constitute a threat of imminent danger of death or serious bodily injury:

1) The ability or apparent ability of the inmate to cause serious injury (disparity in size, age, strength, numbers and level of aggressiveness are important enumerated factors);

2) Opportunity to cause serious bodily injury or death;

3) Imminent jeopardy (i.e. is it reasonable to believe that right now the person's acts could cause serious injury or death); and,

4) Has the officer exhausted all reasonable options.

The policy further clarifies that use of force, security equipment, and restraint equipment are intended only as control measures and

are to be used only when absolutely necessary. Only the minimum amount of force necessary may be used. Force cannot be used for punishment, harassment, coercion, or abuse.

2. Use of Pepperspray/OC

Policy 7.24 provides that OC, the active ingredient in the pepperball gun ammunition, "should only be used in an amount necessary to gain control and cause an inmate to cease [his or her] aggression." OC is defined as an inflammatory agent derived from habanero pepper plants that effects the mucous membranes and upper respiratory system. "[I]t is the policy of the Jail that when use of force has been used, and particularly when OC has been used, the inmate will be examined by medical staff and receive any necessary treatment as soon as possible . . . ." Necessary treatment specifically includes the opportunity to shower as soon as possible.

3. Use of Restraint Chair

Policy 7.24. Restraint chairs are molded of fibreglass and use "soft wrist restraints made of webbed nylon and soft ankle restraints of the same material" to hold a person in the chair. The policy recognizes that use the restraint chair may be necessary to prevent security threats, escape, assault, suicide, to protect staff or inmates, for mental health reasons, or for certain necessary circumstances within the discretion of the Sheriff or designee. Like all uses of force, it should be employed only to the degree necessary to control the inmate and further, it should "only be used as a last resort." It is "not to be used to punish, harass, coerce, or abuse inmates." During restraint, the inmate must be closely monitored and removed from the restraint chair as soon as possible. At a minimum, inmates must be checked every 10 minutes and the checks must be logged and an incident report completed. Once removed from the chair, "the inmate *must* be seen by medical staff." (Emphasis added.) State policy prohibits the use of restraint chairs for State prisoners.

4. Mistreatment of and Assault upon Inmates

Detention officers also have specific obligations to perform their duties in a manner which does not mistreat prisoners. Under Montana Code Annotated § 45-5-204, it is a felony for detention staff responsible for the care or custody of prisoners to purposely or knowingly assault or otherwise injure a prisoner; intimidate, threaten, endanger or withhold reasonable necessities from a prisoner for any purpose, or violate the civil rights of the prisoner. An officer committing such an offense may be fined and must be removed from office or employment. "Knowingly" means that the officer was aware of his own conduct, while "purposely" means that the officer acted deliberately to achieve the result or conduct.[17]

A detention center administrator or staff member commits the offense of inmate endangerment if she or he knowingly uses corporal punishment against an inmate or

[17]Mont. Code Ann. § 45 -2-101 (35), (65).

uses physical force against an inmate without legal justification.[18] Legal justifications for the use of force by detention officers is authorized in very limited circumstances for necessary self-defense, control of inmates, for the protection of another person from imminent physical attack or to prevent a riot or escape.

FACTS

Adele, a young adult, has lived in Missoula for several years and is well known to the various mental health emergency services as well as to the police and Sheriff's departments. She had been committed to MSH two times and to a community inpatient hospital at least twice before this incident. Personable and sunny natured most of the time, Adele has multiple disabilities including psychotic disorder, major depression, mild mental retardation, fetal alcohol syndrome, and PTSD from childhood trauma. Her medical conditions include asthma. She has experienced many losses in her life, including both her natural parents, her home, her language, and more recently, her foster father. She receives supported living and employment services as well as case management services for her disabilities.

Even with community supports, Adele had made 28 visits to the ER over the five years prior to this incident for treatment of her mental illness and had been hospitalized four times before this incident. Transport to and from MSH for emergency detention, returns for judicial hearings and final commitment to MHS is provided by the Missoula County Sheriff's Department. In addition, Adele had been detained at the Jail on at least four previous occasions and has had numerous contacts with the city police. At least two Jail employees or former employees noted that they were well aware Adele has limited cognitive ability and mental illness.

On the weekend of July 4th, Adele had either failed to take her medications as prescribed or they were no longer working. Her case manager had been trying to locate Adele for two days. On Saturday, July 1st, Adele called her foster sister who brought her to the ER around 7:20 p.m. She became agitated, demanded medication and threw other medication on the floor. Failing to consider her mental health issues, the ER nurse determined that Adele had no "medical" issues, and called security officers, who eventually wrestled Adele to the floor. No one else was injured, but Adele suffered a bloody nose. The Missoula City Police were called to arrest her on misdemeanor disorderly conduct charges. 9-1-1 dispatch alerted the Jail that the city police were bringing in a combative woman but apparently gave no other information.

According to video evidence, most of the team on duty that night, one of whom was carrying a tazer, met a crying Adele in the Jail garage or "sally port." Six large officers accompanied Adele into the remand area to be frisked with her hands cuffed behind her

[18]Mont. Code Ann. § 7-32-2248.

back, although only two officers actually touched her to lead her into the remand area. She was crying but not otherwise obviously struggling. Two officers shoved her face-first into a long pad on the wall of the remand area, one officer clamping his hand to the back of her head while the other patted her down.

As soon as she was released from the pat down, non-resisting but crying, she was shoved backwards into a restraint chair by two officers, taking her full weight on her handcuffed arms, while the other officers stood around watching. (The official written report states that she became so combative, all the officers present were needed to gain control of her, which is contradicted by video evidence.) Adele, a city/county detainee, could be put in a restraint chair, but only in conformance with Jail Policy 7.24, and only as a last resort. The video evidence provided failed to justify the use of the restraint chair

There is no evidence that Adele was evaluated medically while in the restraint chair for two and a half hours or after release as required by policy. One female officer apparently observed Adele and agreed she was compliant and could be released, but noted that only the senior detention officer (SDO) could release her. Finally, a sleepy Adele was released from the chair and taken to a cell where she slept for several hours.

Around 2:30 a.m., Adele woke and began screaming and allegedly threatening suicide. The SDO heard the report over the intercom in his office. Before evaluating the situation, he armed himself with a pepperball gun and ammunition. He failed to call for medical assistance to calm her or mental health support to address her alleged suicidality. Contrary to policy, no videotape was made of the incident from inside her cell which would have provided a more complete recording of Adele's alleged suicide threats. The SDO stated the mounted VCR cell unit was not working.

By official report, Adele apparently said , "I know how to kill myself," and climbed on a concrete desk 30 inches high. Other witnesses state she woke crying, screaming and calling for her "daddy" but that they heard no threats of suicide. A female officer on duty allegedly talked her off the bunk or desk before the SDO arrived. There is no independent evidence corroborating that she was actually threatening suicide.

The only video tape of the shooting incident was two or three minutes recorded by a hand-held video camera through the glass in the cell door. The official report alleges she was threatening to throw herself head first off the desk onto the concrete floor, creating a dangerous situation which could only be deterred by shooting Adele with OC. Adele was yelling and crying when the video begins. Adele was standing directly across from the cell door, next to or on the 18-inch high bunk. She is not standing on a desk. There is no evidence of threats to herself. Nor is there any evidence the SDO attempted any other less forceful interventions, to talk to her, try to calm her or call a mental health professional or nurse. The SDO stated he did not try any of these lesser interventions.

The SDO ordered Adele to turn around and kneel. Her response was unintelligible except for "No, . . . come on." In a raised voice he ordered, "On the bunk now," although she was standing on or in front of the bunk at the time. She moved away from the bunk to lean, crying, on the wall, and had now eliminated any possible danger to herself. He then yelled, "On the bunk or force will be used against you." She continued crying against the wall and he fired at least six shots into her body. She cowered, crying harder. He screamed, "Face down on the bunk!" and fired at least three or more shots into the cell. Adele cried that it hurt, moved to the bunk and lay down crying, coughing, and holding her body. He ordered her to lie on her stomach, arms at her side. Crying and squealing, she complied. The officers entered her cell, cuffed her hands behind her back and pulled her up, coughing, and she said she couldn't breathe.

Adele, compliant and non-resistant, was immediately placed in a restraint chair. No effort was made to decontaminate her, wash her face or bare skin. She was not asked about asthma or high blood pressure, either of which can cause death with the use of OC. The facility nurse was called to check Adele at approximately 3:00 a.m. while she was in the restraint chair. The nurse said she was unable to obtain vital signs due to the restraint chair and Adele's alleged aggressive behavior. She told Adele "to try and relax and rest," but made no effort to decontaminate her, and took no medical history although she noted two bruises on Adele's left side and abdomen. According to witnesses, the nurse stated it was obvious Adele had mental retardation. Adele was released from the restraint chair and taken to shower more than 45 minutes later, and returned to her cell.

The next shift finally completed booking Adele into the Jail more than 12 hours after she was arrested, and had her examined by the medical clinic. The nurse practitioner documented that Adele received services from a community provider of mental health and developmental disability services. She also noted that "a friend had called to say Adele was off her medications." Her notes indicate Adele had two noticeable bruises and complained of back pain, had a mental health diagnosis, was prescribed psychotropic medications, and had a developmental disability.

Adele's case manager posted $10.00 bail and took Adele home. She had been without medications for at least four days, and was confused, disoriented, and traumatized. She sought help on July 3rd at the Community Medical Center ER for pain caused by the shooting and then again on July 4th at St. Patrick Hospital ER for pain and confusion. The St. Patrick Hospital ER doctor gave her a 6-day supply of psychotropic medications, but stated she did not need commitment. She was brought by the city police to the ER early on July 6th. When she became loud and disruptive, she finally received a mental health evaluation and was sent on emergency detention to Montana State Hospital.

The Jail has three resources available for an inmate exhibiting a mental health crisis. A psychologist provides court ordered mental

health evaluations; a state-employed social worker is also available as a resource for non-state inmates during normal working hours; and a licensed clinical professional counselor is on-call for after-hours emergencies.

Adele was originally brought in during the medical clinic registered nurses' normal shift. The nurses are available to go to booking if asked, and may offer Ativan to an inmate to calm down. If staff determines it is not safe to open a cell door, they may also call a nurse to offer the inmate Ativan. Nurses are available on-call to see any person agitated enough to restrain. According to clinic personnel, during normal working hours the Jail staff generally call the medical staff "right away" for someone "acting out." None of these resources were called to assist with Adele.

ANALYSIS

1. Statutory Violations

a. Screening and Diversion of Persons with Mental Illness from Detention

The provisions of Montana Code Annotated §§ 53-21-120, 124 and 138, which reflect the policy of this state that people with mental illness be identified and diverted away from jails and back into the mental health treatment system, were clearly not followed. These statutes prohibit holding a person facing commitment proceedings in jail while they await their hearings[19], and require that persons with mental illness be detained in the least restrictive possible environment. Since 2003, jails have been mandated to screen *all* inmates to identify people with mental disorders accused of minor misdemeanors to determine if they may require commitment,[20] and to divert them into mental health treatment facilities. "Minor misdemeanor offense" means non-serious misdemeanors such as criminal trespass to property, loitering, disorderly conduct and disturbing the peace. It covers a broad range of minor crimes which entail no significant injury to other people or property. If a person does require commitment, she or he may not be held in jail pending evaluation and hearing.[21]

The facts show that Adele was already broadly known to the medical, mental health and law enforcement communities of Missoula to be an individual with mental illness – which in the broadest terms means that the nurse at the St. Patrick ER, very probably the security officers at the hospital, the arresting Missoula Police Department officers and the staff on duty at the Jail knew that her behavior was the result of mental illness and that she belonged in a hospital bed. Legally, as medical and law enforcement professionals, they had an

[19]Forty percent of jails acknowledge that in spite of the law, they use minor or no charges to hold people with mental illness until they can release them or obtain community mental health treatment. DRM Jail Survey July 2000, published by Montana Advocacy Program, page 24.

[20]Mont. Code Ann. § 53-21-138.

[21]Mont. Code Ann. § 53-21-120, 124.

affirmative duty to get her into that hospital bed. Instead, this frightened, disoriented, and very vulnerable woman was subjected to hours of abusive and illegal behavior which exacerbated her already fragile condition.

It is DRM's view that there is no excuse for what happened to Adele the night of July 1, 2006. The medical and law enforcement professionals not only should have known but undoubtedly did know that they were mistreating a sick and vulnerable woman, and in spite of that knowledge and with callous indifference to their professional duties, went right ahead and did the wrong thing.

b. Montana Elder and Persons With Disabilities Abuse Prevention Act

The Jail violated Montana Reporting Statute Montana Elder and Persons with Developmental Disabilities Abuse Prevention Act. Mont. Code Ann. § 53-2-801, et seq. The legislature has recognized that there is a need for law enforcement agencies, among others, to prevent "abuse, sexual abuse, neglect and exploitation of Montana's . . . persons with developmental disabilities through the identification, reporting and prosecution of acts of abuse, neglect and exploitation." Abuse means the infliction of physical or mental injury. Law enforcement officers are specifically listed as required to report incidents of abuse to the DPHHS, child or adult protective services, as appropriate. At least seven employees directly participated in or witnessed Adele's unjustified pepperball shooting, the supervising officer's failure to allow her to be decontaminated as soon as possible and her unnecessary restraint after she was compliant. Numerous other employees, including the Jail commander and the Sheriff, were aware of the incident and viewed the video tape of the shooting. Nonetheless, only one officer reported it to the press, to the FBI, and to the ACLU. No officer DRM spoke with was aware of his or her statutory obligation to report abuse. Most unfortunate, the officer who publically reported the incident was fired for making public "confidential information" because he did not know to whom he should report, although he believed that her treatment was abuse. The Sheriff's department failed to adequately train its staff and lacks procedures in the requirements of law enforcement officers to report incidents of abuse or neglect of people with developmental disabilities.

c. Mistreatment of and Assault upon Inmates

Jail inmates are vulnerable to mistreatment and abuse by guards. For that reason, the Montana legislature has both defined what constitutes endangerment of prisoners, and prohibited the practice.[22]

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[22]**Inmate endangerment -- penalty.** (1) A detention center administrator or staff member commits the offense of inmate endangerment if the administrator or staff member knowingly...
(b) uses corporal punishment against an inmate; or
(c) uses physical force against an inmate, except as necessary for:
(i) self-defense;
(ii) control of inmates;
(iii) protection of another person from imminent physical attack; or

If the common run of inmates in detention centers are vulnerable to endangerment, by virtue of being outnumbered, unarmed and frequently restrained, then an inmate who is a person with mental illness or a developmental disability has increased vulnerability. Adele, frightened, short, disoriented, shackled, and outnumbered by male officers with weapons, was helpless against what the few videotapes the Jail has released show as overwhelming aggressive behavior. It is perfectly clear that the Jail staff used the pepper ball gun as well as wrist and ankle shackles and the restraint chair unnecessarily. It is also clear that they used physical force against a helpless and disoriented woman without the justification of a need for self defense, control, protection of others from an imminent physical attack, or possible escape or riot. The statute makes endangerment a crime, and sets a criminal penalty associated with misdemeanors for a "person who commits the offense of inmate endangerment." Elsewhere, the criminal code makes it a felony to mistreat prisoners[23]

(iv) prevention of riot or escape.
(2) A person who commits the offense of inmate endangerment shall be fined an amount not to exceed $500.

Mont. Code Ann. § 7-32-2248.

[23]**Mistreating prisoners.** (1) A person commits the offense of mistreating prisoners if, being responsible for the care or custody of a prisoner, he purposely or knowingly:
(a) assaults or otherwise injures a prisoner;
(b) intimidates, threatens, endangers, or withholds reasonable necessities from the prisoner with the purpose to obtain a confession from him or for any other purpose; or
(c) violates any civil right of a prisoner.

It is a fair interpretation of the videotapes and the records of the Jail that the SDO knowingly armed himself with a weapon with the intention of committing an assault on and otherwise injuring Adele, and in fact accomplished that purpose. It is also a reasonable inference that by keeping Adele confined in a restraint chair while she was coated with OC powder for three quarters of an hour, they knowingly and purposely withheld reasonable necessities from Adele for no lawful reason. It is clear that the actions of the officers and their leadership purposely and knowingly violated Adele's civil rights.

2. Jail Policies and Procedures

The extreme use of a pepperball gun on a confused, crying, and clearly disoriented woman who was not presenting a danger to herself or others was in direct violation of jail policies. The SDO violated Jail Policy 7.24 regarding use of force, which requires that escalating the use of force in the Jail may occur only when a person presents an imminent danger of serious bodily harm or death to staff or third parties, and sets forth criteria to be considered before implementing use of force. There are four factors to be considered before using increasing force: (1) *ability* to harm self or others, (2) *opportunity* to cause serious

(2) A person convicted of the offense of mistreating prisoners shall be removed from office or employment and shall be imprisoned in the state prison for a term not to exceed 10 years or be fined an amount not to exceed $50,000, or both.

Mont. Code Ann. § 45-5-204.

bodily injury, (3) *imminent jeopardy*, and (4) *exhaustion* of all reasonable options.

Adele did not have the *ability* to harm herself or anyone else when six shots were fired into her cell. It is undisputed that Adele was the sole occupant of a locked cell, therefore unable to present a danger to staff or other inmates. The conflicting evidence as to whether Adele actually meant to hurt herself or even had the means to do so is irrelevant. The truncated video of the incident clearly shows that before Adele was shot she had complied with the commands to step down from the bunk - removing any danger of injury to herself. When Adele was shot, she was standing on the floor next to a wall crying and lacked all ability to hurt herself.

Adele did not have the *opportunity* to inflict serious bodily injury when she stood crying next to the wall. Staff must reasonably believe the inmate is within effective range and in a position to cause serious bodily injury or death to a staff or third party before escalating force. However, Adele was not in range of any item to inflict injury or in a position to cause serious bodily injury. Rather, she was trying to obey the officers' orders. When the first and subsequent shots were fired, Adele stood against the wall on the floor.

Without the ability or opportunity to inflict serious bodily injury, it is obvious from the tape no reasonable person would conclude Adele was in *imminent jeopardy* of serious bodily injury or death. She tried to comply with every order the officers shouted at her. She stepped off or away from the bunk and moved away. She was scared and crying, but even if she had earlier been threatening to jump off the bunk on her head, when the officer shot her she was no longer capable of injuring herself or others. In fact she had eliminated any possibility of injury to herself when she left the bunk area.

Officers neither tried, nor *exhausted* all reasonable options to de-escalate the situation before more than six shots were fired into her cell. The decision to pick up and bring the pepperball gun was made without an evaluation of Adele's actual behavior, medical status, or psychological state. The SDO arrived at the scene armed. Anecdotal evidence indicated that Adele had already been talked down from the desk. Incomplete video evidence fails to capture any previous efforts or results before the officer arrived with the pepperball gun. But the video does show he only used orders and commands, escalating in volume and clear anger, with little time to comply before further escalation and threats. At no time on the video does it appear that the officer simply tried to talk to her himself, have another team member talk to her, call a nurse to assist her, or seek guidance from any of the three professional mental health resources available to him.

The SDO violated Jail Policy 7.24 which states: "Force should be employed only to the degree necessary to control the inmate and to the level that will be effective with minimum harm to both staff and inmate," and is "not to be used to punish, harass, coerce or abuse inmates." When the SDO fired the pepperball gun Adele was complying with his commands to the best of

her understanding. Multiple shots were fired without pause between them, indicative more of an intention to punish or cause harm than to bring order to a situation which was not out of control.

The officer also violated Jail Policy 7.24 by using the pepperball gun excessively, rather than as the policy states: "only [] in [the] amount necessary to gain control and cause an inmate to cease [his or her] aggression." Therefore, use of the pepperball gun at all to cause Adele to cease aggression as she was attempting to comply with orders was unjustified: firing multiple shots on rapid fire – the sound on the videotape is that the shots were continuous, rather than spaced, was completely unjustified.

The officers violated Jail Policy 7.24 by failing to both immediately decontaminate Adele or consider any medical effects of the OC. Recognizing the danger of "unduly injur[ing]" an inmate with pepperspray, the Policy states: "[W]hen use of force has been used, and particularly when OC has been used, the inmate will be examined by medical staff and receive any necessary treatment as soon as possible, including the opportunity to shower." Prior to using OC, "the person's medical information shall be considered." No one asked or even considered whether Adele had a medical condition – which in fact she does – which can cause injury or death should she be exposed to pepper spray. Adele was complying with orders when she exited the cell. There is a shower within 60 feet of where Adele was restrained which offered the opportunity for her to wash her face and exposed skin, or for an immediate shower. The officers had water and materials available to wash her face, hands, arms and exposed skin - none of which they did. Instead, she was left nearly immobilized for at least 44 minutes in the chair, coughing, gasping, crying, and calling out that she was dying. Although a nurse came to visit her, the nurse apparently was completely unfamiliar with the effects of OC, noting that Adele's thrashing in pain and to escape the effects of the OC powder seemed "aggressive."

The officers violated Jail Policy 7.24 regarding appropriate use of restraint chairs and soft restraints on wrists and ankles by using metal restraints. The chair is "molded fibreglass and [uses] soft wrist restraints made of webbed nylon and soft ankle restraints of the same material." Soft restraints are necessary to prevent nerve and muscle damage caused by metal cuffs compressing vulnerable nerves against bones of the wrists and ankles. DRM investigators examined the restraint chair used, viewed the special leg restraints and questioned the SDO about the restraints used on Adele. Metal handcuffs were used as Adele came out of the police car and left on her when she was shoved backwards into the restraint chair with her arms captured behind her, risking both wrist damage and shoulder damage. Metal cuffs were also used on her ankles to restrain her legs, contrary to Jail Policy.

The Policy makes clear that use of the restraint chair is justifiable for self defense, protection of others, protection of property, and to prevent escapes. None of these circumstances existed, either when Adele

arrived or after she was shot with OC powder. Moreover, the policy directs that, "[f]orce should be employed only to the degree necessary to control the inmate and to the level that will be effective with minimum harm to both staff and inmate." It is "not to be used to punish, harass, coerce or abuse inmates." When the SDO ordered Adele into the restraint chair the second time, she was compliant according to the official report. The video also showed she was led by her hand out of the cell, crying and stating she was dying. No resistance or aggression is shown on the video tape. The report admits she was compliant with commands and had finished resisting. Nonetheless, she was ordered restrained in the chair and not allowed to decontaminate before such restraint, exposing her to cruelty and abuse, all contrary to Jail Policies.

CONCLUSIONS

From testimony and evidence obtained to date, with minimal cooperation from the Jail and the Sheriff's office, it appears this was an unjustified assault. The SDO did not take the time or correctly interpret the information available to realize that Adele was a person with mental illness and developmental delays. Certainly the Jail administration has violated the Montana statute requiring jails to screen inmates charged with minor crimes for diversion since the Jail had adopted no policies or adequate screening tools to do so, nor has it trained its staff to do adequate mental health screening. The officers on duty and its SDO violated numerous Jail policies and procedures including use of force, use of restraint chairs, and use of OC. There is also serious concern whether the SDO violated Montana statutes prohibiting assault against inmates.

These problems are symptomatic of the issues that currently face the Sheriff's Department. Inadequate training and lack of appropriate oversight leads to erroneous decisions that harm inmates. If the State can serve its prisoners without use of restraint chairs and prohibits their use in local detention facilities, viable alternatives exist for safely controlling and maintaining potentially violent inmates or inmates with mental illness without their use. As this case illustrates, having the restraint chair and pepperball gun available, may lead some staff to rely on equipment before utilizing less intrusive and less forceful methods of calming disruptive, agitated, or mentally ill inmates.

RECOMMENDATIONS

There are five areas where the Sheriff's Department can improve its ability to identify, divert and humanely treat people with mental illness and developmental disabilities who are brought to the Jail as detainees.

1. Screening, Booking and Information Sharing

a. The Jail must develop procedures and tools to comply with the statutory mandate to screen all inmates for

mental illness. The Jail will require validated diversion screening tools to identify people with mental illness and develop agreements with mental health providers to accept inmates so identified who are charged with minor misdemeanors. This evaluation must occur immediately upon detention or as soon thereafter as practical.

b. If a detainee is brought into the Jail in an agitated state that makes it unfeasible to book the person immediately, the detainee must still be asked a series of questions to determine whether the detainee is a person with mental illness or developmental delay, is suicidal, or under the effects of drugs or alcohol. The detainee will also be asked about any medical conditions including asthma, heart conditions or high blood pressure, which would affect decisions regarding use of force.

c. If a detainee is too combative, struggling too much, or refuses to respond, as a first choice the detainee will be placed in a cell until calmer.

d. If a detainee is restrained in a restraint chair after all reasonable alternatives have been tried, at every check the SDO will ask the series of questions regarding mental illness, suicidality, etc., until the person is able to answer the questions or is calm enough to be released and booked.

e. The Jail will find or develop, in conjunction with the Diversion Committee, a validated diversion tool which will be used at every booking to screen and evaluate all inmates for mental illness, suicidality, developmental delays and other disabilities.

f. The booking or receiving officers will obtain information from the transport officers to determine whether the detainee has exhibited any abnormal behavior during transport, or whether the detainee is known to the transporting officers as a person with mental illness, developmental delays or other disabilities and include this information on the booking form.

g. The Jail will compile and make available on its computer system a list of all persons transported by the Sheriff's Department to Montana State Hospital, Montana Developmental Center, or Providence Center on emergency detention or for commitment and all transports to the local emergency rooms for mental health evaluations or treatment. This list will be updated daily and made available to the booking officers so all new detainees can be checked against the list to determine whether he or she has a history of mental illness or developmental disability.

h. The booking officer must make a visual inspection of the detainee to determine whether he or she has any

obvious physical or mental disabilities.

i. Any information obtained from the visual inspection, booking, interview or screening responses given to the form questions that indicates the detainee may have a mental disability, will be (a) recorded on the form, and (b) a supervisor notified. This information will be immediately available to any booking officer when booking the person into the Jail. The booking officer will always check to determine whether the Jail has previous contacts with the detainee which would alert the Jail staff that the person has a mental illness, developmental disability or other disability, and what, if any, accommodations are required to maintain the person's health and safety while in the Jail.

j. If the detainee is charged with a minor crime involving little or no injury to persons or property, the shift supervisor will call a MHP to evaluate the detainee for mental illness or developmental disabilities to determine whether the person requires commitment and to divert the detainee from the criminal justice system.

k. Every inmate will be screened, booked, and evaluated within two hours of arrival unless exceptional circumstances exist. Such exceptional circumstances shall be documented in the inmate's file in lieu of booking. Exceptional circumstances include if the inmate is intoxicated to the point of being unable to cooperate or so agitated that the inmate is unable or unwilling to communicate about the booking and screening process. If an inmate is unable to be screened, evaluated, and booked within 24 hours, the inmate shall be seen by a MHP within that time unless the inmate is too intoxicated to communicate effectively.

l. If after a detainee is booked, Jail personnel suspect that a detainee may have a mental disability, he or she will immediately notify the shift supervisor and the nurses who shall perform the steps set forth in these recommendations. Other than for a psychiatric emergency, only a qualified physician or psychiatrist shall determine the treatment needs of a mentally disabled detainee.

m. If the questions reveal or the detention staff are otherwise aware that a detainee receives support and therapeutic services from the Western Montana Mental Health Center, Winds of Change, AWARE, ORI, or other community providers of mental health or developmental disability services, the Jail staff will immediately notify the provider that the detainee is at the Jail.

n. If it is determined that the person has a mental disability and has committed a crime ineligible for diversion, the

liaison, as designated by the Sheriff, between the Jail and the designated court will notify the mental health court coordinator.

2. Medical Clinic

a. The shift supervisor must direct the detainee with mental illness to the medical clinic for further screening in the following circumstances:

(a) if the person if charged with something other than a minor crime; or
(b) the MHP determines
(i) the person has a mental illness or developmental disability but does not need commitment, or
(ii) the person's disability involves something besides mental illness or developmental disabilities.

b. The medical clinic must complete a secondary questionnaire to elicit additional information as to the patient's disability status and whether necessary accommodations are required to meet the person's needs in the Jail. The medical clinic shall maintain at least one nurse per shift with special training in working with people with mental and developmental disabilities.

c. If, upon further evaluation, the nurse determines the person may have a mental or developmental disability unnoticed by the detention staff, the nurse will direct the detainee to a psychiatrist, doctor, or nurse practitioner with special training in working with people with mental illness and developmental disabilities retained by the Jail for the purposes of providing mental health consultations, examinations and treatment decisions.

d. If a detainee is transferred from a psychiatric hospital to Jail, medical staff will make reasonable efforts, including exercise of the right of jailers to obtain mental health information, to get the necessary records to continue the detainee's treatment at the time the detainee arrives at the Jail. The existing treatment plan will be followed by the Jail until another treatment plan is prescribed by an appropriate physician or psychiatrist.

e. The ratio of medical staff to inmate/detainee ratio shall not be reduced, and all practical efforts will be made to replace medical staff and consultants who stop working for the facility.

f. Nurses and MHPs will be scheduled between the hours of 7:00 a.m. and 10:00 p.m. In addition, MHPs and a nurse will be on-call for the remainder of the day. There will be nurse and MHP coverage every Saturday, Sunday and holiday to distribute psychotropic medications and do mental health evaluations, medical evaluations, and other

services recommended herein. There will be at least one physician or psychiatrist with additional training and experience in psychiatric and developmental disabilities available 24 hours a day for the detention staff to call to discuss necessary responses to psychiatric or medical emergencies and who may come to the Jail as needed for evaluation of emergency medication, restraint or seclusion.

g. Only nurses will distribute psychotropic medications and only appropriately licensed clinicians will proscribe psychotropic medications. Nurses will maintain the medical records, note each time medication is given, note any significant physical or behavioral observations in the detainee's medical records, and will report any problems to a treating physician, nurse practitioner, or psychiatrist. If a detainee refuses medication, it will be documented in the file. The detainee will continue to be offered psychotropic medications after his or her refusal and the detainee will be referred to his or her treating psychiatrist as soon as possible, but no later than 24 hours or upon the next business day, whichever occurs first. If a detainee cheeks or otherwise accumulates medication or inappropriately uses medication, such activity will be noted in his or her file, additional precautions shall be observed when offering medication and medication will continue to be offered as prescribed.

h. A psychiatrist will regularly evaluate the detainees who are on psychotropic medications to recommend whether or not the medication needs are being adequately met or if changes are necessary.

i. If a detainee is determined through the screening process to be mentally disabled, the detainee will be classified for housing pursuant to instructions given by the doctor who is prescribing the treatment plan. If the doctor determines the individual needs to be isolated from the general population for protection of the detainee or other inmates, that person will be detained in a segregated unit but will be provided ample opportunity to leave his or her cell for the number of hours recommended by his or her treating clinician. Isolation aggravates the symptoms of mental illness and causes skills to deteriorate in people with developmental delays, therefore, these conditions will not be used to curtail opportunities for recreation, socialization or physical and mental exercise.

j. All detainee requests for treatment will be documented and included in the medical files and referral of such requests will be made to medical staff.

k. If a detainee is transferred from the Jail to a psychiatric hospital, prison, prerelease center, or other facility, medical staff will make reasonable

efforts to transmit, with the detainee, current treatment plans, and relevant medical records to the new facility. In any event, medical records shall be transmitted within three working days.

3. Training

a. Jail staff will be trained in how to effectively use the screening tools identified or developed by the Diversion Committee.

b. Jail staff will be trained in how to recognize and effectively respond to a psychiatric emergency. In a psychiatric emergency, the Jail personnel will notify the shift supervisor who will contact the on-call MHP to determine what type of intervention is most appropriate. If the on-call MHP is not immediately available or there is a realistic possibility of immediate harm to the person or others, the staff may use the minimal amount of force and restraint necessary to defuse or control the situation, starting with calmly talking to the person, calling a nurse to offer calming medication, then moving up the scale of use of force considering the criteria set forth in the Jail policies and procedures manual. As soon as the detainee desists from aggression or threatening self-harm, the amount of force used will decrease.

c. Once the immediacy of harm is under control, the Jail staff will immediately call the MHP and the nurse on call to evaluate the detainee's mental status and to evaluate whether the detainee has suffered any injury. The MHP will determine whether a physician or psychiatrist should be called to provide medical support. The specific behaviors that predicated intervention, the specific procedures considered, and why they were used will be recorded in the detainee's medical file. The nurse will offer calming medication.

d. All Jail staff will undergo training in the procedures described above before they begin working. Training will address the use of force continuum as it applies to people with disabilities emphasizing de-escalation techniques when a person is responding, as well as the criteria for increasing or decreasing use of force as established in the Jail policies and procedures manual. Retraining in use of force policies will occur no less than every 12 months.

e. Training will address proper restraint of detainees with mental illness and alternatives to restraint. All staff will receive at least 8 hours initial training and thereafter 4 hours of training per year in screening, suicide prevention, side effects of psychotropic medications, and identification of mental disability in classes conducted by an appropriate psychiatric training facility.

f. Specific training, policies, and protocols regarding the use of the pepperball gun and OC will be developed in conjunction with the Diversion Committee. This training, policies and protocols will be maintained in written format and will emphasize the necessity to learn whether a detainee has health conditions which may make the use of these types of force lethal. Such protocols shall include a requirement that the situation must be evaluated before the pepperball gun or other similar devices are brought into use.

g. Jail staff will be trained in how to evaluate and report abuse or neglect of detainees with developmental disabilities or elders as required by Montana statute. In addition, Jail staff will be trained to report such abuse or neglect to Disability Rights Montana.

4. Psychiatric and Other Resources

a. The Jail will enter into a contract with an appropriate resource for 24 hour on-call coverage by MHPs.

b. The Jail will enter into a contract with an appropriate resource for 24 hour on-call coverage by a psychiatrist.

c. The Jail will enter into a contract with an appropriate resource for training by MHPs regarding the criteria for commitment for persons with both mental illness and developmental disabilities.

d. The Jail will enter into a contract with an appropriate resource for training conducted by a psychiatrist for the training noted in Section C above.

e. The Jail will contract with an appropriate mental health provider to obtain training in how to reduce the use of seclusion and restraint when presented with a person with a mental illness.

5. Citizens Oversight Committee

a. The Sheriff's Department will collaborate with the WSAA, the Diversion Committee, the County Attorney and City Attorney offices and the State Office of the Public Defender, and other stake holders to establish a committee made up of interested citizens to whom inmates and citizens may bring concerns regarding the operation of the Jail, the treatment of inmates and other matters arising out of the care, health and safety of inmates at the Jail. This Citizens Oversight Committee will be formed following the recommended practices established by NIC, ACA, or other municipalities in the United States.

Attachments

civil rights protection & advocacy system for montana

disability rights montana

formerly Montana Advocacy Program

October 8, 2008

Mike McMeekin, Sheriff & Coroner
Missoula County Sheriff's Department
200 West Broadway
Missoula, MT 59802

Re: [redacted]

Dear Sheriff McMeekin:

Disability Rights Montana, is a private, non-profit civil rights organization designated by the Governor of Montana as the State's protection and advocacy system for people with disabilities, including people with developmental disabilities and mental illness under Montana Code Annotated § 53-21-169, 42 U.S.C. § 10801 et seq., and 45 C.F.R. § 51. Disability Rights Montana is legally charged to protect the rights of people with developmental disabilities and/or mental illness through activities to ensure the enforcement of the Constitution and Federal and State Statutes, under 42 U.S.C. § 10801(b)(2)(A). Disability Rights Montana is authorized to pursue legal means to achieve enforcement under 42 U.S.C. § 10807.

Disability Rights Montana investigates abuse and neglect of residents at publicly-funded institutions such as the Missoula Detention Center. As you may know, [redacted] was in custody at the Missoula Detention Center on July 1, 2006.

In the course of our investigation, Disability Rights Montana uncovered the information contained in the draft report accompanying this letter. It is one of the functions of Disability Rights Montana to report to governmental agencies, and to the public, conditions or circumstances which burden or hinder the free exercise of civil rights by persons with disabilities. The enclosed is such a report. We have forwarded it to you to give you an opportunity to provide any information that may contradict the assertions or conclusions in the report. We will be finalizing the report in the coming weeks and will incorporate comments we receive from you if you provide them prior to October 20, 2008. Once this report is final, it is our intent to release it to the public.

1022 Chestnut Street Helena, Montana 59601 | Voice/TDD 406-449-2344 Toll-free 800-245-4743 Fax 406-449-2418
advocate@disabilityrightsmt.org | www.disabilityrightsmt.org

In the report, we have not included Ms. [redacted]'s name, but instead used the fictitious name of Adele. If you have any comments or questions about the report or its distribution, please feel free to contact me.

Sincerely,

DISABILITY RIGHTS MONTANA

Bernadette Franks-Ongoy
Executive Director

MISSOULA COUNTY

SHERIFF'S DEPARTMENT
200 W. BROADWAY ST.
MISSOULA MT 59802-4292

MIKE MCMEEKIN
Sheriff & Coroner
JERRY CREGO
Undersheriff

Monday, 13 October, 2008

Bernadette Franks-Ongoy, Executive Director
Disability Rights Montana
1022 Chestnut Street
Helena MT 59601

Dear Director Franks-Ongoy:

Thank you for providing me the opportunity to respond to your organization's report concerning the July, 2006, incarceration of [redacted] at our detention facility.

Nine days (from our receipt of your letter) is clearly insufficient to research, write and submit our response to such a lengthy and damning indictment. In order to properly present such a response, I will need some additional information and/or clarifications of your draft; those information needs are listed below. Once your reply has been received, we will prepare and submit a response as promptly as possible. I would request that completion of your report be delayed until the response process is complete.

1. Please provide documentation of any attempts by any DRM staff member to obtain information from us relating to [redacted] or the operation of our detention facility (*report footnote #3, page 3*). According to our files, the information Ms. Volkerts requested was provided to the Missoula County Attorney's Office in August of 2006 for review, redaction if necessary, then submittal to M.A.P. (now DRM). Did you receive those materials from Mr. Sehestedt?

2. Please explain the facts upon which you base the statement that Ms. [redacted] is, or was in July of 2006, "well known" to the Sheriff's Department.

PHONE: (406) 523-4810 or 721-5700 or (AFTER HOURS) 829-4000 FAX: (406) 721-8575 or (24 HR. @ JAIL) 829-4080

3. Please explain the apparent contradiction between the report's detailed recounting of sallyport and remand area "video evidence" (*pages 8 and 9*) and the statement that the "Sheriff's Department has consistently delayed or refused to provide information to the extent that at the time of this report essential evidence....including video tapes of Adele's arrival at the Jail...has never been provided." ("*Complicating Factors*" *footnote at page 3*).

4. The report seems to use "senior detention officer (SDO)" and "shift supervisor" synonymously (*pages 9, 16, etc.*)? Our senior detention officers are not supervisors and use of that term makes it difficult to understand your interpretation of the decision making process in this context. Are you, in fact, referring to [former] Sergeant Sorini?

5. Please explain the facts upon which you base the statement that "the staff on duty at the Jail knew that her behavior was the result of mental illness and that she belonged in a hospital bed." (*page 12, with foundation language on preceding page*).

6. Please explain the facts upon which you base the statement that Ms. [redacted] has a medical condition "which could cause injury or death should she be exposed to pepper spray." (*page 14*). Specifically, what accredited medical research did you rely upon to reach that conclusion?

7. To who does your use of the term "potential aggressors" on page 15, column two, refer?

8. Please describe, in detail, the "inappropriate spending on unnecessary resources" alleged on page 16; to include expenditure descriptions, amounts of funds expended on each, exact or approximate dates of the expenditures and how those expenditures "starve[ed] the Jail of money for appropriate training."

9. Please clarify whether the "Recommendations" section of your report (*pages 17-23*) is, in fact, a series of recommendations that you believe we <u>should</u> follow or a series of mandates that we <u>will</u> follow, as is implied by the language of each recommendation. If they are mandates, please identify DRM's independent legal authority to order such actions.

10. Please describe with particularity the professional detention and/or corrections officer training and related experience in that capacity for each of the report's authors.

Since Ms. [redacted] was brought to our facility from the institution that we rely on for pre-incarceration assessments and evaluations, it would be helpful for me to have a copy of your report on St. Patrick Hospital before I draft my response; at least the portions that relate to July 1st, 2008.

Sincerely yours,

Michael R. McMeekin

cc: Undersheriff Crego
Captain Susan Hintz, Commander, Detention Division
Charles McNeil, Counsel of Record

October 27, 2008

Sheriff Michael McMeekin
Missoula County Sheriff's Department
200 West Broadway
Missoula, MT 59802-4292

Sent by U.S. Mail and via e-mail

Re: Adele Report

Dear Sheriff McMeekin

I received your response to the Adele Report and note that none of your comments deny any factual allegations of the report. Disability Rights Montana is not pursuing this investigation with the intent of litigation, therefore the interrogatory type of information you are requesting is not necessary for you to supply a response. This report does not contain any information that is new or unexpected. You are familiar with the facts or circumstances surrounding all of these events. If you provide verifiable substantive comments by October 31, 2008, we will make every effort to include them in the Report. The report will be released to the public on November 3, 2008.

In an effort to clarify any misconceptions, I note the following. For ease of comparison, I respond to your comments/questions in the order raised.

1. You request "documentation" of our attempts to obtain information. For instance, Ms. Volkerts orally requested copies of both the Sally Port video tapes and the audio tape located near the shower area from Mike Sehestedt during her interview with SDO Sorini on August 31, 2006. When she did not receive the tapes, she orally requested the audio and video tapes from you during your interview with her on September 19, 2006. According to her notes of that interview, you indicated that the Sally Port videos were in some way unviewable due to a sequencing or timing interface, but you assured her you would resolve this issue and provide the missing tapes. In an e-mail dated September 20, 2008, to Mark Foss, you memorialized the discussion and requested Mark Foss obtain the Sally Port videos, shower audio tape, and a list of times Ms. [redacted] had been at the facility. She did not receive the requested information.

In a letter dated October 24, 2006, to Mike Sehestedt, Ms. Volkerts again requested the tapes. In that letter, she also requested Ms. [redacted]s medical records and copies of her former records and bookings at the Detention Center. She did not receive them.

In her email to you dated January 19, 2007, she reiterated her request for, among other things, the audio tape from the shower area, all information regarding jail staff knowledge of Ms. [redacted]s disabilities including pre-Spectrum medical records, the FBI investigative report, and copies of video training tapes for the use of pepper spray and the pepper ball gun. Again none of this information was provided.

You are well aware of our interviews with SDO Sorini, Capt. Hintz, yourself, NP Judy Munsell, and several inmates who claimed to be witnesses to the pepperball shooting of Ms. [redacted]. You and your attorney curtailed our ability to interview the rest of the A Team. We also interviewed Ms [redacted] and various provider staff and relatives regarding the incidents leading up to and the events subsequent to her pepperball shooting. In addition, we interviewed both former and then current detention staff who knew or knew of Ms. [redacted] and voluntarily provided additional information. We reviewed the hand held video recording of the incident as well as the Remand and Booking area video tapes, SDO Sorini's report, and various other documents you provided.

Our legal authority to access this information was provided to you in Ms. Volkerts' letter dated August 3, 2006, and her letters to Mike Sehestedt dated August 28, 2006, September 14, 2006, and October 24, 2006.

2. Please see my response to your comment ¶ 5. I believe this information is contained within the body of the report, e.g. the second full paragraph on Page 8.

3. SDO Sorini's report alleges that Ms. [redacted] arrived out of control and required all the officers present to control her. Since he stated he was not in the sally port, or even in the remand area when she arrived, he would have only seen her entering the remand area quietly. The evidence available refutes his report. Nonetheless, you failed to provide the sally port videos, among other evidence, after repeated requests.

SDO Sorini's report indicates Ms. [redacted] was restrained for 44 minutes. There is no independent confirmation of how long it took for her to be decontaminated as that information is neither in written records nor on video tape. However, the audio tape at the entrance to the shower area should have established how long she waited at or near

the shower area before she could decontaminate. After repeated requests, both oral and written, that information has never been provided.

4. We will change all references of Shift Supervisor to Senior Detention Officer in response to your comment at ¶ 4.

5. With regard to ¶ 5 (and ¶ 2, as noted above), regarding what the detention staff knew or didn't know about Ms. [redacted] or her mental illness, your employees are imputed with knowledge of what is in your own records. Even the briefest review of her history with the Sheriff's Department would have revealed she had been taken by Sheriff Department staff to Montana State Hospital at least twice for commitment. She had been incarcerated at least four times previously at the Missoula Detention Center on minor charges. Other staff who had worked with her at the detention center stated it was obvious that she suffered from mental illness and/or mental retardation. All this information is set forth in the report.

6. Ms. [redacted] has asthma, which when combined with pepper spray or OC can lead to severe asthma attacks. Since Ms. [redacted] has been incarcerated at least four times previously, one expects that competent Detention Center medical history records would reveal her chronic illnesses. Your own Policy 7.24 requires inquiry into and consideration of the person's health issues when OC is contemplated or used. There is no evidence any inquiry was made: That's the point.

   According to the notes by the RN who visited Ms. [redacted] briefly after she was shot, the nurse failed to ask any questions regarding asthma or high blood pressure, both of which have been connected to deaths in the use of OC. See the U.S. Dept of Justice, Research for Practice, "The Effectiveness and Safety of Pepper Spray."

7. The sentence to which you have objected is unclear, and we will remove it.

8. The basis for our conclusion that Detention staff had inadequate money for training is based on how Ms. [redacted] was treated in this situation and information by former staff regarding the lack of training resources. Trained staff should have treated Ms. [redacted] very differently: first, by following MCDF policies regarding restraint and use of force; second, by calling for medical assistance to offer medication to calm her; and third, by using the mental health staff available or on call to respond to her alleged suicidality. The reference to inappropriate spending on unnecessary resources is not directly related to the investigation and will be removed.

9. In response to your ¶ 9, our recommendations are, as titled, recommendations. We may rewrite this section to clearly reflect these as recommendations. The substance will not change.

10. Your request for the professional detention officer training of our investigators is irrelevant: the Adele Report is not a Complaint. Disability Rights Montana is a civil rights advocacy and protection agency, and our investigator is a trained civil rights attorney who has been involved in issues relating to inmates, jails, and law enforcement in a variety of settings.

The Adele Report is specific to the facility which you supervise. Regardless of what happened at St. Patrick Hospital, your officers used excessive force against a helpless woman with disabilities. The Adele Report stands as an independent document. As a courtesy, when the St. Patrick report is complete, we will provide you with a copy. Publication of the Adele Report will not wait for the completion of the St. Patrick Hospital report.

I look forward to your response.

Sincerely yours,

DISABILITY RIGHTS MONTANA

Bernadette Franks-Ongoy
Executive Director

Bernie Franks-Ongoy

From: Mike McMeekin [mmcmeeki@co.missoula.mt.us]
Sent: Monday, October 27, 2008 8:49 PM
To: Bernie Franks-Ongoy
Subject: Re: Responses to your October 13 letter

Bernie,
I'm having e-mail problems. Did you receive my reply (either once or twice) sent a few minutes ago indicating that I'm at an out of state school all week & can't submit the response by Friday??

Thanks,
mike

Bernie Franks-Ongoy

From: Bernie Franks-Ongoy
Sent: Tuesday, October 28, 2008 9:36 AM
To: 'Mike McMeekin'
Subject: RE: Responses to your October 13 letter

Hi Mike,
This is the only e-mail I received.
Being that you are out of state, we will extend the time for you to respond to close of business Friday, November 7. The report will then be released to the public on Monday, November 10.

Take care, Bernie

-----Original Message-----
From: Mike McMeekin [mailto:mmcmeeki@co.missoula.mt.us]
Sent: Monday, October 27, 2008 8:49 PM
To: Bernie Franks-Ongoy
Subject: Re: Responses to your October 13 letter

Bernie,
I'm having e-mail problems. Did you receive my reply (either once or twice) sent a few minutes ago indicating that I'm at an out of state school all week & can't submit the response by Friday??

Thanks,
mike

Bernie Franks-Ongoy

From: Mike McMeekin [mmcmeeki@co.missoula.mt.us]
Sent: Friday, November 07, 2008 11:34 AM
To: Bernie Franks-Ongoy
Cc: Charles E. McNeil
Subject: Response to [redacted] report

Bernie,

I have not had an opportunity to work on the response this week. Will do my best to complete it this weekend, with an e-mail copy to you by Monday followed by a signed original in the mail.

Have a good weekend,
mike

MISSOULA COUNTY

SHERIFF'S DEPARTMENT
200 W. BROADWAY ST.
MISSOULA MT 59802-4292

MIKE MCMEEKIN
Sheriff & Coroner

JERRY CREGO
Undersheriff

Sunday, 09 November, 2008

Bernadette Franks-Ongoy, Executive Director
Disability Rights Montana
1022 Chestnut Street
Helena MT 59601

Dear Director Franks-Ongoy:

Thank you for agreeing to make the changes noted in numbered subparagraphs 4, 7, 8 and 9 of your October 27th reply to my earlier request for clarifications.

The first sentence of your reply describes my October 13th letter as a "response to the Adele report" and the second sentence states that since you are not pursuing litigation, the interrogatory type of my request was not necessary. I disagree. My letter was clearly intended as a request for clarification of several points in DRM's draft report; never as a response. The questions were necessary in order for me to prepare our response.

Based on the language of your October 27th letter in which you will "make every effort" to include "verifiable substantive comments" from us in your report, it would appear you do not intend to attach our complete response. For that reason, we are preparing a comprehensive response and will independently disseminate it to anyone asking us about the DRM report. You will be provided with a copy as soon as it is completed and approved by counsel.

Please mail me a copy of your report's final version so that our response can be accurate in references to points and page numbers; an e-mail with the report attached will speed up the process. Thank you.

Sincerely yours,

Mike

Michael R. McMeekin

PHONE: (406) 523-4810 or 721-5700 or (AFTER HOURS) 829-4000 FAX: (406) 721-8575 or (24 HR. @ JAIL) 829-4080